

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6001721	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/27/2026
NAME OF PROVIDER OR SUPPLIER CHRISTIAN BUEHLER MEMORIAL HM.		STREET ADDRESS, CITY, STATE, ZIP CODE 3415 NORTH SHERIDAN ROAD PEORIA, IL 61604		
(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
S 000	Initial Comments Complaint Investigation: 25211355/IL198677	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)1) 300.1630 c) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing	S9999		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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S9999	Continued From page 1 care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. Section 300.1630 Administration of Medication c) Medications prescribed for one resident shall not be administered to another resident. These requirements were not met as evidenced by: Based on interview and record review, the facility failed to ensure prescribed medications were administered to the correct resident, resulting in a significant medication error for one (R1) of four residents reviewed for significant medication errors in the sample of four. This failure resulted in R1 receiving R8's angiotensin receptor blocker medication, analgesic, statin (cholesterol reducer), SSRI (selective serotonin reuptake), and 5-alpha reductase inhibitor. This failure caused R1 to experience a hypotensive state that required R1 to be transferred to the hospital where R1 was admitted for medication overdose. The facility's Medication Administration policy dated 1/30/2018 documents, "in order to ensure the correct administration of medication to the residents of the Nursing Center, the following policy is to be followed at all times. Medications	S9999		

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S9999	Continued From page 2 may be administered by the Advanced Practice Nurse, Registered Nurse, or Licensed Practical Nurse... 3. Check the 5 rights of medication administration, a. right person, b. right drug. In the event of a medication error, the medication error form needs to be completed, and the D.O.N (Director of Nursing) and Medical Director are to be notified. 1. Assess the resident's condition, 2. Obtain a set of vitals, including oxygen saturation, 3. Follow any further instructions/orders from the medical director, 4. Call 911, if necessary, 5. Call family/POA (power of attorney)." R1's latest Physicians Order Sheet dated 6/1/2025-6/30/2025 documents, "acetaminophen 325 mg (milligrams), vitamin B complex, carvedilol 3.125 mg, ferrous sulfate 325 mg, furosemide 20 mg, potassium citrate 1080mg ER (extended release), tamsulosin 0.4mg, benzonatate 200 mg, Geri Lanta 30 cc (cubic centimeters). R1's Past Medical History dated 7/9/2024 documents, "chronic kidney disease, prostate carcinoma, previous left nephrectomy, and previous left hip fracture ORIF (open reduction and internal fixation)". The facility's Medication System Worksheet dated 6/3/2025 documents, "drugs involved in error, acetaminophen 1,000mg, atorvastatin 40mg, Entresto 24-26mg, escitalopram 20mg, finasteride 5mg". R1's Nursing Note dated 6/2/2025 at 8:30 PM documents, "earlier in shift, V4 (Registered Nurse) informed this RN (V7 (Registered Nurse) of medication error. The medical doctor was immediately notified, and vital signs were taken. 142/72 (blood pressure), 73 (pulse), 20	S9999		

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S9999	Continued From page 3 (respirations per minute), 97.1 degrees Fahrenheit (temperature), and 97% (oxygen level) on room air at 5:25 PM. The medical doctor instructed to monitor R1's blood pressure, at 6:25 PM, blood pressure was 122/62; at 7:25 PM, blood pressure was 100/50, and rechecked 97/50. The medical doctor was informed of R1's current hypotensive disposition, medical doctor instructed to place R1 in the supine position. Before R1 was able to be placed supine, V4 informed this registered nurse that R1 had a short unresponsive episode and emesis. It was at that time that 911 was called. R1 was taken to the nearby hospital. Medical Power of Attorney informed, Director of Nursing informed." R1's Nursing Note dated 6/3/2025 at 8:30 PM documents, "R1's vitals were monitored closely after medication error. Nurse (V4) was in contact with a medical doctor and followed instructions, except did not lie R1 in the supine position because R1 became unresponsive and then vomited. R1 was kept upright in the chair till the ambulance came". R1's Emergency Department hospital administration visit diagnosis dated 6/3/2025 documents, "Accidental overdose, initial encounter (primary)". V9 (Emergency Room Medical Doctor) note dated 6/3/2025 at 9:45 PM, documents, "R1 is a 99-year-old male, alert, and oriented x's (times) ¾ (person, place, and time) with a past medical history of chronic kidney disease, hypertension, and prostate cancer who presents to the emergency department for low blood pressure and confusion that occurred after being given the blood pressure medication intended for a different resident at his nursing home. R1 was	S9999		

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S9999	Continued From page 4 unresponsive for 5 seconds, requiring staff to perform a sternal rub. R1 was then found to be vomiting and hypotensive. Emergency Medical Services responded to the call. R1 was found to have a systolic blood pressure in the 70s while in triage, which has since elevated significantly." On 1/26/2026 at 1:07 PM, V4 (Registered Nurse) stated she asked R1 if he was R8 because both residents seemed to look the same. "I asked R1 if he was R8, and R1 stated "yes," so I gave him the medication cup that was full of R8's medications." V4 then stated, "I had a bad feeling, then I turned around and realized R1 was not R8". V4 stated that by the time she realized she had made a mistake, R1 had already swallowed R8's medications. On 1/27/2026 at 9:30 AM, V6 (Facility Primary Physician) stated, "I do believe the Entresto did cause R1's blood pressure to drop, which is why I was having the nursing staff monitor his blood pressure when they first called me about the accidental medication error". On 1/27/2026 at 1:30 PM, V2 (Director of Nursing) confirmed all nursing staff should be checking for the correct resident and correct medication, especially if the nurse is unsure. (B)	S9999			