STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL5105892	A. BUILDING: _____ B. WING _____	07/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COPPER CREEK COTTAGES	920 COUNTRY CLUB ROAD MATTOON, IL 61938

(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 295.5000 h)1)2)j)2) 295.6000a)5)	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 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; j) A separate medication record shall be maintained for each resident receiving medication administration and shall include: 2) Name of medication, dosage, directions, and route of administration; These requirements were not met as evidence by: Based on observation, interview, and record	A5000		

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A5000	Continued From page 1	A5000		

review the establishment failed to secure narcotics from resident access. This failure has the potential to affect all 27 residents who reside in the facility. Additionally, the establishment failed to ensure that one (R1) of three residents reviewed for medication administration received the correct dosage of ordered medication. These failures have the potential to cause harm to a resident or creates a substantial probability of harm to a resident or residents.

Findings include:

The facility provided undated resident roster documents 27 residents reside in the facility.

1.)The facility Medication Management policy dated 1/10/23 documents that Medication shall be stored in a locked container, cabinet, or area that is inaccessible to residents. Medication shall not be left unattended by an employee.

On 7/15/25 at 10:15AM the nurse's office door in the East Nurse's station was open and the refrigerator unlocked. In the refrigerator, there were four boxes of Morphine and four boxes of Lorazepam, one box of each for R2, R4, R5 and R6. While the door was open and the narcotics accessible, two memory care residents were sitting outside of the nurse's room working a puzzle with no staff in sight.

On 7/15/25 at 1:45PM, E4 Licensed Practical Nurse stated that the door to the medication room is supposed to be locked and the refrigerator is supposed to be locked with narcotics in it.

2.)On 7/15/25 at 11:00AM, R1's oxygen concentrator was set at 1.5 liters per nasal cannula and R1 appeared to be short of breath.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A5000	Continued From page 2 R1's physician order sheet dated 6/1/25 documents R1's diagnosis of congestive heart failure and an order for oxygen to be provided at two liters per nasal cannula as needed. On 7/15/25 at 11:01AM, R1 stated that she frequently had shortness of breath. On 7/15/25 at 12:15PM, E2 Registered Nurse confirmed that R1 should have had two liters of oxygen as ordered and the potential complication of not receiving the correct dosage of oxygen is shortness of breath.	A5000		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: 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 evidence by:	A6000		

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A6000	Continued From page 3 Based on observation, interview, and record review the facility failed to ensure R1's right to the correct dosage of oxygen administration. This failure has the potential to affect one (R1) of three residents reviewed for resident rights and have the potential to cause harm to a resident or creates a substantial probability of harm to a resident or residents. Findings include: On 7/15/25 at 11:00AM, R1's oxygen concentrator was set at 1.5 liters per nasal cannula, while R1 was having shortness of breath. R1's service plan dated 3/26/25 documents that R1 requires total assistance with oxygen administration. R1's physician order sheet dated 6/1/25 documents R1's diagnosis of congestive heart failure and an order for oxygen to be provided at two liters per nasal cannula as needed. On 7/15/25 at 12:15PM, E2 Registered Nurse confirmed that R1 should have had two liters of oxygen as ordered and that she did not know why it given incorrectly.	A6000		