STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510101	A. BUILDING: _____ B. WING _____	C 05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAPTERS LIVING OF EDWARDSVILLE	7108 MARINE ROAD EDWARDSVILLE, IL 62025

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A 000	Initial Comment Complaint # 2645757 / IL201770 Violations cited: 295.5000 a) d)	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 a) An establishment may provide medication reminders, supervision of self-administered medication, and medication administration as an optional service. 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) Based on interview and record review the facility: a) failed to prevent a Memory Care resident from being given a substance by an unlicensed staff which was identified as a sleep aide by said staff; and 2) failed to follow facility policy of timely internal reporting any medication related incident by witnesses. These failures create a substantial probability of harm to residents in the facility.	A5000		

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A5000	Continued From page 1 Findings include: R1's Reportable Incident dated 5/3/26, documents, "(E4/Former Resident Assistant/RA) reported that when she worked with (E3/Former RA), she observed E3 administering medication from a bottle in her pocket. The medication was in "gummy" form. (E4) stated that (E3) told her it was melatonin (a sleep aide supplement). Nurse Practitioner, Family notified. (E3) suspended while investigation being conducted. (E3) denies allegations." E4's Written signed Statement dated 5/5/26 documents she witnessed (E3) give (R1) two (2) dark purple gummies from her pocket and that she was told by (E3) it was melatonin. In a written statement signed and dated 5/4/26, E5/RA stated, "I witnessed a co-worker (E3) give a resident (R1) 2 gummies after walking (R1) to his bedroom, (E3) had been working on D Hall while I was working B Hall. When she came to B Hall I was under the impression she was a medication tech because she was questioning who was awake. She has seen (R1) walking the halls and asked him if he wanted any "candy" which she later stated was melatonin. The gummies were two (2) orange circular gummies that she got from her pocket. I did not see a bottle or packaging." R1's Police Report dated 5/12/26 documents, "On Monday May 4, 2026, I, (Z2/Police Officer), responded to (Facility Name and address). Upon my arrival, I met with the director of nurses, (E2) WF. (E2) stated on May 3, 2026, an employee at facility told her about an incident with another employee, (E4).	A5000		

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A5000	Continued From page 2 (E4) told her she witnessed (E3) giving a resident, (R1) WM - a substance that (E3) stated was a melatonin gummy. (E4) advised (E2) that (E3) was going into (R1's) room and giving him a substance that she brought from home. (E4) confronted (E3) and (E3) told her not to worry because it was a melatonin gummy and she used to do the same with patients at her previous job. (E2) stated (E3) is not a nurse and is not licensed to give any medication, even a patient's prescribed medication. (E2) advised (R1) is prescribed melatonin that the nurses give to him daily. (E2) stated she has notified (Z1/R1's Power of attorney) and advised him of the incident. (E2) also advised she has filed a report with Illinois Department of Public Heath , but the company policy requires her to make a report with the police. I advised (E2) an informational report would be completed, but Public Health would be handling the investigation and will contact police if they need further assistance." On 5/13/26 at 9:25 AM, E2/Director of Wellness, stated E4 reported to her on 5/3/26 that on 4/29/26, E4 witnessed E3 gave R1 two (2) dark purple gummies from E3's pocket and told her it was melatonin but later claimed during the investigation that she did not see a bottle. E2 stated that during her investigation of the incident, another RA, E5, also told her that on 4/30/26 she witnessed E3 giving R1 two orange colored gummies that E5 saw E3 took from her pocket. E2 stated E3 wrote a statement of what happened but refused to hand it to E2 and tore it when she was advised she was on suspension while the investigation was being conducted. E2 stated E3 is a non licensed care giver and only licensed nurses are allowed to give residents over the counter substances even if they were ordered by the physician like what E3 claimed as	A5000		

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A5000	Continued From page 3	A5000		

melatonin gummies. E2 stated when she was first notified of the incident on 5/3/26 she reported it to Z1, Z3 and filed a police report and to the Department. E2 stated R1 was sent to the ER for drug screen but no tox screen was done and instead R1 was just monitored for four hours in the ER without any acute symptoms arising. E2 added when R1 returned to the facility she bought a local pharmacy toxicology screen kit for urine and was negative for the seven routine drugs screen indicated which melatonin is not included. E2 stated Z1 insisted for a blood test for melatonin screen but the contracted lab could not do it because R1 was taking melatonin daily at night and it would be false positive. E2 stated she still requested for urine toxicology test which the facility has not receive any result yet as of this writing.

On 5/19/26 at 2:10 PM, E2 stated she expected E4 and E5 to report to the nurse and to her immediately when they witnessed E3 giving R1 the gummies. E2 stated all non licensed staff were educated during orientation and periodically and right after she was notified of this incident that only licensed nurses are allowed to give residents medication, over the counter pills that are ordered by the doctor. E2 stated E3 was not allowed to return to work after she was suspended and E3, E4 and E5 were officially terminated on 5/8/2026.

On 5/13/26 at 10:05 AM, E8, Licensed Practical Nurse/LPN, stated he was working on 4/30/26 dayshift and could not recall anything out of the ordinary on R1 from 7AM - 7PM but the usual catnaps, easily redirectable and no behaviors. E8 stated R1 gets Melatonin 5 milligrams by mouth at 6 PM.

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A5000	Continued From page 4 On 5/13/26 at 10:14 AM, E7/RA, stated she worked from 7 AM - 3 PM on 5/1/26 and R1 was his usual self, looking for snacks, walking around the unit on patrol, he was a sheriff, not groggy or unusually sleepy. On 5/19/26 at 4:30 PM, Z4/Pharmacist stated it is unlikely a patient will have a life-threatening reaction to a melatonin overdose since it is a hormone the body naturally produces and any side effects like grogginess, headache , nausea, dizziness usually resolve within a few hours as the supplement leaves the body; melatonin supplement has a very short half life and stay in the system for about 4-5 hours to be cleared and eliminated thereafter. Z4 added there are tests for melatonin panels but these are for the body's own melatonin production for purposes of sleep-wake cycle or circadian rhythm studies so for any suspected overdose should be reported to the poison control agency. R1's Result of 7 Drugs Test Kit dated 5/5/26 showed R1 was negative for amphetamines, cocaine, ecstasy, marijuana, metamphetamines, opiates and phencyclidine. The Facility Medication Incident Reporting Policy dated 5/27/25 documents, "Purpose: To ensure timely identification, documentation, and resolution of medication-related incidents, and to maintain compliance with Illinois Administrative Code Title 59, Part 116, and Title 77, Part 350. Scope. This policy applies to all staff involved in the preparation, assistance, administration, or oversight of medication in SL, IL, AL, and MC programs. Definitions. Medication Incident: Any error in the administration, omission, dosage, timing, or route of a prescribed or over-the-counter medication. Procedures for	A5000		

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A5000	Continued From page 5 Medication Incidents. a. Immediate Action. If a medication incident occurs or is discovered, staff must: Immediately report to a licensed nurse, physician, or other authorized healthcare provider. Monitor the resident for adverse effects."	A5000		