STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146019	A. Building B. Wing	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wabash Senior Living & Rehab	216 College Boulevard Carmi, IL 62821

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 0760 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49714 Based on observation, interview and record review, the facility failed to ensure medications were administered as ordered for 1 (R77) of 10 residents reviewed for medication administration in the sample of 38. This failure resulted in R77 experiencing a significant medication error in which 5 additional doses of diuretic medication were administered resulting in dizziness, abnormal lab values, Intravenous Fluid administration, supplemental Potassium medication, and a hospital admission for an Acute Kidney Injury. This past non-compliance occurred between 3/14/24 and 3/19/24. Findings Include: R77's Admission Record documented R77 was [AGE] years old with an admitted to the facility of 03/08/2023. Diagnoses listed in their entirety on this document are: Alzheimer's Disease with late onset; Essential Hypertension; Dementia in other diseases classified elsewhere, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. R77's Progress Note dated 3/8/2024 with a time of 1:48 P.M. documented V12 (Physician) was here for rounds in which he reviewed medications, labs, vitals and weights. Received new order to start Duo nebs BID (twice daily) x 7 days and Zaroxolyn 5mg (milligrams) daily for 5 days. R77's Progress Note dated 03/18/2024 with a time of 2:23 P.M. documented R77 was complaining of dizziness, reported to V12. New orders were received for a CBC (Complete Blood Count), CMP (Complete Metabolic Panel), UA (Urinalysis Analysis) and orthostatic B/P (blood pressure). R77's Progress Note dated 03/19/2024 with a time of 12:44 A.M. documented R77 is currently receiving 2 diuretics, Furosemide 40 mg two times a day and Zaroxolyn 5 mg in the morning. R77 was noted to be experiencing dizziness, dry mouth, and urinating less this shift. Had to ambulate to the bathroom with one assist. A Progress Note dated 03/19/2024 with a time of 1:31 P.M. documented R77 was prescribed Zaroxolyn on 03/08/2024 intended for 5 days. Medication was ordered in the system for an indefinite end date therefore R77 has been receiving Zaroxolyn since 03/09/2024. Held this AM (03/19/2024) due to symptoms. V12 notified to discontinue medication and V13 (Nurse Practitioner/NP) will see R77 today. R77's Medication Administration Record documented Zaroxolyn was administered daily from 03/09/2024 - 03/18/2024 and held on 03/19/2024. (continued on next page)

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

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F 0760 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	R77's Progress Note dated 03/19/2024 with a time of 1:31 P.M. documented new orders for Potassium 40 meq (milliequivalent) by mouth three times a day and a 500 milliliters intravenous (IV) bolus. R77 was then to have an additional 100 milliliters per hour times two hours, along with a BMP daily for 3 days, and close monitoring for fluid overload. Additionally, R77's Furosemide was to be decreased to 20mg BID for 3 days. A document labeled CBC/CMP dated 03/19/2024 documents the following: BUN (blood urea nitrogen) 96 (high) normal value 7-25, Creatinine 2.8 (high) normal value 0.6-1.3, Sodium 134 (low) normal 136-145, Potassium 2.3 (Low) normal 3.5-5.1, and GFR 14 (low) normal >90. R77's Medication Administration Record dated March 2024 documented the bolus and intravenous fluids ordered to be given were Normal Saline Solution 0.9% with administration completed as ordered. R77's Progress Note dated 03/19/2024 with a time of 6:20 P.M. documented that the certified nurse assistant reported R77 pulled IV out. R77's Progress Note dated 03/19/2024 with a time of 7:15 P.M. documents that IV attempts were made with no success. R77 was refusing additional attempts. R77's Progress Notes further document that on 03/20/2024 at 3:27 A.M., R77 was reapproached and explained the need to restart the IV. R77 tolerated the restart well, and voiced no concerns. IV of Normal Saline was hung at 100 ml / hr (hour). On 03/20/2024 at 05:15 A.M., a note documented that lab was here to draw the BMP at this time. A nurses note dated 03/20/2024 with a time of 10:13 A.M. documented V13 was notified of a BUN critical at 100--new order received to give bolus of 500mL NS (Normal then back to 100mL per hour at previous dosage). A nurses note dated 3/20/2024 with a time of 10:40 A.M. documented an IV of 500mL bolus NS infused and hung new bag, set rate at 100mL per hour. IV site patent at this time and no redness, no edema noted. A nurse note dated 03/20/2024 with a time of 12:06 P.M. documents R77 pulled out IV line. R77 does not comprehend what IV is or what it is for. A nurse note dated 3/20/2024 with a time of 2:40 P.M, documented received order from V13 to send to (name of local hospital) for direct admit. The local hospital discharge summary dated 3/22/24 documented R77 had an admitted to the hospital of 03/20/2024 with a diagnosis of Acute Kidney Injury. This same document noted R77 was having worsening edema in the long term care facility and more aggressive diuretics were ordered however, the length of treatment was extended beyond what was initially ordered. R77 experienced a decline in renal function. R77 had received IV fluids at the facility however, R77 continued to remove the IV. During R77's hospitalization R77 was treated with IV fluids for the Acute Kidney Injury, and diuretics were held. R77 initially had a creatine of 2.9 (No reference range given although lab results indicated high), creatine down to 1.7 (no reference [NAME], although a high but improving level is noted). A Progress Note dated 03/20/2024 with a time of 2:20 P.M. documented R77 admitted back to facility around 12:30 PM. On 04/19/2024 at 8:53 A.M., V3 (Director of Nursing/DON) stated she was made aware of the medication error by V14 (Licensed Practical Nurse). After reviewing the incident, it was discovered that when V10 (LPN) placed the order in the Electronic Medical Record (EMR) system with no end date. The EMR system places an end date of indefinite on each order unless a different date is selected. R77 was assessed by medical staff at the time of the medication error discovery and new orders were received for treatment that same day. R77 was treated in the facility until she wouldn't keep her IV in. V3 started a QAPI (Quality Assurance Performance Improvement) plan on the medication error. V3 checks the physician orders daily to ensure that the orders were written correctly. V3 stated that moving forward, all new orders will be matched against the nurses note. V3 educated all nursing staff on properly placing an order with an end date. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 04/19/2024 at 9:18 A.M. V10 (LPN) stated that she received the order for Zaroxolyn and that she was the nurse who placed the order for R77 Zaroxolyn in the computer. V10 stated that she did not place an end date on the order. V10 stated that she had been educated since the incident to ensure if the order contains an end date to make sure it is on the order in the EMR. On 04/18/2024 at 12:35 P.M., V12 stated that the expectation is that the facility follow physician orders. V12 stated that the extra doses of Zaroxolyn was a medication error. The extra doses of the medication lead to admission to a local hospital with diagnosis of Acute Kidney Injury. V12 stated that there was timely notification of the medication error and the hospitalization was a direct result of the medication error. A document titled Med Error, dated 3/19/24 documented R77 was prescribed Zaroxolyn 5mg daily times 5 days starting on 03/09/2024. When the order was placed there was no end date, so the order was indefinite. R77 has been receiving metolazone (Zaroxolyn) from 03/09/2024 - 03/18/2024 due to medication being held 03/19/2024 due to R77 having symptoms of dizziness. R77 was unable to give description. Action taken documents V13 saw R77 on rounds. Labs were ordered and done on R77. New order for IV fluids for 2 days, Oral Potassium 40 meq three times a day, decrease Furosemide to 20 mg for 3 days then return to 40 mg dose. Monitor for fluid overload. Do BMP daily times three days. A note dated focus area in R77's Plan of Care documented R77 receives diuretic therapy related to edema of bilateral lower legs and feet. The goal listed for this focus area is that R77 will be free of any discomfort or adverse side effects of diuretic therapy through the review date. The policy titled Administering Medications with a revised date of April 2019 documented, Medications are administered in a safe and timely manner. The same policy goes on to state .4. Medications are administered in accordance with prescriber orders, including any required time frame. Prior to the survey date, the facility took the following actions to correct the deficient practice: 1. A Quality Assurance and Performance Improvement (QAPI) meeting was held on 3/20/24. The incident was reviewed and identification of others at risk was discussed. In attendance - V1 (Administrator), V3 (DON) and V12 (Medical Director). 2. Interventions put into place to reduce risk of recurrence: Nursing staff educated regarding double checking orders for end dates upon entry. All nursing staff education was completed by 3/20/24. 3. Monitoring/Effectiveness: Administrator (V1), DON (V3) or designee will monitor order entries for end dates, 2 new orders will be monitored 5 days per week for 4 weeks. Any issue identified will be immediately corrected and re-education will be offerred and reviewed during QAPI Meetings.