STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510250	A. BUILDING: _____ B. WING _____	05/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARTER SENIOR LIVING OF PEKIN	2700 14TH STREET PEKIN, IL 61554

(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 Facility Reported Incident IL201920 295.5000 c) 1) 2) 3) 4)	A 000		
A5000	Section 295.5000 Medication Reminders, Supervision of Self Med This Regulation is not met as evidenced by: TYPE 1 VIOLATION Section 295.5000 Medication Reminders, Supervision of Self-Medication, Medication Administration and Storage 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; These requirements were not met as evidenced by: Based on record review and interview, the establishment failed to provide the required supervision of self administered medications for	A5000		

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A5000	Continued From page 1 one of five sampled residents. (R1) This failure creates a substantial probability of severe harm (or death) to a resident. Findings include: R1's current service plan notes that R1 requires staff to supervise and remind R1 of self administration of medications. Establishment Incident Report dated 5/18/26 reads, "Medication Error: Date of error: 5/17/26. Care team member 1 (E6) called and reported to HWD (E2) that medication supervision was performed prior to breakfast. Care team member 1 did document after task was completed. Care team member 2 (E4) escorted resident (R1) back to her apartment after breakfast and assisted with medication supervision again. Care team member 2 (E4) failed to check documentation, failed to verify correct date and time and handed resident (R1) the morning packet of medications dated 5/18/26. Resident (R1) did not inform care team member 2 (E4) of already taking her morning medications. Resident (R1) received double of the following medications: Calcium / D3 600 - 10 mg Take 1 tablet PO BID, Levothyroxine 50 MCg take 1 tablet PO daily, and Sertraline 50 mg take 1 tablet PO daily. Care team member 1 (E6) was instructed to monitor resident for any adverse effects x 3 days.Instructed to call POA to notify and also faxed MD on 5/17/26. Care team member 2 (E4) was in serviced on medication supervision policy and procedure. Placed on a 30 day improvement plan for re-training. No adverse effects have been observed within the last 24 hours. Continuing to monitor and pending MD response." On 5/26/26 at 10:15 A.M., E2 (Health and	A5000		

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A5000	Continued From page 2 Wellness Director) confirmed that E4 failed to complete the required checks (Documentation and date and time on medication packets) prior to handing R1 her morning medications. E2 stated that this failure resulted in R1 taking double doses of her Calcium, Levothyroxine, and Sertraline on the morning of 5/17/26.	A5000		