STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510338	A. BUILDING: _____ B. WING _____	C 06/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STILLWATER SENIOR LIVING	1111 UNIVERSITY DRIVE EDWARDSVILLE, IL 62025

(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 5-25-25 IL193170 Substantiated, no violations cited. Facility Reported Incident 5-16-25 IL193347 Substantiated Violations cited 295.4010 a)g1)5) and 295.5000a)c)	A 000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: Type 2 Violation Section 295.4010 Service Plan a) Based on the physician's assessment and establishment evaluation (see Section 295.4000), a written service plan shall be developed and mutually agreed upon by the establishment and the resident. (Section 15 of the Act) The establishment shall respect and accept the resident's choices regarding the service plan. g) Service plans shall address: 1) The level of service the resident is receiving, including: 5) Whether the resident requires medication reminders, supervision of self-administered medication, or medication administration. Based on interview and record review, the Establishment failed to ensure (R2) received her medication supervision of a newly ordered antibiotic as identified in the Service Plan. This failure resulted in (R2) not receiving 9 doses of the antibiotic; prolonging the treatment of a Urinary Tract Infection.	A4010		

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A4010	Continued From page 1 Findings Include: R2's Service Plan, dated 2/11/2025 documents that she receives her Medication with Supervision of Wellness Partners to watch. R2's Physician Order's, dated 5/16/2025 document: Sulfa TMP DS, one tab by mouth twice a day for 5 days related to the diagnosis of Urinary Tract Infection. The Establishment's Reportable Incident, dated 5/27/25 documents, "On 5/26/25, it was reported by R2's POA that R2 did not receive the ordered antibiotic for a Urinary Tract Infection. R2 did not receive the antibiotic in the AM on five days from 5/16/25 through 5/20/2025 and on 4 evenings from 5/16/25-5/20/2025." R2's Medication Error Report, dated 5/25/25, Type of Error: Med not given, Explanation: "POA reported medication not given and (MOD) reported to (ED) Executive Director. Medication was not given 5/16/2025-5/19/2025." On 6/2/2025 at 9:00 AM, E1/Executive Director stated that on 5/16/2025, R2's daughter brought in the Sulfa DS antibiotic for R2 and gave them to the Nurse to be put in R2's packets. E1 stated that the Nurse did deliver and package the medications; however the new medication was not communicated or placed on the medication reminder for the Wellness Partners to know R2 had another medication package to be supervised. E1 confirmed that this failure caused R2 to miss 5 morning doses and 4 evening doses delaying her treatment for the Urinary Tract Infection.	A4010		

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A5000	Continued From page 2	A5000		
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 a) An establishment may provide medication reminders, supervision of self-administered medication, and medication administration as an optional service. 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. Based on interview and record review, the Establishment failed to ensure that (R2) received supervision of self- administered medication on a newly ordered antibiotic for a Urinary Tract	A5000		

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A5000	Continued From page 3	A5000		

Infection. The facility staff did not follow standard of care per Physician orders and this failure has the substantial probability of harm to the resident.

Findings include:

The Establishment's Medication Policy/Program, dated 1/8/2025 documents," Policy: The community will provide a medication oversight program for those residents who need medication assistance, and will ensure compliance with all state and federal regulations."

R2's Service Plan, dated 2/11/2025 documents that she receives her Medication with Supervision of Wellness Partners to watch.

R2's Physician Order's, dated 5/16/2025 document: Sulfa TMP DS, one tab by mouth twice a day for 5 days related to the diagnosis of Urinary Tract Infection.

The Establishment's Reportable Incident, dated 5/27/25 documents, "On 5/26/25, it was reported by R2's POA that R2 did not receive the ordered antibiotic for a Urinary Tract Infection. R2 did not receive the antibiotic in the AM on five days from 5/16/25 through 5/20/2025 and on 4 evenings from 5/16/25-5/20/2025."

R2's Medication Error Report, dated 5/25/25, Type of Error: Med not given, Explanation: "POA reported medication not given and (MOD) reported to (ED) Executive Director. Medication was not given 5/16/2025-5/19/2025."

On 6/2/2025 at 9:00 AM, E1/Executive Director stated that on 5/16/2025, R2's daughter brought in the Sulfa DS antibiotic for R2 and gave them to the Nurse to be put in R2's packets. E1 stated

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A5000	Continued From page 4 that the Nurse did deliver and package the medications; however the new medication was not communicated or placed on the medication reminder for the Wellness Partners to know R2 had another medication package to be supervised. E1 confirmed that this failure caused R2 to miss 5 morning doses and 4 evening doses delaying her treatment for the Urinary Tract Infection.	A5000		