STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL5105801	A. BUILDING: _____ B. WING _____	C 03/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDENS AT PARK POINTE	1550 DUPONT AVE MORRIS, IL 60450

(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 IL 200335. 295.5000 d)	A 000		
A5000	Section 295.5000 Medication Reminders, Supervision of Self Med This Regulation is not met as evidenced by: Type 1 Violation 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) Based on record review and interviews, the establishment administered the wrong resident's medications to two of two sampled residents. (R1,R2). This failure resulted in R1 receiving potentially significant health altering medications. This failure created the substantial probability of severe harm or death to R1. Findings include: Establishment incident report narrative dated 2/18/26 reads, "On February 18th, 2026, during morning medication administration, (E3 RN),	A5000		

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A5000	Continued From page 1	A5000		

accidentally gave (R1), a 93-year old, alert and oriented x4, assisted living resident, the medications of an assisted living resident across the hall; (R2), 87-year old, alert and oriented x3. This mistake was realized later during the medication pass when (E3) RN, went to give (R2's) medications to her and they were missing, and realized that (R1's) medications were still there. No adverse reactions were observed at this time. Vitals were WNL. Error explained to resident (R1); resident verbalizes understanding and denies any adverse reactions. PCP gave orders to send to (Local) Hospital ER for further evaluation. Sent (R1) to (Local) Hospital at approximately 10am. Nurse contacts (Local) Hospital for updates at the end of the shift, no further symptoms reported or change noted at this time. Re-educated staff on proper medication administration, further disciplinary action to follow."

Review of R2's medication administration records note that R1 incorrectly received the following medications the morning of 2/18/26:

1) Calcium Carbonate 600 mg
2) Diltiazem HCL Er 300 mg
3) Escitalopram Oxalate 10 mg
4) Esomeprozole Magnesium 40 mg
5) Eye-Vites x2
6) Hydrochlorothiazide 25 mg
7) Levothyroxine Sodium 125 mcg
8) Losartan Potassium 100 mg
9) Potassium Chloride ER 10 meq
10) Probiotic 250 mg
11) Vitamin D 125 mcg
12) Wellbutrin XL 150 mg
13) Carvedilol 12.5 mg
14) Eliquis 2.5 mg
15) Topamax 25 mg

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A5000	Continued From page 2 16) Tylenol ES 500 mg x2 17) Buspirone HCL 10 mg On 3/2/26 at 11:00 A.M., E3 stated that on the morning of 2/18/26 he accidentally administered all of R2's morning medications to R1. E3 stated that he had popped all of R2's medications out into a medication cup and then realized that R2 was still sleeping. E3 stated that there was a lot going on and that he then mistakenly gave R2's medications to R1, whose room is right across from R2. E3 stated that when he realized the mistake, he reported it immediately. R1 was sent to hospital and had no adverse reactions to the medications.	A5000		