STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510217	A. BUILDING: _____ B. WING _____	05/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARHURST OF WATERLOO	526 LEGACY DRIVE WATERLOO, IL 62298

(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 Violations cited: 295.5000 a) b)	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. 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. Based on interview and record review the facility failed to ensure residents are free of medication errors. This failure creates a substantial probability of harm to the residents' health. Findings include: R2's record documents multiple diagnoses significant for Hypertension. R2's current Medication List documents, in part, "Carvidelol 12.5 milligrams by mouth twice a day	A5000		

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A5000	Continued From page 1	A5000		

with meals. Hold if blood pressure is less than 120/80 mmHg/millimeters of mercury."

R2's Incident Report dated 9/13/25 documents, " Date and Time: 9/13/25 at 8:40 PM. During nightly medication reminders, (E8/Certified Nursing Aide) took resident's blood pressure 96/57 and forgot that the resident's carvedilol was packaged in the same packaging as the rest of the resident's medications. The resident took their night time pills. CNA remembered the carvedilol as the resident was swallowing. CNA immediately called nurse and explained the situation. Nurse called doctor who stated " if the resident remains asymptomatic to check their blood pressure every 15 minutes. If they show symptoms or BP drops below 70/40, send the resident out," Nurse called daughter to explain the situation. At 8:50 PM, BP was 81/51, at 9:15 PM, BP was 103/67."

On 5/12/26 at 8:30 AM, E2/Director of Wellness/RN stated R2 is on medication reminders and knows which medication to take out from the packaging if her blood pressure is below the parameter but E8 should have made R2 aware what the BP reading was. E2 stated E8 was retrained and reeducated on the procedure the next day. E2 stated that was the only medication error that was reported since last annual survey.

The Facility Policy on Medication Errors Policy & Procedures dated 8/2024 documents, " It is our policy to report any medication error to the physician, the Resident, and family members as applicable, and as required by the state. If the wrong medication is dispensed, the pharmacy is to be notified as well. Any medication error (wrong or missed dose, wrong Resident, omission, wrong time, wrong route, wrong

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A5000	Continued From page 2 medication, wrong reason, wrong documentation) will require an Incident Report to be completed and followed up by the Director of Nursing or Licensed Nurse, and the Executive Director. "	A5000		