STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510142	A. BUILDING: _____ B. WING _____	07/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EBERHARDT VILLAGE	431 W PALMER ARTHUR, IL 61911

(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 IL 194171 Allegation can be substantiated. General Violation cited at 295.5000 c)	A 000		
A5000	Section 295.5000 Medication Reminders, Supervision of Self Med This Regulation is not met as evidenced by: Violation Section 295.5000 Medication Reminders, Supervision of Self-Medication, Medication Administration and Storage 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 1 These requirements were not met as evidenced by: Based on record review and interview, the establishment failed to ensure R1 received the correct physician ordered medications. The establishment failed to ensure that staff follow their medication policy and procedure ensuring that as needed medication documentation includes the time the medication was received on the resident's medication records. Findings include: R1 was admitted to the establishment on 07-27-2024. R1's diagnoses include rheumatoid arthritis and spinal stenosis. R1's 06-09-2025 incident report was reviewed. The report contains documentation that on 06-09-2025 R1 was given Norco 5/325 instead of the ordered Tramadol 50mg. Documentation includes that the Norco medication was in a medication cup and that staff put the rest of R1's scheduled medications in with the Norco tablet. Further documentation includes that staff notified the nurse onsite, that vital signs were completed, and that R1's physician and family member were notified. The Department was notified. R1's service plan includes documentation that R1 requires medication supervision. R1's 06-09-2025 progress notes include documentation that care staff notified the nurse about giving R1 Norco instead of Tramadol for pain. Documentation includes that R1 had no signs or symptoms of distress, is alert and oriented, and that R1's physician and power of attorney were notified. Further documentation	A5000		

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A5000	Continued From page 2	A5000		

includes that R1's physician's office did not have any further orders and that R1 would be monitored.

R1's physician orders and Medication Administration Records (MAR,) were reviewed. R1's June 2025 Medication Administration Record includes documentation that R1 received as needed Tramadol 50mg on 06-09-2025. There is no time indicated on the June 2025 MAR documenting when R1 received the tramadol. The June 2025 MAR does not include documentation of R1 receiving the Norco medication. R1's June 2025 physician orders does not include orders for Norco.

The establishment's medication policy includes documentation that is, "When a PRN, (as needed medication,) is given, the following will need to be recorded: time, date, initial of staff member assisting with medication, reason for giving the medication, and the results."

On 07-15-2025, at approximately 9:50am, E1, (Community Director,) states that R1 had no adverse side effects from the medication error. E1 further states that R1's family was a little upset but understanding. E1 states that she had their pharmacy come and do training with the staff on medications and that she is trying to get resident narcotic orders on a regular scheduled basis so that errors are less likely to occur.