STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	SHL510025	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSISTED LIVING AT SILVER CREEK	1227 WINDING OAKS LN MASCOUTAH, IL 62258

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comment Complaint #2540825 IL165504 Violation Cited: 295.5000 Medication Error	A 000		
A5000	Section 295.5000 Medication Reminders, Supervision of Self Med This RULE: is not met as evidenced by: TYPE 2 VIOLATION Section 295.5000 Medication Reminders, Supervision of Self-Medication, Medication Administration and Storage a) An establishment may provide medication reminders, supervision of self-administered medication, and medication administration as an optional service. b) Medication reminders include: 1) Reminding residents to take pre-dispensed, self-administered medication; 2) Observing the resident; and 3) Documenting whether or not the resident took the medication. 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	A5000		

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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A5000	Continued From Page 1 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 facility failed to ensure residents are free of medication errors in the facility and failed to ensure a check is in place to confirm residents have obtained and received their medications as ordered by the physician. This failure creates a substantial probability of harm to all residents on supervision of self-administered medication services in the facility. Findings include: The Facility List of Residents on Medication Services presented on 2/10/25 documents there are 20 residents on supervision of self-administered medication including R1, one resident on medication reminder and 12 self medicating residents. R1's Medication List dated week of 1/20/25 documents R1 has an order for Carvidopa-levodopa 25-100 milligram (mg) 2 tablets by oral route AM, early afternoon, and PM. R1's Medication Record for January 2025 documents, "1/25/25 Evening meds wasn't in med planner." On 2/10/25 at 12:35 PM, E1 (Executive Director/Licensed Practical Nurse) stated she was not aware R1 did not get her evening medication on 1/25/25. E1 stated that E6 (Former Employee)	A5000		

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A5000	Continued From Page 2 signed the Medication Record that the evening medication was not in its slot but failed to notify her or investigate whether R1 received the medication from another staff. E1 explained that the contracted pharmacy receives the current medication list for each resident who are not self medicating directly from the physician's office, pharmacy prefills medication planners if the family do not fill the planners. E1 stated that when the facility receives the planners on Monday afternoons from the pharmacy the staff who has the medication room key is responsible for checking that all planners have all slots filled and if not, notify E1 of the discrepancy and E1 will get the missing medication from the pharmacy. If it is after pharmacy hours, E1 will direct the staff to use the next day's medication for the same time slot and E1 will pick up the replacement medication as soon as pharmacy opens. On 2/10/25 at 12:05 PM, E2 (Resident Assistant/RA) stated she always inform E1 of any missing medication from the planner, write it was missing at the back of the medication record and E1 will give instructions to use the next day's medication on the same time slot and E1 will take care the medications are replaced. E2 stated she had training what to do for supervised self administered medications. On 2/10/25 at 12:16 PM, E3, RA stated she had attended in service given by E1 not to touch any pills to give to the residents but pour the pills from the planner into a cup or container or the resident's hand, give them water and make sure the resident has taken the medication. On 2/10/25 at 12:40 PM, E4, RA stated she attended inservice on the procedure when assisting residents who are on medication supervision and have explained to residents	A5000		

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A5000	Continued From Page 3 during medication time that she cannot touch the pills and can only pour the pills from the planner into their hands or into a cup and if there are missing pills in the slot to report it to E1 and write that it's missing in the medication record. On 2/10/25 at 1:15 PM, E1 stated she did not know the facility still needs to check the medications in the planners prepared by the pharmacy when the facility receives them. E1 stated she has never checked the medications in the med planners against the resient medication list in the past. E1 stated the pharmacy gets the current physician orders faxed directly to the pharmacy from the physician's office and the facility gets a copy from the pharmacy with each delivery. The facility doesn't get the medication list from the physician's office unless she requests for it. The Facility Policy on Medication Assistance, undated, documents, "B. Supervision of Self-Administered Medication. 2. Open a medication container for a resident who is physically unable to do so. 3. Empty previously set up medication organizer into a cup and place within reach or in resident's hand for them to take orally. Unless their service plan states differently all meds are to be given in the resident's room. 4. Staff may give the resident food or liquids to accompany the med. 5. Observe the resident to ensure they swallow the medication. 6. Immediately document in the medication book that the resident has taken or refused to take the medication. " The policy does not state it has some measure in place to ensure residents on supervision of self-administered medications are taking the right medication as currently ordered by the physician to conform to the state guidelines.	A5000		

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