| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| S 000 | Initial Comments<br><br>Complaint Investigation #1997348/IL00116376 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations:<br><br>300.610 a)<br>300.1620 a)<br>300.1630 c)<br><br>Section 300.610 Resident Care Policies<br>a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting<br><br>Section 300.1620 Compliance with Licensed Prescriber's Orders<br>a) All medications shall be given only upon the written, facsimile or electronic order of a licensed prescriber. The facsimile or electronic order of a licensed prescriber shall be authenticated by the licensed prescriber within 10 calendar days, in accordance with Section 300.1810. All such orders shall have the handwritten signature (or unique identifier) of the licensed prescriber. (Rubber stamp signatures are not acceptable.) These medications shall be | S9999 | **Attachment A**<br>**Statement of Licensure Violations** | |

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| S9999 | Continued From page 1<br>administered as ordered-by the licensed prescriber and at the designated time.<br><br>Section 300.1630 Administration of Medication<br>c) Medications prescribed for one resident shall not be administered to another resident.<br><br>These regulations were not met as evidenced by:<br><br>Based on interview and record review, the facility failed to prevent a significant medication error for one resident (R2) out of 7 reviewed for medications. This failure led to R2's Intensive Care Unit admission due to hypoglycemia secondary to receiving medications not ordered by physician.<br><br>Findings include:<br><br>R2's progress notes as follows:<br><br>On 9/11/19 at 07:28 AM, documented by V9 (Registered Nurse) "Sleep well most of the shift. and took due medicines in early AM at 5.30 am and back to sleep. At 6.15 am resident noted very sleepy, responding verbally but slow. Vitals taken and read as follows. B/P = 160/70 P 61. R=16 Spo2 room air= 95 %. Respiration regular and easy. Temp=97.9 temp. Skin warm and dry to touch. At 6.40 am (V12- Physician) office called, and he is an on call but not available. Message left as his office phone prompt says. Next shift update for follow up. Resident sleeping, saturation re checked = 94 -95 % room air."<br><br>On 9/11/19 at 08:09 AM, documented by V9: " ...Called V12 (Physician) at 7.45am again. Resident blood sugar checked , still sleepy, 31 mg/dl. Waiting MD return call. Glucagon 1 mg injected IM. Resident on oxygen for comfort, | S9999 | | |

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| S9999 | Continued From page 2<br>Respiration non labored. Skin warm and dry. .ON DNR code status"<br><br>On 9/11/19 at 10:34 AM, documented by V8 (Nurse) "Resident is able to verbalize self, more alert & oriented. Not in any distress. Denies of any pain and discomfort as of this moment. Assisted by staff to get ready for breakfast. Ate & consumed 100% of meal served .... From (V12's) office called back and was informed as well. Rechecked Glucose level @ 10 AM, 106 mg/dl. Will continue to monitor and refer as necessary."<br><br>On 9/12/19 10:16 AM, change in condition, as documented by V6 (Registered Nurse): "Situation: 1. The change in condition, symptoms, or signs observed and evaluated is/are: After breakfast around 945 am patient up in wheelchair and non-verbal, blank stare and not verbally responding, noted with pallor. Confused and checked BS level=162 mg/dl , put to bed right away and VS checked, O2 given. Unable to follow commands, flat affect when tried to shake him, smiled crookedly when asked to. Noted making sounds in his throat. Skin cool to touch.<br>2. This started on: 09/12/2019<br>2a. Since this started, it has gotten: Worse<br>3. Things that make the condition or symptom worse are: BS level went down from 162 to 30 when<br>paramedics arrived.<br>4. Things that make the condition or symptom better are:<br>5. This condition, symptom, or sign has occurred before? Yes<br>5a. Treatment for last episode: Yesterday had hypoglycemic episode and had glucagon injection.<br>6. Other relevant information: Pulse rate kept coming down==100, then 78 and 40 when | S9999 | | |

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| S9999 | Continued From page 3 | S9999 | | |

paramedics came
and patient more sleepy."

On 9/12/19 at 2:34 PM, documented by V6: "Called (local hospital) and also spoke with (V17), patient is admitted for hypoglycemia --he elaborated that they will do a series of test related to his pancreas /endocrinology system since after given D50 IV , BS level went up to 150 and pt. was alert again and after a few minutes, BS level just went down to 35mg/dl ...."

R2's hospital records, titled All results under (lab) miscellaneous test, dated 9/12/19 at 2330 PM, document: "(Glipizide) - positive"

Intensive Care Medicine Resident Admission History and Physical, dated 9/12/19, document: History of Present Illness: " ....presenting with severe hypoglycemia ....Further history gathered from patients nursing home ...Per evening nurse, patient was shaking and had Altered mental status in the morning. Had low glucose level so gave oral glucose. Blood sugar rose to 162 then dropped to 30. Also initially tachycardiac and then bradycardic to the 40's ...This has not happened before, patient is not diabetic, usually eats all meals, no recent medication changes and no sick contacts. In Emergency Department ...transferred to ICU for continued monitoring."

Intensive Resident admission note, dated 9/19/19, document: "Of note: he was admitted to the ICU with hypoglycemia, likely secondary to receiving his roommates sulfonylurea (positive screen)."

R2's facility investigation, dated 9/18/19, documents: " ....Family meeting - the (DON), and SS Director, met with V17 (R2's son) at 1530 on

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| S9999 | Continued From page 4<br><br>Wednesday 9/19/19, this meeting was requested by the son. He expressed concerns that his father may have been given the wrong mediations as indicated at by the hospitalist at (local hospital). The resident's medical records are not accessible to us at this time and updates via telephone are password protected. The son is willing to share the hospital record to complete our ongoing investigation ... Medical records became available on 9/25/19 and were reviewed, It did indicate that (R2) had "unintentionally, or accidentally ingestion of (glipizide)" .... A timeline was completed, and the Nurse was identified as making the error."<br><br>R2's resident information form lists the following diagnosis: "Cerebral Infarction Due To Unspecified Occlusion or Stenosis Of Unspecified Cerebral Artery, Dysphagia, Unspecified Atrial Fibrillation, Anemia, Hypothyroidism, Vitamin B Deficiency, Psychotic Disorder with Delusions Due to known physiological condition, other Psychoactive Substance Use, Depressive Episodes, Major Depressive Disorder, Generalized Anxiety Disorder, Conversion Disorder, Insomnia, Alzheimers' late onset, Glaucoma, Atherosclerotic Heart Disease, Chronic Diastolic Heart Failure, PVD, ORrthostatic Hypotension, GERD, Chronic Kidney Disease, BPH, Bradycardia, Hyperlipidemia"<br><br>There is no diagnosis of Diabetes.<br><br>R2's September 2019 Physician order sheet does not list (Glipizide). R2's order review report authorization date: 09/01/19 - 10/31/19 does not list (Glipizide).<br><br>(R3's resident information lists room/bed: 119-B. According to R3's September 2019 Physician | S9999 | | |

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| S9999 | Continued From page 5<br>Order Sheet documents but not limited to: Glipizide 5 mg tablet.)<br><br>On 10/15/19 at 1:50 PM, V6 (Registered Nurse) was interviewed and stated that R2 was not diabetic, there were no sugar checks needed for him, but had taken it because he had low blood sugar the day before. V6 stated that on 9/12/19, resident was unfocused and pulse was dropping so 911 was called. V6 stated that blood sugar dropped from time she checked and result was 130 to 30 when paramedics came. V6 stated that R2 was admitted to hospital for hypoglycemia and was informed by (V17) that more tests will be done for pancreas because blood sugar was unstable.<br><br>On 10/15/19 at 2:21 PM, V2 (Director of Nurse) was interviewed and stated incident investigation was done for R2. The first one was prompted due to R2's hypoglycemia where nothing was founded and second one - reopened investigation due to (V17) bringing up concern from hospital. V2 stated that medication variance form was done and basing off the second investigation, medication error was made, from hospital record of positive (Glipizide) screen and time line of medication effects, nurse working was identified and was suspended and terminated.<br><br>On 10/15/19 at 3:55 PM, V7(Human Resources Director) was interviewed and stated that V8 was a previous employee, had a reprimand record, was initially suspended pending investigation and terminated on 10/2/19, due to failure to follow policy and procedure for safe medication administration. V7 stated that V8 never returned to work after suspension. V7 stated that V8 declined to make any statement or sign anything. | S9999 | | |

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| S9999 | Continued From page 6<br><br>On 10/16/19 at 10:36 AM, V2 stated the (V8) had statements and did not clearly state or admit to making the medication error, but she was probationary and had been counseled for several instances of her pre pouring medications and labeling them with room numbers, and was reported to be on her phone while doing medication pass, and that would be a distraction. V2 stated that it is not facility practice to be pre pouring meds, it should be go to the room, prepare medications, give medications and sign them after.<br><br>On 10/17/19 at 9:57 AM, V15 (Medical Director) was interviewed that incident was a mistake of administering roommates medication to this resident. V15 stated on review, this patient had no diabetes and no medications for it. V15 stated hypoglycemia resulted from wrong medication and ICU admission was appropriate for closer monitoring and for a person with renal disease - any medication would have prolonged effects in the body as the kidneys are not effectively metabolizing and getting rid of the drug in the system.<br><br>Attempted to contact V8 (Former Employee - Nurse) and V12 (R2's Primary Care Physician) were unsuccessful.<br><br>(Glucotrol - Glipizide) Clinical Pharmacology documents: "Description: is an oral blood-glucose lowering drug of the sulfonylurea class. Indications and usage: ....is indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus. Precautions: ....may be slowed in patients with impaired renal and/or hepatic function. Hypoglycemia: ....renal or hepatic insufficiency may cause elevated blood levels of (Glucotrol), | S9999 | | |

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| S9999 | Continued From page 7<br>....both of which increase risk of serious hypoglycemic reactions."<br><br>(Pharmacy) titled: Medication Administration General Guidelines document under Policy: "Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Procedures: ....6. FIVE RIGHTS - Right resident, right drug, right dose, right route and right time, are applied for each medication being administered. A triple check of these 5 Rights is recommended at three steps in the process of preparation of a medication for administration: (1) when the medication is selected, (2) when the dose is removed from the container, and finally (3) just after the dose is prepared and the medication is put away ....Administration: ....2. Medications are administered in accordance with written orders of the prescriber. 3. When medications are administered by mobile cart taken to the resident's location (room, dining area, etc.) medications are administered at the time they are prepared. Medications are not pre-poured either in advance of the med pass or for more than one resident at a time .....6. Residents are identified before medication is administered using one method of identification. Methods of identification include: a) checking photograph attached to medical record, b) Calling resident by name (except in residents with cognitive impairment) c) having resident verify his/her last name d) if necessary, verifying resident identification with other facility personnel."<br><br>(A) | S9999 | | |