

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>ASL5105751</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/19/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>CHARTER SENIOR LIVING OF SHILOH</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1201 HARTMAN LANE</b> <b>SHILOH, IL 62221</b>
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(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  Complaint Investigation #2449323/IL 180921 295.5000 cited.	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 a) An establishment may provide medication reminders, supervision of self-administered medication, and medication administration as an optional service. b) Medication reminders include: 1) Reminding residents to take pre-dispensed, self-administered medication; 2) Observing the resident; and 3) Documenting whether or not the resident took the medication. 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	A5000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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A5000	<p>Continued From page 1</p> <p>are taking the dosage as prescribed; and</p> <p>7) Documenting in writing that the resident has taken (or refused to take) the medication.</p> <p>f) If an establishment provides medication administration or supervision of self-administered medication, the establishment's medication policies and procedures shall be approved by a physician, pharmacist, or registered nurse and shall address:</p> <ol style="list-style-type: none"> <li>1) Obtaining and refilling medication;</li> <li>2) Storing and controlling medication;</li> <li>3) Disposing of medication;</li> <li>4) Assisting in the self-administration of medication and medication administration, as applicable; and</li> <li>5) Recording of medication assistance provided to residents and maintenance of medication records.</li> </ol> <p>h) Any medication stored by the establishment shall meet the following requirements:</p> <ol style="list-style-type: none"> <li>1) Medication shall be stored in a locked container, cabinet, or area that is inaccessible to residents;</li> <li>2) Medication shall not be left unattended by an employee;</li> <li>3) Medication shall be stored in the original labeled container, except for medication organizers, and according to instructions on the medication label;</li> </ol> <p>Based on interview and record review, the Establishment failed to ensure that residents received their medication as prescribed by the Physician and without error. (R2) This failure has the substantial probability of harm to the residents that reside at the Establishment.</p> <p>Findings include:</p> <p>The Establishment's Medication Management</p>	A5000		

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A5000	<p>Continued From page 2</p> <p>Policy, Revised on 10/21 documents: "Purpose: It is the policy of (Establishment) to provide assistance with self-administration and administer medications as ordered by a licensed medical provider as per regulatory standards. The community provide appropriate methods and procedures for the obtaining, dispensing, and administering of medication approved by the licensed medical provider and consulting Pharmacist."</p> <p>R2's Service Plan, dated 5/28/24 documents she receives Medication reminders with Supervision.</p> <p>R2's Incident Report, dated 10/13/24 at 7:27 PM documents in part: "Care staff called this Nurse to notify that Res (Resident) had taken another Residents (Res with similar name) medication. (both of these Resident's medications were locked securely in the med room). Care staff stated that Res was alert and oriented x 4. @ 7:33 PM, This nurse asked Care staff to stay with Res and this Nurse called NP ( Nurse Practioner) , This Nurse left message for NP to return call. NP returned call at 7:38 PM. This Nurse explained to NP that Res had accidentally received another Resident's (with similar name) medications. This Nurse reported to NP that Res had no known Drug Allergies. This Nurse notified NP of the meds that were taken. They were: Calcium Antacid, Poly Iron 150 Forte, and Levetiracetam 500 MG. NP stated that these particular medications should not harm Res, but the Levetiracetam may make Res drowsy."</p> <p>The Establishments Internal Investigation Statement, documents in part; "R3 and R2's meds were locked in med room and because of similar naming, meds got mixed up, noticed before R3 got meds."</p>	A5000		

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A5000	<p>Continued From page 3</p> <p>On 11/19/2024 at 9:40 AM, E2/LPN stated, "R2's and R3's medication planners were stored in the Medication room because R2's planner did not fit in the shared medication box shared with her daughter and since passed spouse," E2 further stated, "R3's medication box lock had broken so we also stored R3's medication planner there as well, and on 10/13/24 E3/Resident Assistant accidentally picked up R3's medication planner; who has a very similar name as R2 and gave R2 R3's medication in error." E2 confirmed that R2 received the medications Calcium Antacid, Poly Iron 150 Forte and Levetiracetam 500 MG in error.</p> <p>On 11/19/24 at 10:00 AM, R2 confirmed that one time she received R3's medications in error.</p>	A5000		