STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145062	A. Building B. Wing	04/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arc at Streator	1525 East Main Street Streator, IL 61364

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on interview and record review the facility failed to ensure a resident was free from significant medication error. This applies to 1 of 4 residents (R1) reviewed for medications in the sample of 4. The findings include: R1's face sheet shows she has diagnoses including COPD, type 2 diabetes, hypertensive heart disease, major depressive disorder and anxiety. On 4/17/26 at 11:33 AM, V4 (Licensed Practical Nurse/LPN) said on 4/8/26, she got R2's morning medications ready and went to her room. R2 was in the bathroom. She placed R2's medication cup and insulin pens on top of the nursing cart set to the side. V4 said she then went to R1's room and pulled R1's medications and grabbed R2's insulins pens. When I gave R1 the insulin, she said, Oh I get three shots today. V4 said she left the room to check R1's orders. R1 has orders for one injectable medication but does not take insulin. V4 said she notified the physician, V2 (Director of Nursing/DON), and V3 (Assistant Director of Nursing/ADON) about R1 accidentally receiving insulin. She received orders to monitor R1's blood sugar every two hours. V4 said she was extremely worried, she had snacks and juices at the bedside for R1. V4 said she administered R2's insulin to R1 by mistake. R1 received 4 units of lispro (short acting insulin) and 35 units of Lantus (long-acting insulin). V4 said we should discard the medications if the resident is not available during med pass. V4 said that day she came in early at 2:00 AM instead of 6:00 AM. R1 was monitored throughout the day without any adverse side effects. On 4/17/25 at 10:58 AM, V2 (DON) confirmed R1 was administered the wrong medications. V4 administered R2's insulin to R1 by mistake. R1's blood sugar was monitored every two hours and did not have any adverse effects. When administering medications nursing should verify the five rights including, right resident, right medication, right time, right route, and right dosage. Nursing should discard medications they pull if the resident is not available and medications should not be left on the cart. R1's Physician Orders dated April 2026 show there are no orders for insulin to be administered. R1's P.O.S. shows orders including metformin extended release 750 mg (milligrams) twice a day and Tirizepatide inject 2.5 mg subcutaneously one time a day every Wednesday. R1's Medication Error Report dated 4/8/26 V4 (LPN) documents I had gotten a prior resident's medications and insulin ready, but that resident was in the restroom, so I put the meds to the side. I went ahead and gotten current resident meds ready to administer.I grabbed the insulin pen.and administered to (R1). R1's nurses note dated 4/9/26 documents IDT (Interdisciplinary team) reviewed incident. Root cause, resident was mistakenly administered medications intended for another resident. The facility's Medication Administration Policy dated 2026 states, Administration of Medications: Medications must be administered in accordance with a physician's order e.g., the right resident, right medication, right dosage, right route and right time.

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