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RADCLIFF AT WOOD DALE	276 EAST IRVING PARK ROAD WOOD DALE, IL 60191

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A 000	Initial Comment Complaint Investigation Survey IL00191830/ 2574010- Substantiated, 295.3000, 295.3020, 295.4010, 295.4060, 295.5000, 295.6000	A 000		
A3000	Section 295.3000 Personnel Requirmts, Qualifns, and Trng This Regulation is not met as evidenced by: 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) These requirements are not met as evidenced by: Based on interview and record review, the establishments failed to provide adequate staff to provide care for residents. These affected all residents on all floors. Findings include: An onsite visit was conducted on 5/13/25 and 5/14/25. On entrance, E2 (Director of Nursing) indicated they do not have Resident Council. E2 also said, they do not have a Grievance log. On 5/13/25 at 3:41pm, E11 (Certified Nursing Assistant CNA) said, there are times they do not have enough staff. E11 said, there is one staff on	A3000		

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A3000	Continued From page 1	A3000		

each floor. There were not enough staff on the PM shift, at times E11 would take care of 30 residents, part of the staff's responsivities was to pass meds, do laundry, pass dinner trays, pick up trays afterwards, answer call lights, assist with toileting, getting residents ready for bed and answer call lights. E11 said, sometimes she was late fulfilling these responsibilities.

On 5/13/25 at 4:06pm, E12 (CNA) also said about pm shift, it is better to have two staff. When there are call off there is no coverage and this has been happening frequently.

On 5/13/25 at 2:29pm, R5 said the establishment do not have enough staff to help residents.

On 5/13/25 at 2:43pm, E10 (CNA) was observed escorting one resident after the other. E10 was asked how many CNA were working on the floor with her. E10 said she was alone at this time. E10 said, she just needed to keep on moving. Two staff would be a lot better. E10 was covering the PM shift at the time of observation.

On 5/13/25 at 3:16pm, E14 (CNA) said, "I have 12 residents on the 6th floor. Most days, I am alone, I can manage alone on the 6th floor. But I worked on other floors where there are more residents, it is a lot of work." E14 was covering the PM shift at the time of interview.

Review of second floor (Assisted Living) , Actual staffing schedule indicated the following: No staff on schedule for PM shift (2pm-10pm): 4/1/25, 4/20,4/27/25, 4/28/25,5/6/25, 5/11/24, 5/17/25. Except on 4/6/25, 4/26 where there were two staff on schedule the rest of the days, only one staff on schedule.

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A3000	Continued From page 2 On the Fifth floor (Assisted Living), on 4/7/25, 5/3/25, and 5/12/25, there was only one staff working till 6pm. No coverage until 10pm. On 4/14/25, there was no staff covering the floor. On 5/9/25, 5/10/25, there was only one staff covering from 6am- 2pm, and no coverage until 10pm. The number of residents requiring one person assist, and bathroom assist, according to a document titled "Rent Roll" submitted by E1 (Executive Director): Second floor: 22 residents. 1needs 2 person assist. Third floor: 31 residents Fourth floor: 25 residents Fifth floor: 29 residents Sixth floor: 10 residents On 5/14/25 at 2:41pm, E1 was asked if there is another staffing schedule, since there were days there were no staff on schedule on the Actual staffing schedule submitted for review. E1 said the floors are always covered, the staff will be pulled from another floor. E1 was then asked, who will then cover the floor where the staff was pulled from since according to the staffing schedule most of the time, there was only one staff per floor, E1 had no answer.	A3000		
A3020	Section 295.3020 Employee Orientation and Ongoing Training This Regulation is not met as evidenced by: Section 295.3020 Employee Orientation and Ongoing Training	A3020		

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A3020	Continued From page 3 c) Each manager and direct care staff member shall complete a minimum of 8 hours of ongoing training, applicable to the employee's responsibilities, every 12 months after the starting date of employment. The training shall include: 4) Assisting residents in self-administering medications; d) All training shall be documented with: 1) Date; 2) Starting and ending time; 3) Instructors and their qualifications; 4) Short description of content; and 5) Staff member's written signature. e) An employee who has not demonstrated to the establishment that he or she is competent to perform a particular task may perform that task only under the direct supervision of an employee who has demonstrated competence in performing the task. These requirements were not met as evidenced by: Based on interview and record review the establishment failed to ensure staff training regarding medication policy and procedure were documented and kept available for review upon request by the Department. This deficient practice involved three (E5, E7, E8) staff reviewed for medication training and have the probability to	A3020		

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A3020	Continued From page 4 affect all residents in the Assisted Living. Findings include: An onsite visit was conducted on 5/13/25 and 5/14/25. On at 5/13/25 at 11:13am, E4 (Nurse), "There have been some changes in the schedule. The CNAs (Certified Nursing Assistant) are supposed to remind the residents to take their medications. I don't know when it started. This morning, I did not pass meds." On 5/13/25 at 11:27am, E5 (Certified Nursing assistant-CNA) was observed in R1's apartment. E5 removed a pill caddy from a green lockbox. E5 opened the pill caddy labelled "Tuesday Noon", removed medication. The medicine was placed in a small cup. E5 told R1 she had the noon meds, E5 handed the small cup containing the meds to R1. The resident took the meds with water. R1 was asked if he know what medication he took, R1 said, "I don't know." 5/13/25 at 11:19am, E5, "The new medication reminders (by CNA) started last week Friday, it just started and we are learning." E5 said, she does not pass insulin. "I don't know what medication is being given to resident. The nurse prepares the medications." On 5/13/25 at 11:58am, E7 (CNA) also confirmed she pass medications. E7 indicated she also have administered R2's insulin. E7 indicated no training was provided for her as she a nurse in Poland but not in Illinois. E7 expressed concern regarding safety of residents when unlicensed nurse pass medications to residents.	A3020		

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A3020	Continued From page 5 5/13/25at 12:20pm, E8 (CNA) was observed in R4's apartment, E8 opened green lockbox. Took out pill caddy, opened pill caddy labeled "Tuesday". Took out the pill, poured it to medication cup. Gave the medication to the husband. Then E8 left the apartment. Unknown if R4 took the medication. E8 was asked if she know what medication was in the container, E8 said, "I don't know." On 5/13/25 at 12:23pm, E8 opened the green lockbox located inside R3's apartment. E8 removed pill caddy from lockbox. Open pill caddy labeled "Tuesday noon". Poured the pill in a medication cup. E8 brought a cup of water and the medication cup with pill to R3. R3 swallowed the pill with water. Z2 (Daughter) who was present at that time said," It used to be the nurse giving the medication, now it is the CNA." On 5/13/25 at 1:03pm, E2 (Director of Nursing) said, the CNA reminds residents to take meds. This process involved the following; remove the meds from the lockbox, pour it in a medication cup and hand it over to the resident and they watch the resident consume the pills and document that they have given it. "If the resident is able to take the medication, we try as much as we can to let them do it ...Insulin, they dial it up and give it to the resident and the resident will inject it to themselves, and if the resident can't, then the nurse will do it." Reminded E2 the process and definition of "Medication Reminder" per requirement. At that time, E21 (Establishment Owner) joined the interview, around 1:15-1:20 pm. E21 said, it appeared the medication reminder was not how it was practiced in the establishment.	A3020		

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A3020	Continued From page 6 There was no proof of training submitted to ensure CNA/Caregivers were given appropriate training regarding medications. Training documents for the staff was requested from E2, none provided. Multiple staff were also interviewed indicating they pass medications to residents.	A3020		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Section 295.4010 Service Plan a) Based on the physician's assessment and establishment evaluation (see Section 295.4000), a written service plan shall be developed and mutually agreed upon by the establishment and the resident. (Section 15 of the Act) The establishment shall respect and accept the resident's choices regarding the service plan. g) Service plans shall address: 5) Whether the resident requires medication reminders, supervision of self-administered medication, or medication administration. These requirements are not met as evidenced by: Based on observation, interview and record review, the establishment failed to follow medication administration interventions as stated on resident's service plan. This deficient practice affected four (R1, R2, R3, R4) of four residents reviewed for medication administration and has	A4010		

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A4010	Continued From page 7 the probability to affect all residents. Findings include: On 5/13/25 at 11:27am, E5 was observed at R1's apartment. E5 removed a pill caddy from a green lockbox. E5 opened the pill caddy labelled "Tuesday Noon", removed medication. The medicine was placed in a small cup. E5 told R1 she had the noon meds, E5 handed the small cup containing the meds to R1. The resident took the meds with water. R1 was asked if he know what medication he took, R1 said, "I don't know." Per R1's face sheet, R1 is 91 years old. R1's Service plan with assessment date 11/3/23 stated in part; "Medications administered by Nurse." R1's diagnoses include but not limited to Hypertension and Parkinson's Disease. Per R1's face sheet, R1 is 91 years old. According to R1's Medication Administration Record, R1's medication includes but not limited to Losartan Potassium 20 mg, Carbidopa/Levodopa 25-100mg, Amlodipine 2.5mg 2 tabs. Service plan also indicated R1 has short and long term memory loss. On at 5/13/25 at 11:13am, E4 (Nurse), "There have been some changes in the schedule. Last time I picked up, I was passing meds, do vital signs, Accu-Check and other nursing responsibilities. There is currently a new system, resident's medications are in their rooms in a lockbox. The CNAs are supposed to remind the residents to take their medications. I don't know when it started. This morning, I did not pass meds." 5/13/25 at 11:19am, E5 (Certified Nursing assistant-CNA) said, "The new medication	A4010		

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A4010	Continued From page 8	A4010		

reminders (by CNA) started last week Friday, it just started and we are learning." E5 said, she does not pass insulin. "I don't know what medication is being given to resident. The nurse prepares the medications."

On 5/13/25 11:25am, Z1 (Visiting Nurse) assigned to R1 since January, stated R1 is alert enough, but unable to administer his own medication. He has diminished cognitive functions, to the extent that he needs 24 hour supervision. Unable to know his medications. Z1 expressed concern of current medication administration, with R1's medications, (Losartan, Amlodipine), since these medications has some precautions such as to check blood pressure, for Carbidopa/Levodopa, to monitor for somnolence.

On 5/13/25 11:36pm, E4 was asked about R1's blood pressure: "I do not know his blood pressure this morning, I was not instructed to take the blood pressure. I did Accu-Check. I do not know how the CNA were trained on what to do with meds."

On 5/13/25 at 11:58am, E7 (CNA) also confirmed she pass medications. E7 was asked how the medication responsibilities are carried out. E7 said, "When giving medications, check the name, date, if AM,PM. If it is AM, tear packet from the medication roll. Open packets take out the pill. Put the pill in a medication cup. Bring a cup of water and medication cup with pill to the resident. Wait until the resident take the medications. There is a book that we have to sign that medication was given." How were you train to give medications? "Because I am a nurse in Poland, no training was given. Other CNA/Caregivers are also giving medications, not sure if training was provided ... The residents we

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A4010	Continued From page 9	A4010		

are giving these medications to are not alert, oriented. I have given insulin before. " E7 said, she is not a licensed nurse in Illinois. E7 said, "It is not safe for residents to be given medications by staff who are not a nurse." E7 was asked who did she administer the insulin to? E7 said, "(R2)". E7 was asked, how did she know how much insulin to administer, E7 escorted surveyor to R2's room and showed surveyor a small piece of paper with it written " Insulin 20 units". An Insulin Glargine Kwik pen was in the green lock box. According to E7, she administered the insulin to R2 using the Kwik pen.

R2's document titled, " ....-Monthly Resident Insulin Supervision Log indicated, E7's initials on 5/13/25, indicating 20 units of Basaglar was administered to R2.

On 5/13/25 at 2:18pm, R2 was asked who gives her medications, R2 said the nurse, R2 was asked who gave her meds that morning, if it was E7. R2 said yes. R2 also said E7 gave the insulin too.
R2's Service plan with assessment date 11/3/24, "Medications administered by Nurse." R2's diagnoses include but not limited to Hypoglycemia, and Hypertension. Per R2's face sheet, R2 is 85 years old.

On 5/13/25 ta 2:36pm, E9 (Registered Nurse) said, R2 is forgetful. And cannot self- administer medications. E9 was assigned on R2's floor. E9 said most of the residents on the 2nd floor are unable to self-administer medications. E9 said, residents who can self-administer meds are those who know what medication they are to take, medication indication and when they take it.

5/13/25at 12:20pm, E8 (CNA) was observed. E8

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A4010	Continued From page 10	A4010		

went to R4's apartment. R4 was in a wheelchair. R4 was eating lunch; husband was also on the table with R4. E8 opened green lockbox. Took out pill caddy, opened pill caddy labeled "Tuesday". Took out the pill, poured it to medication cup. Gave the medication to the husband. Then E8 left the apartment. Unknown if R4 took the medication. E8 was asked if she know what medication was in the container, E8 said, "I don't know."
R4's Service plan with assessment date of 4/23/24 stated in part, "Medications will be administered by nurse." R4's diagnoses include but not limited to Dysphasia, and Diabetes Mellitus. Per R4's face sheet, R4 is 84 years old. R4's Physician orders include but not limited to; Lorazepam 2 mg at bedtime, Pregabalin 75 mg, and two other anti-hypertensive pills (Diltiazem and Metoprolol). Lorazepam is a benzodiazepine and a controlled substance.

On 5/13/25 at 12:23pm, E8 opened the green lockbox located inside R3's apartment. E8 removed pill caddy from lockbox. Open pill caddy labeled "Tuesday noon". Poured the pill in a medication cup. E8 brought a cup of water and the medication cup with pill to R3. R3 swallowed the pill with water. Z2 (Daughter) who was present at that time said," It used to be the nurse giving the medication, now it is the CNA."
R3's Service plan with assessment date of 3/13/25, 24 stated in part, "Medications will be administered by nurse." According to face sheet, R3 is 95 years old, with diagnoses which include Dysphagia and Respiratory Failure.

This practice of removing medication from the pill caddy or from the medication packets roll does not follow what medication reminder as defined on this requirement. The CNA were administering

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A4010	Continued From page 11 the medications based on what medication was due. The observed medication pass performed by the unlicensed staff (CNA) were the same as the responsibility of a licensed nurse.	A4010		
A4060	Seciton 295.4060 Alzheimer's and Demential Programs This Regulation is not met as evidenced by: Section 295.4060 Alzheimer's and Dementia Programs g) If an establishment accepts any individuals with cognitive impairments that prevent them from safely evacuating the establishment independently, sufficient staff members shall be present and awake 24 hours a day to assist in evacuation. h) An establishment that offers to provide a special program for persons with Alzheimer's disease and related disorders shall: 6) Provide an appropriate number of staff for its resident population. The establishment shall provide staff sufficient in number, with qualifications, adequate skills, education, and experience to meet the 24-hour scheduled and unscheduled needs of the residents and who participate in ongoing training, to serve the resident population. At a minimum, at least one staff member shall be awake and on duty at all times;	A4060		

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A4060	Continued From page 12 9) Develop emergency procedures and staffing patterns to respond to the needs of residents; (Section 150(f) of the Act) These requirements are not met as evidenced by: Based on interview and record review, the establishment failed to ensure, staffing ratio was followed as stated on the establishment's Dementia disclosure. This deficient practice has the potential to affect all residents residing in the Memory Care unit. Findings include: An onsite visit was conducted on 5/13/25 ad 5/14/25. The Actual staffing schedule was requested to E2 (Director of Nursing). According to the April 1, 2025, resident roster, there were 34 residents on the 3rd floor Memory Care unit. Establishment's Alzheimer's Disease Special Care Disclosure Form- Part-A, stated in part; "In addition, to community management, licensed and non- licensed staff, the minimum number of direct care staff, will depend on occupancy of the neighborhood. Generally speaking, the minimum staffing ration will be 1staff to 12 residents. The maximum staffing ration will be 1 staff member to every 8 residents. The 2025 Actual Staffing schedule submitted for review, indicated; from 10pm- to 6am, there was only one staff on the schedule for the third floor memory care unit on the following dates: 3/30, 3/31 4/1, 4/2, 4/3, 4/4, 4/6, 4/7, 4/8, 4/9, 4/10,	A4060		

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(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
A4060	Continued From page 13 4/11, 4/12, 4/13, 4/14, 4/15, 4/16, 4/17, 4/18, 4/19, 4/20, 4/21, 4/22, 4/23, 4/24, 4/25, 4/26, 4/27, 4/28, 4/29, 4/30, 5/1, 5/2, 5/3, 5/4, 5/5, 5/6, 5/7, 5/8,5/9, 5/10, 5/11, 5/12. If this staffing ratio was followed, there should have been 2 staff on duty. On 5/13/25 at 1:03pm, E2 (Director of Nursing) said, there are 34 residents (Memory Care). No nurse at night, on the AM shift, there are 4 caregiver, and one nurse, PM shift has 3 caregivers, one nurse until 7pm. On the night shift, 2 caregivers. NO nurse. E2 said, "There is always a floater staff until 10pm for all floors. This statement did not reflect on the actual staffing schedule provided for review. 5/14/25 2:41pm, E1 (Executive Director) was unable to provide answer who were the staff working on the blank spaces on the schedule. E1 said, the floors are always covered. At times a staff is pulled from another floor to cover. E1 was asked, who will cover the floor where the staff pulled from, E1 had no answer.	A4060		
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 a) An establishment may provide medication reminders, supervision of self-administered medication, and medication administration as an	A5000		

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A5000	Continued From page 14 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 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.	A5000		

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A5000	Continued From page 15 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) e) Medication stored by a resident in the resident's unit shall be stored and controlled as stated in the resident's service plan and shall be inaccessible to other residents. f) If an establishment provides medication administration or supervision of self-administered medication, the establishment's medication policies and procedures shall be approved by a physician, pharmacist, or registered nurse and shall address: 1) Obtaining and refilling medication; 2) Storing and controlling medication; 3) Disposing of medication; 4) Assisting in the self-administration of medication and medication administration, as applicable; and 5) Recording of medication assistance provided to residents and maintenance of medication records. g) If an establishment provides medication administration or supervision of self-administered medication, a drug reference guide, no older than 2 years from the copyright date, shall be available and accessible for use by employees.	A5000		

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A5000	Continued From page 16 h) Any medication stored by the establishment shall meet the following requirements: 1) Medication shall be stored in a locked container, cabinet, or area that is inaccessible to residents; 2) Medication shall not be left unattended by an employee; 3) Medication shall be stored in the original labeled container, except for medication organizers, and according to instructions on the medication label; 4) A bathroom or laundry room shall not be used for medication storage; and 5) Any expired or discontinued medication, including those of deceased residents, shall be disposed of according to the establishment's medication policies and procedures. i) Except for medication organizers, resident medication shall not be pre-poured. Medication organizers may be prepared up to one month in advance by the following individuals: 1) A resident or the representative; 2) A resident's relatives; 3) A nurse; or 4) As otherwise provided by law. j) A separate medication record shall be maintained for each resident receiving medication	A5000		

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A5000	Continued From page 17 administration and shall include: 1) Name of resident; 2) Name of medication, dosage, directions, and route of administration; 3) Date and time medication is scheduled to be administered; 4) Date and time of actual medication administration; and 5) Signature or initials of the employee administering medication. These requirements are not met as evidenced by: Based on observation, interview and record review, the establishment failed to ensure, medications are passed by a licensed nurse as required and defined on this requirement. This affected four (R1, R2, R3, R4) of four residents reviewed for medications and has the potential to affect all residents. Findings include: On 5/13/25 at 11:27am, E5 was observed at R1's apartment. E5 removed a pill caddy from a green lockbox. E5 opened the pill caddy labelled "Tuesday Noon", removed medication. The medicine was placed in a small cup. E5 told R1 she had the noon meds, E5 handed the small cup containing the meds to R1. The resident took the meds with water. R1 was asked if he know what medication he took, R1 said, "I don't know." Per R1's face sheet, R1 is 91 years old. R1's Service plan with assessment date 11/3/23 stated	A5000		

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in part; "Medications administered by Nurse." R1's diagnoses include but not limited to Hypertension and Parkinson's Disease. Per R1's face sheet, R1 is 91 years old.
According to R1's Medication Administration Record, R1's medication includes but not limited to Losartan Potassium 20 mg, Carbidopa/Levodopa 25-100mg, Amlodipine 2.5mg 2 tabs. Service plan also indicated R1 has short and long term memory loss.

On at 5/13/25 at 11:13am, E4 (Nurse), "There have been some changes in the schedule. Last time I picked up, I was passing meds, do vital signs, Accu-Check and other nursing responsibilities. There is currently a new system, resident's medications are in their rooms in a lockbox. The CNAs are supposed to remind the residents to take their medications. I don't know when it started. This morning, I did not pass meds."

5/13/25 at 11:19am, E5 (Certified Nursing assistant-CNA) said, "The new medication reminders (by CNA) started last week Friday, it just started and we are learning." E5 said, she does not pass insulin. "I don't know what medication is being given to resident. The nurse prepares the medications."

On 5/13/25 11:25am, Z1 (Visiting Nurse) assigned to R1 since January, stated R1 is alert enough, but unable to administer his own medication. He has diminished cognitive functions, to the extent that he needs 24 hour supervision. Unable to know his medications. Z1 expressed concern of current medication administration, with R1's medications, (Losartan, Amlodipine), since these medications has some precautions such as to check blood pressure, for

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Carbidopa/Levodopa, to monitor for somnolence.

On 5/13/25 11:36pm, E4 was asked about R1's blood pressure: "I do not know his blood pressure this morning, I was not instructed to take the blood pressure. I did Accu-Check. I do not know how the CNA were trained on what to do with meds."

On 5/13/25 at 11:58am, E7 (CNA) also confirmed she pass medications. E7 was asked how the medication responsibilities are carried out. E7 said, "When giving medications, check the name, date, if AM,PM. If it is AM, tear packet from the medication roll. Open packets take out the pill. Put the pill in a medication cup. Bring a cup of water and medication cup with pill to the resident. Wait until the resident take the medications. There is a book that we have to sign that medication was given." How were you train to give medications? "Because I am a nurse in Poland, no training was given. Other CNA/Caregivers are also giving medications, not sure if training was provided ... The residents we are giving these medications to are not alert, oriented. I have given insulin before. " E7 said, she is not a licensed nurse in Illinois. E7 said, "It is not safe for residents to be given medications by staff who are not a nurse." E7 was asked who did she administer the insulin to? E7 said, "(R2)". E7 was asked, how did she know how much insulin to administer, E7 escorted surveyor to R2's room and showed surveyor a small piece of paper with it written " Insulin 20 units". An Insulin Glargine Kwik pen was in the green lock box. According to E7, she administered the insulin to R2 using the Kwik pen.

R2's document titled, " ....-Monthly Resident Insulin Supervision Log, E7's initials was on

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5/13/25, indicating 20 units of Basaglar was administered to R2.

On 5/13/25 at 2:18pm, R2 was asked who gives her medications, R2 said the nurse, R2 was asked who gave her meds that morning, if it was E7. R2 said yes. R2 also said E7 gave the insulin too.

R2's Service plan with assessment date 11/3/24, "Medications administered by Nurse." R2's diagnoses include but not limited to Hypoglycemia, and Hypertension. Per R2's face sheet, R2 is 85 years old.

On 5/13/25 ta 2:36pm, E9 (Registered Nurse) said, R2 is forgetful. And cannot self- administer medications. E9 was assigned on R2's floor. E9 said most of the residents on the 2nd floor are unable to self-administer medications. E9 said, residents who can self-administer meds are those who know what medication they are to take, medication indication and when they take it.

5/13/25at 12:20pm, E8 (CNA) was observed. E8 went to R4's apartment. R4 was in a wheelchair. R4 was eating lunch; husband was also on the table with R4. E8 opened green lockbox. Took out pill caddy, opened pill caddy labeled "Tuesday". Took out the pill, poured it to medication cup. Gave the medication to the husband. Then E8 left the apartment. Unknown if R4 took the medication. E8 was asked if she know what medication was in the container, E8 said, "I don't know."

R4's Service plan with assessment date of 4/23/24 stated in part, "Medications will be administered by nurse." R4's diagnoses include but not limited to Dysphasia, and Diabetes

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Mellitus. Per R4's face sheet, R4 is 84 years old. R4's Physician orders include but not limited to; Lorazepam 2 mg at bedtime, Pregabalin 75 mg, and two other anti-hypertensive pills (Diltiazem and Metoprolol). Lorazepam is a benzodiazepine and a controlled substance.

On 5/13/25 at 12:23pm, E8 opened the green lockbox located inside R3's apartment. E8 removed pill caddy from lockbox. Open pill caddy labeled "Tuesday noon". Poured the pill in a medication cup. E8 brought a cup of water and the medication cup with pill to R3. R3 swallowed the pill with water. Z2 (Daughter) who was present at that time said," It used to be the nurse giving the medication, now it is the CNA."

R3's Service plan with assessment date of 3/13/25, 24 stated in part, "Medications will be administered by nurse." According to face sheet, R3 is 95 years old, with diagnoses which include Dysphagia and Respiratory Failure.

On 5/13/25 at 1:03pm, E2 (Director of Nursing) said, the CNA reminds residents to take meds. This process involved the following; remove the meds from the lockbox, pour it in a medication cup and hand it over to the resident and they watch the resident consume the pills and document that they have given it. "If the resident is able to take the medication, we try as much as we can to let them do it ...Insulin, they dial it up and give it to the resident and the resident will inject it to themselves, and if the resident can't, then the nurse will do it." Reminded E2 the process and definition of "Medication Reminder" per requirement. At that time, E21 (Establishment Owner) joined the interview, around 1:15-1:20 pm. E21 said, it appeared the medication reminder was not how it was practiced

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A5000	Continued From page 22 in the establishment. Requested for these residents' assessments to self- medicate and staff training records for medications from E2, none provided. On 5/13/25 at 2:43pm, E10 (CNA), confirmed she also have medication responsibilities. E10 said, "I did medication reminder". How do you do it? On the resident's medication roll, do you select the medication whether am, pm or other times? E10 said, "yes". E10 said, tear the medication packet off the roll, put it in a medication cup. Give the medication cup to the resident to take. E10 was asked, if the resident point out to her what medication the resident is going to take from the medication roll? E10 said "No". On 5/13/25 at 3:41pm, E11(CNA) also verified she pass medications to residents. On 5/13/25 at 4:06pm (CNA) indicated she was asked to pass medications but refused, because she was concerned, she might make mistakes and loss CNA certificate. According to documents, Policies & Procedures, updated 5/5/25, it stated in part; MEDICATION REMINDERS AND SUPERVISION PROTOCOL 1. Medication Reminders Include: a. Reminding residents to take pre-dispensed, self- administered medication; b. Observing the resident; and c. Documenting whether or not the resident took medication. 7. To self -medicate, Residents must have a "Self-medicating Release Form," ....signed by Resident, Responsible Party, a Witness, and their Physician ...The form includes an evaluation of which types of medication the resident is able to self-administer.	A5000		

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A5000	Continued From page 23 This practice of removing medication from the pill caddy or from the medication packets roll does not follow what medication reminder as defined on this requirement. The CNA were administering the medications based on what medication was due. The observed medication pass performed by the unlicensed staff (CNA) were the same as the responsibility of a licensed nurse. There was no cognitive assessment done to ensure residents can safely and independently administer their own medications.	A5000		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: Section 295.6000 Resident Rights a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of his or her status as a resident of an establishment, nor shall a resident forfeit any of the following rights: 5) The right to receive the services specified in the service plan, to review and renegotiate the service plan at any time; and to be informed of the cost of the changes; This requirement is not met as evidenced by: Based on observation, interview and record review, the establishment failed to follow medication administration interventions, for	A6000		

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medications to be administered by nurse, as stated on service plan. This deficient practice affected four (R1, R2, R3, R4) of four residents reviewed for medication administration and has the probability to affect all residents.

Findings include:

On 5/13/25 at 11:27am, E5 was observed at R1's apartment. E5 removed a pill caddy from a green lockbox. E5 opened the pill caddy labelled "Tuesday Noon", removed medication. The medicine was placed in a small cup. E5 told R1 she had the noon meds, E5 handed the small cup containing the meds to R1. The resident took the meds with water. R1 was asked if he know what medication he took, R1 said, "I don't know."
Per R1's face sheet, R1 is 91 years old. R1's Service plan with assessment date 11/3/23 stated in part; "Medications administered by Nurse."
R1's diagnoses include but not limited to Hypertension and Parkinson's Disease. Per R1's face sheet, R1 is 91 years old.
According to R1's Medication Administration Record, R1's medication includes but not limited to Losartan Potassium 20 mg, Carbidopa/Levodopa 25-100mg, Amlodipine 2.5mg 2 tabs. Service plan also indicated R1 has short and long term memory loss.
On at 5/13/25 at 11:13am, E4 (Nurse), "There have been some changes in the schedule. Last time I picked up, I was passing meds, do vital signs, Accu-Check and other nursing responsibilities. There is currently a new system, resident's medications are in their rooms in a lockbox. The CNAs are supposed to remind the residents to take their medications. I don't know when it started. This morning, I did not pass meds."
5/13/25 at 11:19am, E5 (Certified Nursing

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assistant-CNA) said, "The new medication reminders (by CNA) started last week Friday, it just started and we are learning." E5 said, she does not pass insulin. "I don't know what medication is being given to resident. The nurse prepares the medications."
On 5/13/25 11:25am, Z1 (Visiting Nurse) assigned to R1 since January, stated R1 is alert enough, but unable to administer his own medication. He has diminished cognitive functions, to the extent that he needs 24 hour supervision. Unable to know his medications. Z1 expressed concern of current medication administration, with R1's medications, (Losartan, Amlodipine), since these medications has some precautions such as to check blood pressure, for Carbidopa/Levodopa, to monitor for somnolence.
On 5/13/25 11:36pm, E4 was asked about R1's blood pressure: "I do not know his blood pressure this morning, I was not instructed to take the blood pressure. I did Accu-Check. I do not know how the CNA were trained on what to do with meds."

On 5/13/25 at 11:58am, E7 (CNA) also confirmed she pass medications. E7 was asked how the medication responsibilities are carried out. E7 said, "When giving medications, check the name, date, if AM,PM. If it is AM, tear packet from the medication roll. Open packets take out the pill. Put the pill in a medication cup. Bring a cup of water and medication cup with pill to the resident. Wait until the resident take the medications. There is a book that we have to sign that medication was given." How were you train to give medications? "Because I am a nurse in Poland, no training was given. Other CNA/Caregivers are also giving medications, not sure if training was provided ... The residents we are giving these medications to are not alert,

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RADCLIFF AT WOOD DALE	276 EAST IRVING PARK ROAD WOOD DALE, IL 60191

(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
A6000	Continued From page 26	A6000		

oriented. I have given insulin before. " E7 said, she is not a licensed nurse in Illinois. E7 said, "It is not safe for residents to be given medications by staff who are not a nurse." E7 was asked who did she administer the insulin to? E7 said, "(R2)". E7 was asked, how did she know how much insulin to administer, E7 escorted surveyor to R2's room and showed surveyor a small piece of paper with it written " Insulin 20 units". An Insulin Glargine Kwik pen was in the green lock box. According to E7, she administered the insulin to R2 using the Kwik pen.
R2's document titled, " ....-Monthly Resident Insulin Supervision Log indicated, E7's initials on 5/13/25, indicating 20 units of Basaglar was administered to R2.
On 5/13/25 at 2:18pm, R2 was asked who gives her medications, R2 said the nurse, R2 was asked who gave her meds that morning, if it was E7. R2 said yes. R2 also said E7 gave the insulin too.
R2's Service plan with assessment date 11/3/24, "Medications administered by Nurse." R2's diagnoses include but not limited to Hypoglycemia, and Hypertension. Per R2's face sheet, R2 is 85 years old.
On 5/13/25 ta 2:36pm, E9 (Registered Nurse) said, R2 is forgetful. And cannot self- administer medications. E9 was assigned on R2's floor. E9 said most of the residents on the 2nd floor are unable to self-administer medications. E9 said, residents who can self-administer meds are those who know what medication they are to take, medication indication and when they take it.

5/13/25at 12:20pm, E8 (CNA) was observed. E8 went to R4's apartment. R4 was in a wheelchair. R4 was eating lunch; husband was also on the table with R4. E8 opened green lockbox. Took out pill caddy, opened pill caddy labeled "Tuesday".

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510499	A. BUILDING: _____ B. WING _____	C 05/15/2025

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Took out the pill, poured it to medication cup. Gave the medication to the husband. Then E8 left the apartment. Unknown if R4 took the medication. E8 was asked if she know what medication was in the container, E8 said, "I don't know."
R4's Service plan with assessment date of 4/23/24 stated in part, "Medications will be administered by nurse." R4's diagnoses include but not limited to Dysphasia, and Diabetes Mellitus. Per R4's face sheet, R4 is 84 years old. R4's Physician orders include but not limited to; Lorazepam 2 mg at bedtime, Pregabalin 75 mg, and two other anti-hypertensive pills (Diltiazem and Metoprolol). Lorazepam is a benzodiazepine and a controlled substance.

On 5/13/25 at 12:23pm, E8 opened the green lockbox located inside R3's apartment. E8 removed pill caddy from lockbox. Open pill caddy labeled "Tuesday noon". Poured the pill in a medication cup. E8 brought a cup of water and the medication cup with pill to R3. R3 swallowed the pill with water. Z2 (Daughter) who was present at that time said," It used to be the nurse giving the medication, now it is the CNA."
R3's Service plan with assessment date of 3/13/25, 24 stated in part, "Medications will be administered by nurse." According to face sheet, R3 is 95 years old, with diagnoses which include Dysphagia and Respiratory Failure.

On 5/13/25 at 1:03pm, E2 (Director of Nursing) said, the residents' and family members reactions to this current medication pass, "were overwhelmingly negative". E2 said, it's been ongoing for a week. The CNAs were passing meds. E2 said, the residents think the nurses should pass the medications. "And I explain it to them that the nurse is preparing the meds, but all

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A6000	Continued From page 28 the caregivers do is to open the green box. Tearing up the medication from roll and giving it to the resident. They can tear off the medication cover, pour in a cup and give it to the resident if they cannot do it themselves." This practice of removing medication from the pill caddy or from the medication packets roll does not follow what medication reminder as defined on this requirement. The CNA were administering the medications based on what medication was due. The observed medication pass performed by the unlicensed staff (CNA) were the same as the responsibility of a licensed nurse. E2 also said resident families were not notified. Residents were notified, at the same time the system was started.	A6000		