

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145680	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/16/2025
NAME OF PROVIDER OR SUPPLIER Celebrate Sr Living of Moline		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 34th Avenue Moline, IL 61265	

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)
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>(continued on next page)</p>

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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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on record review and interview, the facility failed to use two patient/resident identifiers during medication administration, which resulted in the wrong medication being administered to one resident (R1) of three residents reviewed for medication administration in a total sample of three residents. Findings include: the facility policy, entitled: Standards & Guidelines: Medication Administration, revised 11/22/2024, document: Standard: It will be the standard of this facility to administer medications in a timely manner and as prescribed by the physician, unless otherwise clinically indicated or necessitated by other circumstances such as lack of availability of medication or refusals of medication by the resident; 3. Medications should be administered in a timely manner and in accordance with the physician's orders; 7. Use at least two patient or resident identifiers when administering medications. The patient's or resident's room number or physical location is not used as an identifier. Note: At the first encounter, the requirement for two identifiers is appropriate; thereafter, and in any situation of continuing one-on-one care in which the individual providing care knows the patient or resident, one identifier can be facial recognition; 9. Medications should be administered within one (1) hour before or after their prescribed time. 10. After successfully identifying the resident to receive medication administration, the individual administering the medication should ensure that the right medication, right dosage, right time and right method of administration are verified. R1's Electronic Medical Record/EMR document R1's diagnoses to include: Diabetes Mellitus Type II, Squamous Cell Carcinoma of the Skin, End Stage Renal Disease, Dependence on Renal Dialysis, Atherosclerotic Heart Disease [ACHD], Paroxysmal Atrial Fibrillation, Overweight, Dysphagia, Hypertension, Abnormalities of Gait, Muscle Weakness, Hypothyroidism, Hyperlipidemia, Muscle Wasting, Sepsis, and Lack of Coordination. R1's form, entitled PRIVILEGED AND CONFIDENTIAL - NOT PART OF THE MEDICAL RECORD - DO NOT COPY TEST, dated 9/21/25, document: Medications administered include: Gabapentin 300 mg [milligrams], GuaiFENesin ER 600 mg, Norco 5/325 mg [confirmed to be 7.5/325 mg per R2's Medication Administration Record/MAR and V2 interview], Magnesium oxide 420 mg, Melatonin 12 mg [confirmed to be 6 mg per R2's Medication Administration Record/MAR and V2 interview], Metoprolol 50 mg, Multaq 400 mg, Pravastatin 20 mg, trazadone 200 mg; *During a routine medication pass in the dining room, the 300 hall nurse [V3/Registered Nurse] administered [R2's] medication to [R1]. Both residents were initially seated at the same dining room table and both wearing hats. Nurse stated she did not realize the medication error had occurred until she left and returned to the dining room and noticed that [R2] was moved to a different table. Nurse misidentified the resident - Both residents seated near each other and wearing hats - Nurse did not verify using two resident identifiers prior to administration therefore, did not follow the 7 rights and two identifier protocol. R1's Medication Administration Record/MAR document R1's scheduled 6:00 p.m. medications included: Midodrine 10 mg [for blood pressure/BP less than 100/60 in which R1's BP was 90/46], Senna Plus 8.6-50 mg, and Gabapentin 300 mg, were administered 9/21/25. R2's MAR document R2's scheduled 8:00 p.m. medications were: Gabapentin 300 mg [milligrams], GuaiFENesin ER 600 mg, Norco 7.5/325 mg, Magnesium oxide 420 mg, Melatonin 6 mg, Metoprolol 50 mg, Multaq 400 mg, Pravastatin 20 mg, and trazadone 200 mg. On 10/16/25, at 11:45 a.m., V2 (Director of Nurse) confirmed V3 administered R2's medications to R1; and it is V2's expectation that two resident identifiers are used during medication administration and to be administered within the 1 hour before/after scheduled times. On 10/16/2025, at 1:35 PM, V3 confirmed administering R2's 8 PM medication's to R1, saying, I miss identified the gentleman and confused him with someone else.</p>		