STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009740	A. BUILDING: _____ B. WING _____	C 04/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON SENIOR LIVING	1201 NEWCASTLE WASHINGTON, IL 61571

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S 000	Initial Comments Complaint Investigation 2323316/IL158961	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.690a) 300.690b) 300.690c) 300.1210b) 300.1210d)1) 300.1630c) 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. Section 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident.	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence. 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 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	S9999		

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S9999	Continued From page 2 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 record review and interview the facility failed to properly prepare and administer medications to prevent a significant medication error and failed to notify the state reporting agency of a significant medication error for one resident (R3); and failed to prepare medications properly for three residents (R5, R6, and R8) of four residents reviewed for medication administration in a total sample of four. These failures resulted in R3 receiving the wrong medication and being hospitalized for low blood pressure and cardiac monitoring. Findings Include: The Facility's "Medication Administration" Policy dated February 2014 documents "Setting up of doses for more than one (1) scheduled administration is not permitted." The policy documents "Residents will be positively identified prior to medication administration and shall not be left alone until the medication is consumed or refused." Policy also documents "Medications errors, drug side effects and adverse drug	S9999		

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S9999	Continued From page 3	S9999		

reactions, including overdoses or poisoning, will be immediately reported to the attending physician, Director of Nursing, and pharmacist. The error or clinical symptoms will be documented in the clinical record and on the facility designated form."

The Facility's "Medication Error Investigation Summary" dated 4/20/2023 documents "Nurse reported to nurse supervisor of administering wrong medication to (R3). (R3) was given (R4)'s medications on 4/19/23 around 6:30 PM and had low blood pressure and became lethargic and was sent to the Emergency Room."

V9 (LPN) statement on 4/19/23: "I grabbed the wrong cup of medications and administered the Seroquel and Trazodone to (R3)."

On 4/25/23 at 12:30 PM V3 (LPN/Acting Director of Nursing) stated that on 4/19/23 around 6:30 PM R3 received all of R4's 4PM and 8PM scheduled medications to include: Atorvastatin Calcium 80 mg (milligrams), Docusate Sodium 200 mg, Quetiapine 625 mg, Trazadone 150 mg, Eliquis 5 mg, Lactobacillus 1 capsule, Sennosides Tablet 8.6 mg, Topamax 100 mg and Gabapentin 300 mg. V3 stated, "(V9) had pulled (R4)'s medication up and labeled the cup and gave them to (R3) by mistake." V3 stated, "Medications should not be prepared and left in the top of the cart for administration later."

On 4/25/23 at 10:30 AM V3 (LPN/Acting Director of Nursing) stated "I didn't know that I had to report that."

R3's Progress Notes dated 4/19/23 at 6:55 PM documents, "gave wrong medication, very tired,

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S9999	Continued From page 4 low bp (blood pressure) 72/44, did vitals called 911 notified md (Medical doctor) and called son but there was no answer sent to (Emergency Room) for evaluation. Resident was responsive and answering questions." R3's Emergency Room Record dated 4/19/23 at 8:00 PM, "Poison Control initial note: Case # 5175395. Goals for labs: Mag 2, Potassium 4, Calcium 9. Combination of meds will cause hypotension (low blood pressure), drowsiness and lethargy. Titrate (Norepinephrine/blood pressure maintenance support) as needed. Repeat EKG (electrocardiogram/cardiac monitoring) in 6 hours." R3's Emergency Room Record dated 4/19/23 documents R3 was admitted to the hospital for "hypotension due to drugs, accidental medication error." On 4/25/23 at 11:00 AM V14 (Nurse Practitioner) stated, "That (medication error on 4/19/23) was definitely a significant medication error, R3 is in the hospital receiving treatment for low blood pressure directly related to the error." R3's Medical Record documented she was hospitalized from 4/19/23 until 4/26/23 for treatment of low blood pressure. On 4/26/23 at 10:45 AM V15 (Pharmacist) stated that R3 receiving R4's 4:00 PM and 8:00 PM medications on 4/19/23, "certainly qualifies as significant." On 4/25/23 at 12:50 V10 (RN) had a medication cup with R5's name on it and a pill inside of it in the top drawer of her medication cart. V10 stated, "That is (R5)'s Buspar." There was	S9999		

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S9999	Continued From page 5 another empty cup with R7's name on it with "Zoloft" written on it. V10 stated that was to remind her to administer R7's medications. There was a medication cup with a small amount of crushed up pill noted in it with R6's name on it. V10 stated the crushed-up medication was R6's "Eliquis". On 4/25/23 at 1:00 PM V11 (LPN) had a medication cup with R8's name on it and a pill inside of it in the top drawer of her medication cart. V11 stated, "That is (R8)'s Gabapentin." (A)	S9999		