STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510252	A. BUILDING: _____ B. WING _____	C 07/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARTER SENIOR LIVING OF WASHINGTON	100 GRAND VICTORIAN PLACE WASHINGTON, IL 61571

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comment Facility Reported Incident/IL202877 to 7/17/26 295.6000a)13) cited	A 000		
A6000	Section 295.6000 Resident Rights This Regulation is not met as evidenced by: Section 295.6000 Resident Rights a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of his or her status as a resident of an establishment, nor shall a resident forfeit any of the following rights: 13) The right to be free of abuse or neglect or financial exploitation or to refuse to perform labor; Type 1 Violation Based on observation, interview, and record the establishment neglected to ensure physician ordered medications were transcribed correctly by the contracted pharmacy for one (R1) of three residents reviewed for medication management in the sample of four. This failure resulted in R1 receiving ten times greater the dosage of a physician ordered medication for three months, R1 suffering hallucinations, increased fall risk, a fall from bed, and a hospital visit for hallucinations. This failure caused severe harm to a resident or creates a substantial probability of severe harm to a resident or residents. Findings include: The establishments Resident Rights policy and procedure dated 4/17/2024 documents "The	A6000		

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A6000	Continued From page 1	A6000		

facility will comply with all current Federal, State and local laws and regulations concerning resident care, resident rights and protections and privacy disclosure requirements." This policy documents residents have the right to "receive all prescribed medications in the dosage and at intervals prescribed by a practitioner."

The Health and Wellness Director job description dated 5/2026 includes Primary Responsibilities as: "Ensure that the care provided to our residents exceeds operational standards and is in compliance with state and federal regulations; Adhere to all policies and procedures of (establishment); and Provide oversight and management to the medication program within the community."

The establishments Incident and Accident Report for R1, sent to the State Agency on 7/16/26 documents a medication error was discovered on 7/15/26. R1 had a physician order for Amitriptyline 10 mg (milligrams) that was incorrectly transcribed by the contracted pharmacy as Amitriptyline 100 mg, Amitriptyline 100 mg was sent to the establishment, and R1 received Amitriptyline 100 mg for 90 days. The contracted Pharmacy apologized for the error, contacted Z3 (R1's) PCP (Primary Care Physician) and a new order was obtained to titrate R1's Amitriptyline down.

The Medication List from Z3 (R1's) PCP dated 4/1/26 that was sent to the contracted pharmacy and the medication list dated 7/15/26 for R1 documents the physician order for Amitriptyline is 10 mg to be given daily at bedtime.

The Medication List in R1's EHR documents the psychotropic Amitriptyline was entered by the

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A6000	Continued From page 2	A6000		

contracted pharmacy as Amitriptyline 100 mg to be given daily at 8:00 pm.

On 7/22/26 at 8:10 am R1 was sitting in a wheelchair propelling self to towards the dining room for breakfast. On this same date at 12:00 pm R1 was sitting in a wheelchair in her room. R1 stated everything was fine until the facility took over ordering her medications; she has been weak, can't walk, had multiple falls, was seeing things, and has been to the hospital a few times. R1 stated she is not sure what happened but knows something got messed up.

On 7/22/26 at 9:00 am E2 HWD (Health and Wellness Director) stated the establishment began supervising R1 with self-administration of her medications on 4/15/26. E2 HWD stated (E2) got R1's medication orders from Z3 (R1's) PCP (Primary Care Physician) and faxed the orders to the contracted Pharmacy, the Pharmacy put all the orders into the establishments EHR, packaged the medications and sent them to the establishment. E2 HWD stated when the medications came in (E2) looked over the medications and all the packaged strips of medications matched the list in the EHR. E2 HWD stated she did not notice the Amitriptyline dosage difference, "I missed it." R1 received Amitriptyline 100 mg dose for three months and should have gotten 10 mg. "I didn't catch it." On 7/15/26 E2 HWD discovered the error after speaking with Z3 (R1's) Family Member who was questioning R1's behaviors. E2 HWD stated the pharmacist was "flabbergasted", the order should have been Amitriptyline 10 mg, Pharmacy entered the Amitriptyline as 100 mg in R1's EHR, and Pharmacy sent 100 mg tablets to the facility.

On 7/22/26 at 1:26 pm Z4 Pharmacist stated the

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A6000	Continued From page 3 pharmacy received an order for R1 for Amitriptyline 10 mg at bedtime on 4/14/26 and "unfortunately, it was entered into the system as 100 mg and 100 mg tablets were sent to the facility. The order was typed into the system as 100 mg not 10 mg and was not caught during the initial review." Z4 Pharmacist stated the facility notified the Pharmacy of the error on 7/15/26, Z3 (R1's) PCP was called and the error discussed with agreement to titrate the Amitriptyline back down to 10 mg. Z4 Pharmacist stated the possible side effects of the higher dose of Amitriptyline could cause hallucinations, increased fall risks, decrease in appetite, and vision problems. Z4 Pharmacist stated, "I do believe we cannot discount the hallucinations as side effect to receiving the higher dose of Amitriptyline for a couple of months." Z4 Pharmacist also stated that during this time frame R1 had received two different antipsychotics for hallucinations and psychosis. On 7/23/26 at 1:41 pm E1 ED/Executive Director and E2 HWD confirmed R1 had falls on 4/17/26, 4/21/26, and 7/16/26. R1 was sent out to the local hospital for evaluation for the 4/21/26 fall which resulted in no fractures but did have facial bruising. E1 ED and E2 HWD confirmed during the time frame of R1 receiving Amitriptyline 100 mg R1 had three falls, one requiring a hospital visit, a hospital visit on 5/22/26 for hallucinations, has received two different antipsychotic medications for hallucinations and is currently still taking one.	A6000		