| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | ASL510494 | A. BUILDING: _____ B. WING _____ | C 10/29/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SILVERADO ST CHARLES | 4058 E MAIN STREET ST CHARLES, IL 60174 |

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| A 000 | Initial Comment<br><br>Facility Reported Incident of 10/22/25/ IL198203 295.5000d) cited | A 000 | | |
| A5000 | Section 295.5000 Medication Reminders, Supervision of Self Med<br><br>This Regulation is not met as evidenced by:<br>Type 2 Violation<br><br>Section 295.5000 Medication Reminders, Supervision of Self-Medication, Medication Administration and Storage<br><br>d) Medication administration refers to a licensed health care professional employed by an establishment engaging in administering routine insulin and vitamin B-12 injections, oral medications, topical treatments, eye and ear drops, or nitroglycerin patches. Non-licensed staff may not administer any medication. (Section 70 of the Act)<br><br>This requirement was not met as evidenced by:<br><br>Based on observation, interview and record review the facility failed to monitor resident's narcotic analgesic patches to ensure they were being administered for the duration of time ordered by the physician. This applies to 2 of 3 residents (R1 and R2) reviewed for medication administration in the sample of 3. This failure has the substantial probablility to cause harm to a resident or residents.<br><br>The findings include:<br><br>R1's current Physician's Order Sheet shows an | A5000 | | |

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| A5000 | Continued From page 1 | A5000 | | |

order for Fentanyl 12 micrograms (mcg)/hour (hr) 1 patch every 3rd day.

R2's current Physician's Order Sheet shows an order for Fentanyl 50 mcg/hr 1 patch every 72 hours.

R1's Service Plan dated 9/20/25 states, "Resident is not able to take medication without assistance."

R2's Service Plan dated 8/6/25 states, "Resident is not able to take medication without assistance."

On 10/29/25 at 9:15 AM E2 stated, "The nurses pass all the medications. Nurses count the narcotics every shift and we have had no problems with the counts. The patches have been missing off the residents- so we have started putting Tegaderm over the patches to try to get them to stay in place. For (R2) two nurses saw her's on the day prior to the day they were to be changed and then it was found on her arm with tape on it. (R1's) patch was never found. We put a date on them when we put them on. They are for pain management and they are changed every three days. Now we are checking them every shift and we were not doing that prior to this incident."

On 10/29/25 E3( LPN-Licensed Practical Nurse) stated, "Me and (E4- LPN) found them to be missing. On the 19th, I put 2 (Fentanyl- narcotic analgesic) patches on (R2) because hospice increased her order (to 50 mcg) and we only had the 25 mcg patches. I put one on each side of her chest. I was off on the 20th. On the 21st one of the caregivers came to me and said, "I don't want to get anyone in trouble but (R2) has 2 patches on." I told her that was correct- so I know she had them both on. Then on the 22nd when I went to

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| A5000 | Continued From page 2 | A5000 | | |

put the new one on, one of the patches was missing. So I asked (E4) to check on (R1) and his patch was missing too. (R3's) patches have been ok the whole time. We started putting Tegaderm (transparent occlusive dressing) over them to try to keep them on and writing 'do not remove' on the Tegaderm. They did an inservice and let the caregivers know who has patches and they are to notify the nurse if they are not on and we monitor every shift to make sure they are still on. It has been a while since we had anyone with Fentanyl patches in the facility.

On 10/29/25 at 10:35 AM E4 stated, "(R1's) patch has been missing twice and I told (E2- Director of Nursing) about it. The first time was on the 20th. I went to put the new one on and I couldn't find the old one and then on the 22nd, when (E3) asked me to check, his was not due until the 23rd , but it was not there on the 22nd. We were told we can't go off the schedule so we just waited until the 23rd to apply the new patch. We are putting Tegaderm over them now and they are not coming off with the Tegaderm. With (R2) we were able to find hers stuck to her arm, she sweats a lot, but we never found (R1's). (R2) showed increased signs of pain, like facial grimacing and saying 'ow, ow, ow' when the staff were providing care for her. (R1) did not show any increased signs of pain. We let hospice know about (R2) and they told us to apply the new patch. We didn't notify the doctor for (R1)- just stuck to the schedule."

On 10/29/25 at 10:40 AM Surveyor and (E3) approached (R2) sitting in a reclining wheelchair in the dining room. E3 pulled down the neck of R2's T-shirt slightly to reveal a 50 mcg Fentanyl patch on her right chest. There was no Tegaderm over the top of it.

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| A5000 | Continued From page 3<br><br>Surveyor and E3 then approached R1, also in the dining room, sitting in his wheelchair eating a yogurt. E3 showed Surveyor R1's Fentanyl 12 mcg patch on his upper back covered with a Tegaderm.<br><br>At 11:00 AM Surveyor returned to R2 in the dining room to confirm there was no Tegaderm over the Fentanyl patch and Surveyor was unable to see patch on R2's chest. Surveyor looked at R2's left hand and saw the patch wrapped around the tip of R2's index finger. Surveyor looked for a nurse and at 11:15AM found E1 (Administrator) and showed her the situation with R2. Then E4 arrived to the dining room, saw R2's patch on her finger and stated, "Again". E4 applied gloves, removed the patch from R2's finger and placed the patch back on R2's chest this time covering it with a Tegaderm.<br><br>At 11:20 AM E1 stated, "We did an inservice with all the staff and implemented a new procedure of checking the placement of the patches every shift, letting the caregivers know who has the patches and if they notice that one is not on they are to notify the nurse right away and covering the patches with Tegaderm to keep them from falling off." E1 confirmed that the facility did not write a new policy for the use of the patches.<br><br>The facility policy entitled Documentation and accountability of Medication Administration and Supply dated 6/15/24 states, "Licensed nursing is responsible for knowing that residents take all of their medications as ordered." | A5000 | | |