| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | ASL510114 | A. BUILDING: _____ B. WING _____ | C 10/08/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CLARENDALE OF ALGONQUIN | 2001 WEST ALGONQUIN RD ALGONQUIN, IL 60102 |

| (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<br><br>Investigation of Incident of 9/12/25/IL197560- No Violations<br>Investigation of Incident of 9/18/25/IL197662 - 295.5000f)1)4)5) cited. | A 000 | | |
| A5000 | Section 295.5000 Medication Reminders, Supervision of Self Med<br><br>This Regulation is not met as evidenced by:<br>Type 3 Violation<br><br>Section 295.5000 Medication Reminders, Supervision of Self-Medication, Medication Administration and Storage<br>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:<br>1) Obtaining and refilling medication;<br>4) Assisting in the self-administration of medication and medication administration, as applicable; and<br>5) Recording of medication assistance provided to residents and maintenance of medication records.<br><br>This Requirement was NOT MET as evidenced by:<br><br>Based on interview and record review, the facility failed to ensure residents medications were given as ordered for one of three residents (R2) reviewed for medications in the sample of three.<br><br>The findings include: | A5000 | | |

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| A5000 | Continued From page 1<br><br>On October 8, 2025 at 9:48 AM E2 Director of Health Services said she told Z1 R2's daughter what medications R2 was taking. Z1 told E2 that the dose of amantadine was not correct so E2 researched the orders. E2 said that the amantadine order was supposed to be changed on September 11, 2025 to capsule because of insurance purposes. E7 Nurse Practitioner hand written that order. E2 said the pharmacy said the capsule was not available so the order was supposed to go back to the original order. E2 said E5 Licensed Practical Nurse was supposed to write a new order to show amantadine 50mg tablet twice daily but only crossed off the two zeros on the 100 mg on the original order. E2 said the pharmacy read the order as amantadine 150 mg twice daily because E5 did not cross off the 100 completely. E2 said that the entire dosage should have been crossed out.<br><br>On October 8, 2025 at 11:23 AM Z1 R2's Daughter said originally her mom was taking amantadine 100 mg daily capsule and her mother wanted it switched to amantadine 50mg twice a day because R2 was sleeping a lot. The facility had to switched to tablets as they could not split a capsule. Z1 said she requested a copy of what medications her mother was on, and that is how Z1 found out R2 was taking amantadine 150 mg twice a day. Z1 said it should have been amantadine 50mg twice a day. Z1 said she believed it was a "clerical issue". Z1 said R2 is not able to give herself her own medications and requires assistance from the facility staff..<br><br>R2's Physician Orders sheet dated September 11, 2025 shows an order for, "Change amantadine tablet to capsule." Directly underneath this order shows, "Amantadine 100 | A5000 | | |

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| A5000 | Continued From page 2<br>mg tab twice daily" but the two zeros were scribbled out and 50 written above them.<br><br>R2's Electronic Medication Administration Record shows that R2 received amantadine 150 mg from September 13, 2025-September 18, 2025.<br><br>The facility's Incident Report Investigation dated September 19, 2025 shows, "While handwriting the telephone order, the nurse made an error and wrote 100 mg instead of 50 mg. The nurse then proceeded to make the correction by striking out the 100 mg and writing 50 mg on top of it. However, the correction, which the nurse made appeared she only crossed off the two zeros in 100 mg and wrote 50 above the zeroes so the dose appeared to read 150 mg. The pharmacy transcribed the order as 150 mg. Amantadine 150 mg twice a day was given from September 13, 2025 until September 18, 2025.<br><br>The facility's Medication Management Policy revised March 2025 shows, "The purpose of this policy is to guide preparation, administration and document of prescribed medications. When a resident has been evaluated as requiring assistance with medication administration, medications will be administer as prescribed by a trained and/or certified or appropriately licensed staff member." | A5000 | | |