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	ASL510379	A. BUILDING: _____ B. WING _____	10/21/2024

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EVERGREEN PLACE	4114 WEST SPRINGFIELD AVE CHAMPAIGN, IL 61822

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A 000	Initial Comment Complaint Investigation 2468205/IL179090 Complaint can be substantiated.	A 000		
A2030	Section 295.2030 Establishment Contacts This Regulation is not met as evidenced by: Type 2 Violation Section 295.2030 Establishment Contracts a) A contract between an establishment and a resident must be entitled "assisted living establishment contract" or "shared housing establishment contract" as applicable, shall be printed in no less than 12 point type, and shall include at least the following elements in the body or through supporting documents or attachments: 8) A description of any additional services to be provided for an additional fee by the establishment directly or by a third party provider under arrangement with the establishment; 17) A statement detailing the admission and residency termination criteria and procedures as set forth in the Act and this Part; Based on record review and interview, the establishment failed to ensure the establishment contracts with R1 and R2 were followed. The establishment failed to ensure R1 and R2 had service plans completed upon admission and attached to the establishment contracts. The establishment failed to ensure R1 and R2 received assistance required upon admission to the establishment.	A2030		

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A2030	Continued From page 1 Findings include: 1. R1 was admitted to the establishment on 08-22-2024. R1's diagnoses include Chrohn's disease, mild cognitive impairment, and essential hypertension. R1's Assisted Living Establishment Contract, signed and dated 08-21-2024 by R1 and an establishment representative, contains documentation under Section "A. Services" that the service plan is attached to this contract and is made a part of the contract. Further documentation is that the rate includes all services agreed to in the service plan. There is no service plan attached to this contract. R1's 08-28-2024 service plan includes documentation that R1 receives medication supervision. R1's August 2024 medication supervision record was reviewed. The record only includes documentation for August 31st morning medications and documents "see progress notes." Progress notes for this date were not provided to this Surveyor, as requested on 10-17-2024 during the investigation and on 10-21-2024 by electronic mail; both requests were made to E1, Executive Director. R1's September 2024 medication supervision record was reviewed. The record includes documentation that R1 received observation of the morning medications on the 1st, 3rd-7th, 9th-12th. New documentation for observation of the morning medications was started on the 13th, and documentation includes that the morning medications were observed from the 13th through the 30th. Documentation of observation of the	A2030		

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A2030	Continued From page 2	A2030		

evening medications is included for the 3rd through the 30th with R1 marked out of building and hospitalized on the 1st and 2nd.

R1's 08-15-2024 physician signed medication list includes documentation of all medications to be taken daily except for the albuterol inhaler which is to take every four to six hours for wheezing/cough or shortness of breath. No other medications were noted to be ordered as needed. The list also contains documentation that R1 is to take loperamide one, two milligram tablet every evening.

R1's electronic medical record contains documentation of R1 being in the hospital 09-01-2024 to 09-02-2024 with a diagnosis of COVID 19.

R1's 10-02-2024 progress note contains documentation that R1 was taken to the local emergency room by R1's son due to constipation and not feeling well.

R1's August 2024 documentation of tasks completed contains documentation starting on 08-27-2024 and continuing through 08-31-2024. There is no documentation of tasks being completed from date of admission on 08-22-2024 through 08-26-2024.

R1's September and October 2024 documentation of tasks completed were both reviewed. October 2024's documentation contains documentation of tasks such as bathing/showering, meal escorts, and well-being checks have documentation starting on the 1st and continues through to the 21st. R1's October 2024 medication supervision records contain documentation of R1 being out of the building or

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A2030	Continued From page 3	A2030		

in the hospital starting the evening of 10-02-2024 and continues through the 21st. It is not clear why tasks were being documented as getting done in October 2024 for R1 when R1 was in the hospital.

2. R2 was admitted to the establishment on 08-22-2024. R2's diagnoses include malignant neoplasm right bronchus/lung and hypertension.

R2's 08-21-2024 Assisted Living Establishment Contract, signed and dated on 08-21-2024 by R2 and an establishment representative, contains documentation under Section "A. Services" that the service plan is attached to this contract and is made a part of the contract. Further documentation is that the rate includes all services agreed to in the service plan. There is no service plan attached to this contract.

R2's 08-28-2024 service plan includes documentation that R2 receives medication supervision.

R2's August 2024 task documentation was reviewed. The documentation starts on 08-27-2024 and continues through the 31st. R2's September and October 2024 task documentation was also reviewed. There is no documentation of tasks being completed from date of admission on 08-22-2024 through 08-26-2024.

R2's 08-15-2024 physician signed medication list includes albuterol inhaler, hydrocodone-acetaminophen, odanasetron, and prochlorperazine with documentation of these medications "as needed." All other medications were documented on a scheduled basis.

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A2030	Continued From page 4 R2's 10-06-2024 progress note includes documentation that R2 reported having emesis three times that morning and not wanting to take the offered medication for nausea but wanting to wait for R2's daughter. R2's 10-08-2024 progress note includes documentation that R2's daughter reported to the establishment that R2 was admitted to the hospital due to confusion. R2's 10-13-2024 physician orders contain documentation that the scheduled senna was discontinued and senna was now ordered every 24 hours as needed. R1 and R2 were not in the establishment or available for interview during this investigation. On 10-17-2024, E1, Executive Director and Wellness Director, states that R1 and R2 were both recently admitted and that both residents had physician signed orders that were followed. E1 states that R1 ended up in the hospital with a fecal impaction. E1 further states that the medications have to do with Immodium and Senna and that she explained to the residents how this occurred. On 10-23-2024, E1, states in electronic mail that the previous Wellness Coordinator had opened the Standardized Interview on 08-21-2024, completed it on 08-22-2024, and failed to lock it; which is what triggers the service plan. E1 states that when it was locked on 08-28-2024, that it triggered the service plan and that this is why the dates do not correspond. E1 also states that staff were informed of R1 and R2's admission and that tasks were communicated to caregivers and nurses. E1 states that she does not have any	A2030		

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A2030	Continued From page 5 other documentation on this to provide. On 10-24-2024, at approximately 12:15pm, E2, Licensed Practical Nurse, states that none of the staff even knew R1 and R2 were in the building or admitted to the establishment for two days and that there was no verbal communication from management about this. E2 states that there was nothing in the electronic records regarding either R1 or R2. E2 states that the service plans show the date it was started on and the date they were created on. E2 showed this Surveyor in the electronic records R2's service plan and where the started and created dates are located. Both dates on R2's service plan are documented as 08-28-2024. E2 printed R2's service plan that was shown in the electronic records. E2 states that both residents are now discharged from the establishment. E2 states that R1 received the immodium for another week after it was discontinued; that the pharmacy put the pill in the packs and caregiver staff still gave the meds. E2 further states that a week went by with the immodium in the packs before it was removed. E2 states that E1 is to check the medications in the packs from pharmacy and that she doesn't think this was done. E2 states that she found this out from caregiver staff afterwards, about the immodium being given. E2 states that the nurses keep the pharmacy packing slips and provided a copy dated 09-19-2024. E2 states that the pharmacy sends two weeks worth of medications for residents. The09-19-2024 packing slip documents that an "anti-diarrheal tablet of 2mg: was placed in R1's med packs with 14 of the tablets being sent to the establishment. E2 printed a copy pf R2's "Standard Interview Assessment" that contains documentation of being signed by E3 on 08/28/2024. E2 also printed out the signed orders for R1 dated	A2030		

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A2030	Continued From page 6 09/03/2024 by the physician that shows where the physician documented immodium is to be changed to as needed.	A2030		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Type 2 Violation Section 295.4010 Service Plan a) Based on the Physician's assessment and establishment evaluation (see Section 295.4000), a written service plan shall be developed and mutually agreed upon by the establishment and the resident. (Section 15 of the Act) The establishment shall respect and accept the resident's choices regarding the service plan. d) The service plan, which shall be reviewed annually, or more often as the resident's condition, preferences, or service needs change, shall serve as a basis for the service delivery contract between the provider and the resident (see Section 294.2030). (Section 15 of the Act) Based on record review and interview the establishment failed to ensure R1 and R2 had service plans developed upon admission. Findings include: 1. R1 was admitted to the establishment on 08-22-2024. R1's diagnoses include Chrohn's disease, mild cognitive impairment, and essential hypertension.	A4010		

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A4010	Continued From page 7 R1's Assisted Living Establishment Contract, signed and dated 08-21-2024 by R1 and an establishment representative, contains documentation under Section "A. Services" that the service plan is attached to this contract and is made a part of the contract. Further documentation is that the rate includes all services agreed to in the service plan. There is no service plan attached to this contract. R1's 08-28-2024 service plan includes documentation that R1 receives medication supervision. R1's August 2024 medication supervision record was reviewed. The record only includes documentation for August 31st morning medications and documents "see progress notes." Progress notes for this date were not provided to this Surveyor, as requested on 10-17-2024 during the investigation and on 10-21-2024 by electronic mail; both requests were made to E1, Executive Director. R1's September 2024 medication supervision record was reviewed. The record includes documentation that R1 received observation of the morning medications on the 1st, 3rd-7th, 9th-12th. New documentation for observation of the morning medications was started on the 13th, and documentation includes that the morning medications were observed from the 13th through the 30th. Documentation of observation of the evening medications is included for the 3rd through the 30th with R1 marked out of building and hospitalized on the 1st and 2nd. R1's 08-15-2024 physician signed medication list includes documentation of all medications to be taken daily except for the albuterol inhaler which	A4010		

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A4010	Continued From page 8	A4010		

is to take every four to six hours for wheezing/cough or shortness of breath. No other medications were noted to be ordered as needed. The list also contains documentation that R1 is to take loperamide one, two milligram tablet every evening.

R1's electronic medical record contains documentation of R1 being in the hospital 09-01-2024 to 09-02-2024 with a diagnosis of COVID 19.

R1's 10-02-2024 progress note contains documentation that R1 was taken to the local emergency room by R1's son due to constipation and not feeling well.

R1's August 2024 documentation of tasks completed contains documentation starting on 08-27-2024 and continuing through 08-31-2024. There is no documentation of tasks being completed from date of admission on 08-22-2024 through 08-26-2024.

R1's September and October 2024 documentation of tasks completed were both reviewed. October 2024's documentation contains documentation of tasks such as bathing/showering, meal escorts, and well-being checks have documentation starting on the 1st and continues through to the 21st. R1's October 2024 medication supervision records contain documentation of R1 being out of the building or in the hospital starting the evening of 10-02-2024 and continues through the 21st. It is not clear why tasks were being documented as getting done in October 2024 for R1 when R1 was in the hospital.

2. R2 was admitted to the establishment on

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A4010	Continued From page 9 08-22-2024. R2's diagnoses include malignant neoplasm right bronchus/lung and hypertension. R2's 08-21-2024 Assisted Living Establishment Contract, signed and dated on 08-21-2024 by R2 and an establishment representative, contains documentation under Section "A. Services" that the service plan is attached to this contract and is made a part of the contract. Further documentation is that the rate includes all services agreed to in the service plan. There is no service plan attached to this contract. R2's 08-28-2024 service plan includes documentation that R2 receives medication supervision. R2's August 2024 task documentation was reviewed. The documentation starts on 08-27-2024 and continues through the 31st. R2's September and October 2024 task documentation was also reviewed. There is no documentation of tasks being completed from date of admission on 08-22-2024 through 08-26-2024. R2's 08-15-2024 physician signed medication list includes albuterol inhaler, hydrocodone-acetaminophen, odanasetron, and prochlorperazine with documentation of these medications "as needed." All other medications were documented on a scheduled basis. R2's 10-06-2024 progress note includes documentation that R2 reported having emesis three times that morning and not wanting to take the offered medication for nausea but wanting to wait for R2's daughter. R2's 10-08-2024 progress note includes	A4010		

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A4010	Continued From page 10	A4010		

documentation that R2's daughter reported to the establishment that R2 was admitted to the hospital due to confusion.

R2's 10-13-2024 physician orders contain documentation that the scheduled senna was discontinued and senna was now ordered every 24 hours as needed.

R1 and R2 were not in the establishment or available for interview during this investigation.

On 10-17-2024, E1, Executive Director and Wellness Director, states that R1 and R2 were both recently admitted and that both residents had physician signed orders that were followed. E1 states that R1 ended up in the hospital with a fecal impaction. E1 further states that the medications have to do with Immodium and Senna and that she explained to the residents how this occurred.

On 10-23-2024, E1, states in electronic mail that the previous Wellness Coordinator had opened the Standardized Interview on 08-21-2024, completed it on 08-22-2024, and failed to lock it; which is what triggers the service plan. E1 states that when it was locked on 08-28-2024, that it triggered the service plan and that this is why the dates do not correspond. E1 also states that staff were informed of R1 and R2's admission and that tasks were communicated to caregivers and nurses. E1 states that she does not have any other documentation on this to provide.

On 10-24-2024, at approximately 12:15pm, E2, Licensed Practical Nurse, states that none of the staff even knew R1 and R2 were in the building or admitted to the establishment for two days and that there was no verbal communication from

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A4010	Continued From page 11 management about this. E2 states that there was nothing in the electronic records regarding either R1 or R2. E2 states that the service plans show the date it was started on and the date they were created on. E2 showed this Surveyor in the electronic records R2's service plan and where the started and created dates are located. Both dates on R2's service plan are documented as 08-28-2024. E2 printed R2's service plan that was shown in the electronic records. E2 states that both residents are now discharged from the establishment. E2 states that R1 received the immodium for another week after it was discontinued; that the pharmacy put the pill in the packs and caregiver staff still gave the meds. E2 further states that a week went by with the immodium in the packs before it was removed. E2 states that E1 is to check the medications in the packs from pharmacy and that she doesn't think this was done. E2 states that she found this out from caregiver staff afterwards, about the immodium being given. E2 states that the nurses keep the pharmacy packing slips and provided a copy dated 09-19-2024. E2 states that the pharmacy sends two weeks worth of medications for residents. The09-19-2024 packing slip documents that an "anti-diarrheal tablet of 2mg: was placed in R1's med packs with 14 of the tablets being sent to the establishment. E2 printed a copy pf R2's "Standard Interview Assessment" that contains documentation of being signed by E3 on 08/28/2024. E2 also printed out the signed orders for R1 dated 09/03/2024 by the physician that shows where the physician documented immodium is to be changed to as needed.	A4010		
A5000	Section 295.5000 Medication Reminders, Supervision of Self Med	A5000		

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A5000	Continued From page 12 This Regulation is not met as evidenced by: Type 2 Violation Section 295.5000 Medication Reminders, Supervision of Self-Medication, Medication Administration and Storage c) Supervision of self-administered medication means assisting the resident with self-administered medication using any combination of the following. Supervision of self-administered medication by unlicensed personnel shall be under the direction of a licensed health care professional. 1) Reminding residents to take medication; 2) Confirming that residents have obtained and are taking the dosage as prescribed; 3) Reading the medication label to residents; 4) Checking the self-administered medication dosage against the label of the medication; 5) Opening the medication container for a resident who is physically unable to do so; 6) Confirming that residents have obtained and are taking the dosage as prescribed; and 7) Documenting in writing that the resident has taken (or refused to take) the medication. Based on interview and record review the establishment failed to ensure R1 was provided with supervision of medications as prescribed. Findings include: 1. R1 was admitted to the establishment on 08-22-2024. R1's diagnoses include Chrohn's disease, mild cognitive impairment, and essential hypertension.	A5000		

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A5000	Continued From page 13 R1's Assisted Living Establishment Contract, signed and dated 08-21-2024 by R1 and an establishment representative, contains documentation under Section "A. Services" that the service plan is attached to this contract and is made a part of the contract. Further documentation is that the rate includes all services agreed to in the service plan. There is no service plan attached to this contract. R1's 08-28-2024 service plan includes documentation that R1 receives medication supervision. R1's August 2024 medication supervision record was reviewed. The record only includes documentation for August 31st morning medications and documents "see progress notes." Progress notes for this date were not provided to this Surveyor, as requested on 10-17-2024 during the investigation and on 10-21-2024 by electronic mail; both requests were made to E1, Executive Director. R1's September 2024 medication supervision record was reviewed. The record includes documentation that R1 received observation of the morning medications on the 1st, 3rd-7th, 9th-12th. New documentation for observation of the morning medications was started on the 13th, and documentation includes that the morning medications were observed from the 13th through the 30th. Documentation of observation of the evening medications is included for the 3rd through the 30th with R1 marked out of building and hospitalized on the 1st and 2nd. R1's 08-15-2024 physician signed medication list includes documentation of all medications to be taken daily except for the albuterol inhaler which	A5000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510379	A. BUILDING: _____ B. WING _____	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A5000	Continued From page 14 is to take every four to six hours for wheezing/cough or shortness of breath. No other medications were noted to be ordered as needed. The list also contains documentation that R1 is to take loperamide one, two milligram tablet every evening. R1's electronic medical record contains documentation of R1 being in the hospital 09-01-2024 to 09-02-2024 with a diagnosis of COVID 19. R1's 10-02-2024 progress note contains documentation that R1 was taken to the local emergency room by R1's son due to constipation and not feeling well. On 10-17-2024, E1, Executive Director and Wellness Director, states that R1 and R2 were both recently admitted and that both residents had physician signed orders that were followed. E1 states that R1 ended up in the hospital with a fecal impaction. E1 further states that the medications have to do with Immodium and Senna and that she explained to the residents how this occurred. On 10-23-2024, E1, states in electronic mail that the previous Wellness Coordinator had opened the Standardized Interview on 08-21-2024, completed it on 08-22-2024, and failed to lock it; which is what triggers the service plan. E1 states that when it was locked on 08-28-2024, that it triggered the service plan and that this is why the dates do not correspond. E1 also states that staff were informed of R1 and R2's admission and that tasks were communicated to caregivers and nurses. E1 states that she does not have any other documentation on this to provide.	A5000		

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A5000	Continued From page 15 On 10-24-2024, at approximately 12:15pm, E2, Licensed Practical Nurse, states that none of the staff even knew R1 and R2 were in the building or admitted to the establishment for two days and that there was no verbal communication from management about this. E2 states that there was nothing in the electronic records regarding either R1 or R2. E2 states that the service plans show the date it was started on and the date they were created on. E2 showed this Surveyor in the electronic records R2's service plan and where the started and created dates are located. Both dates on R2's service plan are documented as 08-28-2024. E2 printed R2's service plan that was shown in the electronic records. E2 states that both residents are now discharged from the establishment. E2 states that R1 received the immodium for another week after it was discontinued; that the pharmacy put the pill in the packs and caregiver staff still gave the meds. E2 further states that a week went by with the immodium in the packs before it was removed. E2 states that E1 is to check the medications in the packs from pharmacy and that she doesn't think this was done. E2 states that she found this out from caregiver staff afterwards, about the immodium being given. E2 states that the nurses keep the pharmacy packing slips and provided a copy dated 09-19-2024. E2 states that the pharmacy sends two weeks worth of medications for residents. The09-19-2024 packing slip documents that an "anti-diarrheal tablet of 2mg: was placed in R1's med packs with 14 of the tablets being sent to the establishment. E2 printed a copy pf R2's "Standard Interview Assessment" that contains documentation of being signed by E3 on 08/28/2024. E2 also printed out the signed orders for R1 dated 09/03/2024 by the physician that shows where the physician documented immodium is to be	A5000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A5000	Continued From page 16 changed to as needed.	A5000		