STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL5108136	A. BUILDING: _____ B. WING _____	C 03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REVELA AT O'FALLON	1022 EAST WESLEY DRIVE O FALLON, IL 62269

(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: IL187022 Survey Completed Violations cited: 295.5000 Medications	A 000		
A5000	Section 295.5000 Medication Reminders, Supervision of Self Med This Regulation is not met as evidenced by: Section 295.5000 Medication Reminders, Supervision of Self-Medication, Medication Administration and Storage 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) VIOLATION TYPE 2 This Regulation is not met as evidenced by; Based on record reviewed interview the Establishment failed to ensure residents receive the correct medication. This failure resulted in R1 not receiving their medication. This failure of residents has the probability to affect all the residents who receive medications	A5000		

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A5000	Continued From page 1 Findings include, During record review, the Individual Service Plan, dated 05/19/24, identifies R1 who has lived at this Establishment since 05/17/23. This Individual Service Plan documents R1 as being diagnosed with Dementia and is to receive her medications by administeration, by a licensed team member. An Establishment form titled 'Medication Variance Report', dated 02/11/25 reveals on 02/11/25 R1 received medication that was not presribed for her. A employee, E8, immediately noticed that this was a medication error and discontinued the medication administration. Then R1 began being monitored for adverse reaction, no adverse reaction was noted. During an interview with E2, Nursing, E2 stated that this incident happened on 02/11/25, R1 displayed no adverse reaction. The Establishment policy was followed and E8 was removed from being allowed to administer any medication until this incident was investigated and retraining was completed.	A5000		