STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510508	A. BUILDING: _____ B. WING _____	C 11/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAN GABRIEL MEMORY CARE	813 LARS HOFFMAN CROSSING GODFREY, IL 62035

(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 Facility Reported Incident Investigation to Incident Report dated 11/11/25 / IL198565 Violations cited: 295.2050 a) b) 295.5000 a) d) j) 1) 2)	A 000		
A2050	Section 295.2050 Incident and Accident Reporting This Regulation is not met as evidenced by: TYPE 3 VIOLATION Section 295.2050 Incident and Accident Reporting a) An establishment shall report to the Department an incident or accident that has a significant negative effect on a resident's health, safety or welfare. A significant negative effect shall be assumed whenever an unplanned or unscheduled visit to a hospital is necessary as a result of that incident or accident, treatment is provided, and follow-up care is required. b) The report shall be made by contacting the Department of Public Health Central Complaint Registry or by fax or by other electronic means within 24 hours after the occurrence of the incident or accident. Based on interview and record review the facility failed to ensure a medication error was reported to the Department within 24 hours following facility policy.	A2050		

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A2050	Continued From page 1 Findinds include: R1's Incident Report, dated 11/11/25, documents, "Incident Date: 11/9/25. Time: 12:30 PM. Description of Incident: Hospice resident was refusing drink, food, and spitting out oral medications. Resident was being physically and verbally aggressive per staff. After resident spit out oral meds, (E3/Licensed Nurse) proceeded to administer comfort medication rectally. Nurse contacted hospice provider to notify of administration route. Hospice sent oncall nurse to assess resident. Hospice nurse provided orders to crush medication and dissolve in water to administer orally via syringe." On 11/20/25 at 10:10 AM, E1/Building Manager, stated staff reported the incident to her on 11/9/25. E1 admitted she reported the incident late to IDPH on 11/11 and didn't realize their policy states to report within 24 hours.. On 11/20/25 at 10:45 AM, E5/Care Partner stated R1 was verbally and physically aggressive before lunch on 11/9/25 and E3/Licensed Nurse made several attempts to give R1 his medication to calm him down and R1 refused. E5 stated E3 wanted R1 in bed and when R1 was in bed, E5 witnessed E3 roll R1 to one side pulled down his pants and inserted what looked like a small white pill and a larger oblong pill into his rectum. E5 stated she then notified E1 of what she witnessed because she knew they were oral medication and did not seem right. Z1's (Hospice Nurse) signed written statement dated 11/20/25, documents,"Hospice had orders in place for R1's medication to be given by mouth whole or crushed however patient tolerates.	A2050		

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A2050	Continued From page 2 There was not an existing order for rectal administration." On 11/20/25 at 11:05 AM, E1/Manager stated R1 was monitored closely throughout the entire day after the medication was administered rectally, and did not present any negative effects. E1 stated a hospice nurse came in the afternoon to assess R1 for any adverse effects to the rectal administration with none noted. E3 was given disciplinary action, re-education provided on medication administration and was suspended without pay and quit. The Facility Policy on Incident and Accident Reporting, undated, documents, "State Reportable Incidents consist of, but are not limited to: Medication Errors. " The policy further documents, " If it is a state reportable it must be reported to IDPH within 24 hours."	A2050		
A5000	Section 295.5000 Medication Reminders, Supervision of Self Med This Regulation 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. d) Medication administration refers to a licensed	A5000		

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A5000	Continued From page 3 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) j) A separate medication record shall be maintained for each resident receiving medication administration and shall include: 1) Name of resident; 2) Name of medication, dosage, directions, and route of administration; Based on interview and record review the facility failed to ensure medications are administered following physician's order. This failure resulted in R1 being administered oral medication by rectal route and creates a substantial probability of harm to residents. Findings include: R1's Incident Report, dated 11/11/25, documents, "Incident Date: 11/9/25. Time: 12:30 PM. Description of Incident: Hospice resident was refusing drink, food, and spitting out oral medications. Resident was being physically and verbally aggressive per staff. After resident spit out oral meds, (E3/Licensed Nurse) proceeded to administer comfort medication rectally. Nurse contacted hospice provider to notify of administration route. Hospice sent oncall nurse to assess resident. Hospice nurse provided orders	A5000		

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A5000	Continued From page 4	A5000		

to crush medication and dissolve in water to administer orally via syringe."

R1's Medication List for November 2025 documents in part, "Hydrocodone 5-325 milligrams/mg tablet p.o. (by mouth) prn (as needed) every 6 hours and Ativan 0.5 mg tablet p.o. (by mouth) three times a day as needed for anxiety."

R1's Controlled Substance Audit Forms for Hydrocodone and Ativan received 11/5/25 each documents one hydrocodone tablet and one ativan tablet was signed out respectively by E3 at 12 PM on 11/9/2025.

On 11/20/25 at 10:45 AM, E5/Care Partner stated R1 was verbally and physically aggressive before lunch on 11/9/25 and E3/Licensed Nurse made several attempts to give R1 his medication to calm him down and R1 refused. E5 stated E3 wanted R1 in bed and when R1 was in bed, E5 witnessed E3 roll R1 to one side pulled down his pants and inserted what looked like a small white pill and a larger oblong pill into his rectum. E5 stated she then notified E1 of what she witnessed because she knew they were oral medication and did not seem right.

Z1's (Hospice Nurse) signed written statement dated 11/20/25, documents,"Hospice had orders in place for R1's medication to be given by mouth whole or crushed however patient tolerates. There was not an existing order for rectal administration."

On 11/20/25 at 11:05 AM, E1/Manager stated R1 was monitored closely throughout the entire day after the medication was administered rectally, and did not present any negative effects. E1

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A5000	Continued From page 5 stated a hospice nurse came in the afternoon to assess R1 for any adverse effects to the rectal administration with none noted. E3 was given disciplinary action, reeducation provided on medication administration and was suspended without pay and quit. The Facility Policy on Medication Administration dated 6/2/25, documents, " 9. A separate medication record shall be maintained for each resident receiving medication administration and shall include: i. Name of resident. ii. Name of medication, dosage, directions, and route of administration iii. Date and time medication is scheduled to be administered..."	A5000		