STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510006	A. BUILDING: _____ B. WING _____	05/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARTER SENIOR LIVING OF MOLINE	900 43RD AVENUE MOLINE, IL 61265

(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 Annual Licensure Survey. 295.4010 g) 5)	A 000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Section 295.4010 Service Plan g) Service plans shall address: 5) Whether the resident requires medication reminders, supervision of self-administration, or medication administration. VIOLATION Based on record review and interview, the establishment failed to address medication needs on the service plan for one of three sampled residents. (R2) Findings include: Review of R2's current service plan dated 12/19/24 noted that medications needs were not addressed. On 5/16/25 at 10:50 A.M., E2 (Wellness Director) confirmed that they failed to address R2 medication needs on the service plan.	A4010		