STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510246	A. BUILDING: _____ B. WING _____	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILL CREEK ALZHEIMER'S SCC	3319 GINGER CREEK DR SPRINGFIELD, IL 62711

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A 000	Initial Comment Facility Reported Incident Investigation IL 195033 Type 2 Violations cited 295.5000 d) 295.6000 a) 5)	A 000		
A5000	Section 295.5000 Medication Reminders, Supervision of Self Med This Regulation is not met as evidenced by: Type 2 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) These requirements were not met as evidenced by: Based on record review and interview the establishment failed to ensure R1 through R17 received physician ordered medications the evening of 06-14-2025. The establishment failed to ensure staff follow their medication policy and procedure. These failures create a substantial probablity of harm to R1 through R17.	A5000		

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A5000	Continued From page 1 Findings include: This is a memory care facility. The 06-14-2025 incident report and final investigation, including interviews was reviewed. The incident report includes documentation that on 06-14-2025 that E3, (Registered Nurse,) failed to administer medications as ordered to 17 residents. The Health Services Director was notified until 06-15-2025 regarding medications not being given. E3 was placed on suspension on 06-15-2025. Staff interviews were done and confirmed that E3 failed to communicate with the two other nurses in the establishment that the medications were not given as ordered. The investigation reveals that 17 residents did not receive evening medications and that no adverse reactions were noted. All resident power of attorneys and physicians were notified of the incident. E3 was terminated. Establishment interview with E3 on 06-16-2025 includes documentation that E3 started to feel ill between 1:30pm and 2:30pm; stating that she went to the front lobby bathroom and sat on the toilet for two to two and a half hours with diarrhea and vomiting. E3 states that no one came to check on her during this time except for another nurse who yelled through the door about 6:00pm asking if E3 was ok. E3 stated she was in the restroom from 2:30pm to 6:00pm. E3 states that she went back into the establishment and charted the morning and noon medications prior to leaving the establishment for the evening. E3 states that she told E5, (nurse) that she did not get any of the evening medications administered. E3 states that she did not reach out to the Health Services Director and doesn't know why she did	A5000		

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A5000	Continued From page 2 not call her. Establishment interview with E5 on 06-17-2025 includes documentation that E5 worked as a caregiver on 06-14-2025 from 2:00pm to 6:00pm. E5 states that she took over the medication carts around 8:45pm and that she was told E3 left around 7:35pm. E5 states that it was around 6:00pm that she found out E3 was sick when several resident family members needed to use the restroom in the lobby area. E5 states that E3 never told her medications did not get passed, and that E3 did not do narcotic counts, leaving the keys on top of the medication cart in the medication room. E5 states that she passed the medications associated with her shift. E2 's witness statement contains documentation that she was notified by E4, (Licensed Practical Nurse,) on 06-15-2025 that the medication pass on 06-14-2025 had not been completed, that E4 didn't know why E3 didn't complete the medication pass or where E3 was for the last portion of the shift. The witness statement contains documentation that E2 notified E1 and that E2 contacted E3 placing E3 on suspension. The establishment's "Medication Management" policy was reviewed. The policy includes documentation that all medications are to be administrated according to the prescribed physician orders and that when a staff personfails to administer a medication as ordered that the incident will be investigated. The establishment's "Medication Errors" policy was reviewed. The policy includes documentation that is, "Medication assistance and/or administration will be provided to residents in a manner that is safe and consistently free of	A5000		

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A5000	Continued From page 3	A5000		

errors." Further documentation is that when a medication error is committed, the error must be reported to the Health Services Director immediately and that the Health Services Director will report to the Executive Director.

The establishment's investigation includes documentation of a list of resident's involved in not receiving their 06-14-2025 evening medications. This list includes the resident's name, date of birth, medication and dosage involved, the resident's diagnoses and the resident's SLUMS, (Saint Louis University Mental Status,) examination scores.

Resident records for R1 through R17 were reviewed. The resident Medication Administration Records for R1 through R17 do not include documentation of receiving medications the evening of 06-14-2025.

On 06-26-2025, at approximately 9:45am, E1, (Executive Director,) states that E3 had not said anything to the other nurses working that shift about not giving resident medications or about needing help. E1 states that E3 had some stomach issues and received FMLA, (Family Medical Leave Act,) for this reason; but that E3 had not called her or E2, (Health Services Director,) to report being sick or about needing to go home. E1 states that E3 refused to sign the paperwork after being suspended and that no residents were affected by this incident. E1 states that E3 was terminated on 06-19-2025 and provided documentation of electronic mail sent to the corporate office regarding E3's termination.

On 06-26-2025, at approximately 10:25am, E2 states that the list of residents attached to the establishment's investigation include the

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A5000	Continued From page 4 residents that did not get medications administered that evening. E2 states that she notified all resident power of attorneys and each resident's physician regarding the medication incident.	A5000		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: Type 2 Violation 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; These requirements were not met as evidenced by: Based on record review and interview the establishment failed to ensure R1 through R17 received physician ordered medications the evening of 06-14-2025, as specified in resident service plans. This failure creates a substantial probablity of harm to R1 through R17. Findings include: This is a memory care facility.	A6000		

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A6000	Continued From page 5 The 06-14-2025 incident report and final investigation, including interviews was reviewed. The incident report includes documentation that on 06-14-2025 that E3, (Registered Nurse,) failed to administer medications as ordered to 17 residents. The Health Services Director was notified until 06-15-2025 regarding medications not being given. E3 was placed on suspension on 06-15-2025. Staff interviews were done and confirmed that E3 failed to communicate with the two other nurses in the establishment that the medications were not given as ordered. The investigation reveals that 17 residents did not receive evening medications and that no adverse reactions were noted. All resident power of attorneys and physicians were notified of the incident. E3 was terminated. Establishment interview with E3 on 06-16-2025 includes documentation that E3 started to feel ill between 1:30pm and 2:30pm; stating that she went to the front lobby bathroom and sat on the toilet for two to two and a half hours with diarrhea and vomiting. E3 states that no one came to check on her during this time except for another nurse who yelled through the door about 6:00pm asking if E3 was ok. E3 stated she was in the restroom from 2:30pm to 6:00pm. E3 states that she went back into the establishment and charted the morning and noon medications prior to leaving the establishment for the evening. E3 states that she told E5, (nurse,) that she did not get any of the evening medications administered. E3 states that she did not reach out to the Health Services Director and doesn't know why she did not call her. Establishment interview with E5 on 06-17-2025 includes documentation that E5 worked as a	A6000		

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A6000	Continued From page 6	A6000		

caregiver on 06-14-2025 from 2:00pm to 6:00pm. E5 states that she took over the medication carts aroun 8:45pm and that she was told E3 left aroun 7:35pm. E5 states that it was around 6:00pm that she found out E3 was sick when several resident family members needed to use the restroom in the lobby area. E5 states that E3 never told her medications did not get passed, and that E3 did not do narcotic counts, leaving the keys on top of the medication cart in the medication room. E5 states that she passed the medications associated with her shift.

E2 's witness statement contains documentation that she was notified by E4, (Licensed Practical Nurse,) on 06-15-2025 that the medication pass on 06-14-2025 had not been completed, that E4 didn't know why E3 didn't complete the medication pass or where E3 was for the last portion of the shift. The witness statement contains documentation that E2 notified E1 and that E2 contacted E3 placing E3 on suspension.

The establishment's "Medication Management" policy was reviewed. The policy includes documentation that all medications are to be administrated according to the prescribed physician orders and that when a staff personfails to administer a medication as ordered that the incident will be investigated.

The establishment's "Medication Errors" policy was reviewed. The policy includes documentation that is, "Medication assistance and/or administration will be provided to residents in a manner that is safe and consistently free of errors." Further documentation is that when a medication error is committed, the error must be reported to the Health Services Director immediately and that the Health Services Director

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A6000	Continued From page 7 will report to the Executive Director. The establishment's investigation includes documentation of a list of resident's involved in not receiving their 06-14-2025 evening medications. This list includes the resident's name, date of birth, medication and dosage involved, the resident's diagnoses and the resident's SLUMS, (Saint Louis University Mental Status,) examination scores. Resident records for R1 through R17 were reviewed. The resident Medication Administration Records for R1 through R17 do not include documentation of receiving medications the evening of 06-14-2025. Resident service plans for R1 through R17 all include documentation that residents receive medication administration. On 06-26-2025, at approximately 9:45am, E1, (Executive Director,) states that E3 had not said anything to the other nurses working that shift about not giving resident medications or about needing help. E1 states that E3 had some stomach issues and received FMLA, (Family Medical Leave Act,) for this reason; but that E3 had not called her or E2, (Health Services Director,) to report being sick or about needing to go home. E1 states that E3 refused to sign the paperwork after being suspended and that no residents were affected by this incident. E1 states that E3 was terminated on 06-19-2025 and provided documentation of electronic mail sent to the corporate office regarding E3's termination. On 06-26-2025, at approximately 10:25am, E2 states that the list of residents attached to the establishment's investigation include the residents that did not get medications administered that evening. E2 states that she	A6000		

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A6000	Continued From page 8 notified all resident power of attorneys and each resident's physician regarding the medication incident.	A6000		