STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145601	A. Building B. Wing	02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aviston Countryside Manor	450 West 1st Street Aviston, IL 62216

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure medications were administered as ordered for 1 (R5) of 3 residents reviewed for medication administration in the sample of 5.Findings Include:R5's face sheet documents that R5 was admitted to the facility on [DATE]. The diagnoses listed on the face sheet include unspecified fracture of left pubis, urinary tract infection, heart failure, unspecified atrial fibrillation, essential hypertension, chronic kidney disease, and hyperkalemia. R5's admission MDS (Minimum Data Set) dated 10/13/2025 documented a BIMS (Brief Interview of Mental Status) of 15, indicating R5 is cognitively intact.R5's progress note dated 11/11/2025, timed 12:25 A.M., authored by V12 (Licensed Practical Nurse) documented R5 received Keppra 750mg and Metoprolol 100 mg in error. The on-call nurse practitioner called and notified him of error. Vital signs at 10:39 P.M. were blood pressure 128/52 and pulse of 74. Per nurse practitioner monitor vital signs during the evening. 11:03 P.M. blood pressure 118/56 and pulse 69. On call facility nurse notified of error. R5 currently at nurses' station for monitoring. No adverse reactions noted. Power of Attorney notified. R5's progress note dated 11/23/2025, timed 11:48 A.M., authored by V19 (Licensed Practical Nurse) documented R5 has no adverse side effects from medication error on last shift. R5 able to voice needs. No new orders at this time.R5's Order history with a date range of 10/07/2025-02/10/2026 document no orders for Keppra or Metoprolol. On 02/06/2026 at 9:23 A.M. V2 (Director of Nursing) stated the facility has not had any medication errors and does not have any medication error reports.On 02/06/2026 at 2:02 P.M. V6 (Licensed Practical Nurse) stated there is a nurse on night shift that gave the wrong resident the wrong medications. V6 stated this has been reported to V2 and nothing was done about it. V6 stated the nurse who made the medication error still talks about it occurring. On 02/06/2026 at 2:20 P.M. V8 (Licensed Practical Nurse / Assistant Director of Nursing) stated she is not aware of any medication errors.On 02/08/26 at 4:52 AM V12 (Licensed Practical Nurse) stated there was an incident about two months ago when she was helping another nurse with her mediation pass. V12 stated she was passing the C hallway and the right side of A hallway, and the other nurse was passing B hallway and the left side of A hallway. V12 stated the other nurse was running a little bit behind so she decided to help them out. V12 stated she probably shouldn't have done it but she did. V12 stated she went down and pulled the residents medication out of the med-cart and took it down to the A hallway. V12 stated she had the medication pulled for the resident in the second room on the left and she accidentally gave them to the person in the first room on the left side of the A hallway. V12 stated she reported it immediately to the DON, family, and the doctor. V12 stated she monitored R5's vital signs and they kept R5 up close to the nurse's station so they could monitor them closely. V12 stated she charted and done everything she was supposed to regarding the incident.On 02/10/2025 at 10:58 A.M. V2 (Director of Nursing) stated she asked V12 (Licensed Practical Nurse) when she was in the facility over the weekend about what the surveyor had asked her (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	about. V2 stated V12 told her about medication error questions. V2 stated she asked V12 how she responded and V12 told her that she told the surveyor about when she gave the wrong medications to the wrong resident. V2 stated she was not aware at the time of the incident and was only made aware the other night. V2 stated she is aware that it was a resident on A hall, and the resident had been discharged . V2 stated she is actively reading through charts trying to determine who the resident was.On 02/10/2026 at 11:34 A.M. V2 stated that she has determined that R5 was the resident who was given the wrong medication. V2 stated she looked and V8 (Licensed Practical Nurse / Assistant Director of Nursing) would have been the nursing administration on call. V2 stated she asked V8 and V8 stated she was not made aware of the medication error. V2 stated if she had been notified herself and V8 would have investigated it and followed the facility policy on medication errors.On 02/20/2025 at 12:54 P.M. V1 stated he was not made aware of the medication error until today. V1 stated that it is his expectation for all medication errors to be reported and handled appropriately. V1 stated he expects the facility follow all proper nursing standards to prevent medication errors.Facility policy titled Preventing and Detecting Adverse Consequences and Medications Errors documents J. The following information is documented in an incident report and in the resident's clinical record: 8) factual description of error, 9) name of physician and time notified, 10) physician's subsequent orders, 11) resident's condition for 24 -72 hours or as directed. K. Each incident report is forwarded to the Director of Nursing / Quality Assurance, Medical Director / Consultant Pharmacist.