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 _____	05/12/2025

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 Complaint # 2543513 / IL190683 Violations cited: 295.3000 Repeat Violation 295.5000 Facility Reported Incident Investigation to Incident Report dated 4/20/25 / IL191135 Violations cited: 295.3000 Repeat Violation 295.5000	A 000		
A3000	Section 295.3000 Personnel Requirmts, Qualifns, and Trng This RULE: is not met as evidenced by: TYPE 2 VIOLATION Section 295.3000 Personnel Requirements, Qualifications and Training a) The establishment shall have staff sufficient in number with qualifications, adequate skills, education and experience to meet the 24 hour scheduled and unscheduled needs of residents and who participate in ongoing training to serve the resident population. (Section 35(a)(3) of the Act) Based on interview and record review the facility failed to ensure a licensed health care nurse employed by the facility is on duty to administer medications as prescribed by the physician to residents in the Memory Care facility. This failure led to residents missing their medications or having family members give residents their	A3000		

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A3000	Continued From Page 1 medications. This failure creates a substantial probability of harm to the residents' health in the facility. Findings include: The Facility Reportable Incident Report dated 4/28/25 documents, "During audit of med carts several missed medications were found. Investigation showed that medications were missed on 4/17, 19 and 20. On these dates our nurse was (E3/Licensed Practical Nurse/LPN). (E3) failed to come in for her shift on 4/20 which was the bulk of the missed medications. (E3) has subsequently been terminated from our employment." On 5/6/25 at 12:30 PM, E1 (Facility Manager) stated that on 4/20/25, E3 did not notify the facility that she was not coming to work as scheduled on the day shift and after looking for another licensed nurse for coverage without success, E1 called the respective residents' family member/Power of Attorney to come to the facility to give the morning and noon medications to their resident. E1 stated she was made aware that family members are allowed to pass medications that are prepackaged by pharmacy and added all of their residents' medications are delivered prepackaged by pharmacy. E1 stated there were 16 out of the total census of 31 residents who received medications from their family members, including R1, R2, R3 and R4. E1 added that the remaining 15 residents who had scheduled morning medications and did not receive their medications included R5, R6, R7 and R8. E1 stated E3 reported to work from 3 PM - 8 PM and administered the evening and bedtime medications.	A3000		

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A3000	Continued From Page 2 E1 stated she could not find documentation that the physicians were notified of the missed medications or the residents were closely monitored for any adverse effects resulting from the missed medications. A review of the Medication Administration Record for April 2025 for residents who did not receive their medications or received medications from their family members documented the following. R1 - received morning meds from Z1(R1's family member) on 4/20. R2 - received A.M. and noon meds from Z1 on 4/20. R3 - received morning meds from family on 4/20. R4 - received A.M. meds from family on 4/20. R5 - missed morning meds including Buspar (for anxiety), Celexa (for depression), Levothyroxine (for hypothyroidism), Metoprolol (for hypertension), Memantine (for dementia) on 4/20. R6 - missed morning meds including Alogliptin and Pioglitazone (for diabetes), Tolterodine (for overactive bladder) on 4/20. R7 - missed morning meds including Fluoxetine (for depression), Seroquel (for depression), Depakote (for mood) on 4/20. R8 - missed morning Buspar (for anxiety), Citalopram (for depression), Seroquel (for depression) on 4/20. R1's through R8's 2024 - 2025 Medication Service Plans document, " Nurse to administer all medications." The Facility Policy on Medication Errors, undated, documents, "2. The nurse will report any medication error to the resident's primary physician/ordering practitioner and power of attorney. 3. The nurse will monitor the resident for any adverse effects and report to the manager,	A3000		

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A3000	Continued From Page 3 primary physician and power of attorney." The Facility Policy on Medication Policy and Procedures, undated, documents,"Medication Administration. 1. A licensed nurse will oversee medications and conduct follow-up care."	A3000		
A5000	Section 295.5000 Medication Reminders, Supervision of Self Med This RULE: is not met as evidenced by: TYPE 2 VIOLATION (Repeat Violation from Annual Survey 4/18/25) 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 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) Based on interview and record review the facility failed to ensure residents received medications according to physician orders; failed to ensure the physician is notified of missed medications; failed to ensure residents who missed their prescribed	A5000		

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A5000	Continued From Page 4 medications are monitored for side effects/adverse effects, and failed to provide a licensed health care professional to administer medications resulting in family members giving medications to residents in the Memory Care facility. These failures create a substantial probability of harm to the residents' health in the facility. Findings include: The Facility Reportable Incident Report dated 4/28/25 documents, "During audit of med carts several missed medications were found. Investigation showed that medications were missed on 4/17, 19 and 20. On these dates our nurse was (E3/Licensed Practical Nurse/LPN). (E3) failed to come in for her shift on 4/20 which was the bulk of the missed medications. (E3) has subsequently been terminated from our employment." On 5/6/25 at 12:30 PM, E1 (Facility Manager) stated that E3 did not notify the facility that she was not coming to work as scheduled on the day shift and after looking for another licensed nurse for coverage without success, E1 called the respective residents' family member/Power of Attorney to come to the facility to give the morning and noon medications to their resident. E1 stated she was made aware that family members are allowed to pass medications that are prepackaged by pharmacy and added all of their residents' medications are delivered prepackaged by pharmacy. E1 stated there were 16 of the total census of 31 residents who received medications from their family members, including R1, R2, R3 and R4. E1 added that the remaining 15 residents who had	A5000		

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A5000	Continued From Page 5 scheduled morning medications and did not receive their medications included R5, R6, R7 and R8. E1 stated E3 showed up to work from 3 PM - 8 PM to administer the evening and bedtime medications. E1 stated she could not find documentation that the physicians were notified of the missed medications or the residents were closely monitored for any adverse effects resulting from the missed medications. A review of the Medication Administration Record for April 2025 for residents who did not receive their medications or received medications from their family members documented the following. R1 - missed bedtime Seroquel (for depression, mood) on 4/17 and 4/19; received morning meds from family member on 4/20. R2 - missed bedtime Lipitor (for cholesterol), Depakote (for mood) on 4/17; received A.M. and noon meds from R1's family member on 4/20. R3 - missed bedtime Pravastatin (for high lipid), Donepezil (for dementia) on 4/17 and 4/19; received morning meds from family on 4/20. R4 - missed bedtime Carbidopa (for Parkinson's), Donepezil (for dementia) on 4/17/and 4/19; received A.M. meds from family on 4/20. R5 - missed bedtime Risperdal (for behaviors), Seroquel (for depression), Trazodone (depression, sleep) on 4/17, missed morning meds on 4/20. R6 - missed bedtime Rosuvastatin (for high lipids), Donepezil (for dementia), Venlafaxine (for depression) on 4/17 and 4/19; missed morning meds on 4/20. R7 - missed bedtime Tamsulosin (enlarged prostate) on 4/17 and 4/19; missed morning meds on 4/20. R8 - missed bedtime Melatonin (for sleep), Olanzapine (for behaviors), Seroquel (for depression) on 4/17 and 4/19; missed morning	A5000		

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A5000	Continued From Page 6 Buspar (for anxiety) , Citalopram (for depression), Seroquel (for depression) on 4/20. R1's through R8's 2024-2025 Medication Service Plans document, " Nurse to administer all medications." The Facility Policy on Medication Errors, undated, documents, "2. The nurse will report any medication error to the resident's primary physician/ordering practitioner and power of attorney. 3. The nurse will monitor the resident for any adverse effects and report to the manager, primary physician and power of attorney." The Facility Policy on Medication Policy and Procedures, undated, documents,"Medication Administration. 1. A licensed nurse will oversee medications and conduct follow-up care."	A5000		