STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146028	A. Building B. Wing	04/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wealshire Ctr of Excellence	150 Jamestown Lane Lincolnshire, IL 60069

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 35119 Based on observation, interview, and record review the facility failed to ensure medications were administered according to professional standards for 2 of 3 residents (R1, R8) reviewed for medications in the sample of 8. The findings include: 1. On 4/30/24 at 9:55 AM, R1 said a couple weeks ago, a night nurse left his 12:00 AM medications on his table under the TV. R1 said he had fallen asleep in his chair and when he woke up after 1:00 AM he went to the nurse and asked for his medications and she said she left them in his room on his table. On 4/30/24 at 2:40 PM, V5 Registered Nurse said when she was making her rounds one night, R1 was asleep in his chair. V5 said she didn't want to wake him up to take his medications, so she left in on his table under his TV. R1's Progress Note dated 4/10/24 by V5 shows Noted resident sleeping on his motorized wheelchair during initial rounds. Around 1:00 AM, resident wheeled himself outside the nurses station asking for his midnight meds then ranting out that his sleep would be late because he didn't get his meds on time. Told him that he was sleeping on his wheelchair when I was about to give his meds, and left the meds by the TV where he could easily see them when he wakes up. 2. On 4/30/24 at 10:21 AM, R8 was sitting in her wheelchair in her room at the bedside. R8's bedside table was next to her and had an empty medication cup sitting on it. R8 said she likes to go outside in the morning so the nurses leave her medications on the bedside table for her to take when she gets back. R8 said the nurse this morning left them for me and motioned to the cup on the bedside table. R8 said the nurses don't check that I take them, they know. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/30/24 at 11:40 AM, V3 Licensed Practical Nurse said R8 is alert and oriented and propels herself outside to smoke in the morning. V3 said R8 will request for you to leave her medications on her bedside table for her to take when she gets back. V3 said R8 did ask this morning for him to leave her morning medications on her table. V3 said R8 told him she was going to take her medications before she went outside so he left the medications on the bedside table. V3 said R8 came out for breakfast and left her medications on the table and took them later. V3 said when passing medications you should watch the resident take the medications to make sure that the medications were administered. V3 said he left all of R8's morning medications including R8's scheduled alprazolam (antianxiety medication) and blood pressure medications. R8's Medication Administration Record for April 2024 shows R8 receives 6 medications as 9:00 AM including an antidepressant, 2 blood pressure medications and an alprazolam (controlled substance) for anxiety. The same MAR shows on 4/30/24, R8's 9:00 AM medications are signed off as given by V3. The facility's undated Administering Medications Policy shows Medications are administered in a safe and timely manner, and as prescribed. For residents not in their rooms or otherwise unavailable to receive medication on the pass, the Medication Administration Records may be flagged. After completing the medications pass the nurse will return to the missed resident to administer the medication.