STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145000	A. Building B. Wing	04/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Washington Senior Living	1201 Newcastle Washington, IL 61571

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33970 Based on observation, interview and record review the facility failed to treat a wound timely and perform wound treatment dressing change as ordered for two residents (R1 and R3) of three residents reviewed for wound care. Findings Include: The Facility's Pressure Ulcers/Skin Breakdown-Clinical Practical dated 8/2008 documents The Physician will authorize pertinent orders related to wound treatments, including pressure redistribution surfaces, wound cleansing and debridement approaches, dressings (occlusive, absorptive, etc.) and application of topical agents. R1's Medical Record documents she was admitted to the facility 12/7/21 with Alzheimer's, Anxiety, Hypothyroidism, Insomnia, history of falling, Osteoarthritis, and diaphragmatic hernia. R1's Treatment Administration Record for April 2023 documents a treatment for R1's sacrum cleanse area with wound cleaner, pat dry, place crushed 500 mg Flagyl medication to wound bed, apply Dakin 1/8 or 1/4 strength-soaked sterile gauze, cover with (Gauze) pad every day and evening shift for pressure wound. On 4/21/23 at 10:30 AM R1 did not have any dressing on her sacrum. V8 (CNA) stated, There was no dressing on it when I came in this morning, I told the nurse (V5/RN) and she told me the wound nurse would come do it at some point. So, I got her (R1) up for breakfast without one. On 4/21/23 at 10:35 AM V5 (RN) stated, The wound nurse will be around to do rounds and do everyone's dressings. On 4/21/23 at 11:00 AM V4 (RN/Wound Care Nurse) stated, The floor nurse (V5/RN) should have either called me to come do the dressing or done it herself before (R1) was gotten up for the day. On 4/25/23 V17 (Wound Care Physician) stated, Residents who have open wounds should never be gotten up without a dressing on the wound. 2. R3's Medical Record documents she was admitted on ,d+[DATE] with diagnosis of humerus fracture, hypotension, heart failure, anemia, tremors and osteoarthritis. (continued on next page)

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's Skin and Wound Evaluation dated 3/17/23 documents a blister measuring 1 cm (centimeter) x .8 cm. R3's Physician Order Sheet and Treatment Administration Record do not document any treatment being done until 3/31/23 after R3 was seen by V17 (Wound Care Physician). On 3/31/23 V17 ordered Xeroform three times a week for 16 days and cover with gauze. On 4/21/23 V3 (LPN/Acting Director of Nursing) stated, I don't know why there was a delay in treatment. I had to terminate the previous wound care nurse for not fulfilling her duties.

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that residents are free from significant medication errors. 33970 Based on record review and interview the facility failed to properly prepare and administer medications to prevent 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. These failures resulted in an immediate Jeopardy. While the immediacy was removed on 4/26/23. The facility remains out of compliance at severity level 2 while the Facility continues to educate the nursing staff on proper medication preparation and administration and conduct audits to ensure continued compliance. 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 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). 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. R3's Progress Notes dated 4/19/23 at 6:55 PM documents, gave wrong medication, very tired, 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. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	R3's emergency room Record documents admit to hospital due to 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 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. The immediate Jeopardy began on 4/9/23 at 5:45 PM when V9 administered the wrong pre-prepared medications to R3. V1 (Administrator) was notified of the Immediate Jeopardy on 4/27/23 at 12:48 PM. The surveyor confirmed through observation, interview, and record review that the facility took the following actions to remove the Immediate Jeopardy: 1. R3's medical record confirms R3 was sent immediately to the emergency room for treatment of low blood pressure and remained in the hospital until 4/26/23. 2. On 4/19/23 the V2 (DON/Director of Nursing) immediately in-serviced the nurse involved in the medication error on proper medication pass procedures. 3. On 4/20/23 V3 (LPN/Acting Director of Nursing) completed all nursing staff training on proper med pass procedures and to never open medications prior to administering to residents. A whole house nursing staff training was repeated on 4/25/23 and 4/26/23 and all nursing staff reviewed proper procedure instructions and signed off. Anyone not signed off will review and signoff on training prior to their next scheduled shift. 4. On 4/25/23 an audit of all med carts to ensure no other medications were opened in advance of administering to residents was completed by V3 and continued 4/26/23. 5. DON or Designee will audit all med carts, 5 days a week, for 4 weeks to make sure no pills are opened in advance of administering to residents. 6. The facility will audit medication carts at least quarterly X 1 year to ensure that corrections are achieved. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	7. On 4/25/23 V9 (LPN) confirmed that she had gotten immediate education on how to properly dispense medications. 8. On 4/27/23 V4 (LPN) V9 (LPN), V10 (RN), V11 (LPN), V12 (RN) and V13 (RN) confirmed they had received education and multiple trainings on proper medication preparation and administration procedures since 4/20/23. 9. On 4/27/23 V3 stated that she will be auditing all medication carts daily five times a week for 4 weeks to check for pre-prepared medications. Then the audits will be done at least quarterly for a year. 10. On 4/27/23 Medication Cart Audit completed by V3 (LPN) was reviewed with no concerns. 11. On 4/27/23 Education on Proper Medication Administration dated 4/25/23 and 4/26/23 sign in sheets and course material reviewed with no concerns.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 33970 Based on observation, interview and record review the facility failed to properly store medications for 13 residents (R8-R20) on 4/25/23 during a medication pass observation. Findings Include: The Facility's Medication and Treatment Cart Policy dated 1/1/15 documents, It is the policy of this facility to maintain stocked medication and treatment carts for nursing personnel administering medications, treatments, or emergency wound care. The medication/treatment cart shall be locked or stored in a secure location when not in use. On 4/25/23 at 12:26 PM The Medication Cart on the Southwest Wing was unlocked, and no staff members were visible. On 4/25/23 at 12:30 PM V11 (LPN) returned to the hallway and stated, I just ran up front to ask a question for a resident. My cart should have been locked. On 4/25/23 at 1:30 PM V2 (Director of Nursing) provided a list of residents whose medication would be stored in the cart that was unlocked to include R8-R19. V2 stated, The Medication carts should be locked at all times. 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 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 and I give it to him little by little through the day in juice and/or food. On 4/26/23 at 10:45 AM V15 (Pharmacist) stated no medications should be stored in the top of the medicine cart and given little by little over the course of a shift due to possible loss of the entire dose. 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. On 4/26/23 at 8:00 AM V12 (RN) left all R20's morning medications on top of her medication cart while she went to look for metoprolol. On 4/26/23 at 8:05 AM V3 (LPN/Acting Director of Nursing) confirmed R20's morning medications were on top of V12's medication cart accessible to anyone who would be walking by. V3 confirmed the medications to be Eliquis 5 mg (Milligrams), Citalopram 40 mg, Levetiracetam 500 mg, Progesterone 100 mg, Potassium Chloride 20 meq (Milliequivalents) and Spironolactone 25 mg. V3 stated Medications cannot be left unattended on the top of the medication cart.