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| S 000 | Initial Comments<br><br>Complaint Investigation<br><br>2177534/IL139126 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violation<br><br>300.610a)<br>300.1210b)<br>300.1210d)1)<br>300.1210d)2)<br>300.3220f)<br><br>Section 300.610 Resident Care Policies<br><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 300.1210 General Requirements for Nursing and Personal Care<br><br>b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care | S9999 | **Attachment A**<br>**Statement of Licensure Violations** | |

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| S9999 | Continued From page 1<br>plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.<br><br>d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:<br><br>1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.<br><br>2) All treatments and procedures shall be administered as ordered by the physician.<br><br>Section 300.3220 Medical Care<br><br>f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. (Section 2-104(b) of the Act)<br><br>These Requirements were not met as evidenced by:<br><br>Based on observation, interview and record review the facility failed to ensure R1 received insulin as ordered by the physician and failed to ensure R4's cardiac medication was administered as ordered by the physician. These failures resulted in R1 sustaining elevated blood sugars and R4 requiring intravenous fluids and experiencing low blood pressure on multiple days. This affects 2 of 4 residents (R1, R4) reviewed for improper nursing and medication administration | S9999 | | |

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| S9999 | Continued From page 2<br>in the sample of 9.<br><br>Findings include:<br><br>1. The EMR (Electronic Medical Record) shows R1 was admitted to the facility on September 2, 2021. The EMR continues to show R1 was transferred from the facility to the local hospital on September 5, 2021 and admitted to the hospital with a diagnosis of DKA (Diabetic Ketoacidosis). R1 did not return to the facility. R1 had multiple diagnoses including acute osteomyelitis of the right ankle and foot, acquired absence of the right toe, rheumatoid arthritis, diabetes, cellulitis of the lower right limb, heart failure, lack of coordination, and reduced mobility.<br><br>R1's MDS (Minimum Data Set) dated September 5, 2021 shows R1 was cognitively intact, required supervision with locomotion and eating, extensive assistance with bathing, and limited assistance with all other ADLs (Activities of Daily Living).<br><br>R1's hospital transfer/discharge medication list, dated September 2, 2021 at 6:00 PM, shows multiple medication orders for R1 including empagliflozin (diabetes medication) 10 mg orally every morning, insulin aspart (fast-acting insulin) subcutaneously, three times a day before meals, with the next dose of insulin aspart due on September 3, 2021. The discharge medication list continues to show insulin glargine (long-acting insulin) subcutaneously, two times a day, with the next dose due on September 2, 2021 "PM." The hospital discharge paperwork shows R1's blood sugar was 231 at dinner on September 2, 2021 prior to discharge from the hospital to the facility.<br><br>The EMR shows the empagliflozin 10 mg orally every morning was ordered for R1, and Humalog | S9999 | | |

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| S9999 | Continued From page 3<br>(fast-acting insulin) was ordered on a sliding scale three times a day, with blood glucose monitoring.<br><br>The facility did not have documentation to show R1's insulin glargine (long-acting insulin) was ordered or administered to R1 while residing at the facility. The facility does not have documentation to show R1's physician was notified of the order for the long-acting insulin or the reason the resident was not receiving the medication as ordered.<br><br>R1's blood sugars while residing at the facility were documented and treated as follows:<br><br>9/3/21 9:00 AM: 283 - gave 6 units of Humalog insulin<br>9/3/21 1:00 PM: 344 - gave 8 units of Humalog insulin<br>9/3/21 5:00 PM: 216 - gave 4 units of Humalog insulin<br>9/4/21 9:00 AM: 362 - gave 10 units of Humalog insulin<br>9/4/21 1:00 PM: 307 - gave 8 units of Humalog insulin<br>9/4/2021 5:00 PM: 113 - no coverage required<br>9/5/2021 5:00 PM: 350 - gave 8 units of Humalog insulin<br><br>Facility documentation shows R1 experienced multiple bouts of nausea on September 3, 4, and 5, 2021. R1 received anti-nausea medication. Nursing documented the medication was effective three of the five times the medication was administered on September 3, 4, and 5, 2021.<br><br>On September 5, 2021 at 3:25 AM, V10 (Registered Nurse/RN) documented R1 was | S9999 | | |

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"having nausea/vomiting/diarrhea." R1 was sent to the local hospital via 911 ambulance. V10 documented at 6:53 AM, R1 was admitted to the local hospital's intensive care unit with a diagnosis of "DKA" (Diabetic Ketoacidosis).

Hospital documentation dated September 5, 2021 shows R1 was admitted to the local hospital with a blood glucose level of "333 mg/dL (milligrams/deciliter) (High)" DKA, leukocytosis, and vomiting.

On October 18, 2021 at 2:56 PM, V9 (Consultant Pharmacist) said, "The [long-acting insulin] medication was never ordered by the facility. Nursing staff should clarify medication orders and dosages with the physician when the orders come from the hospital. Our pharmacy sent a recommendation to the facility to request the facility staff obtain the order for the long-acting insulin and clarify the dosage after we reviewed the hospital orders and saw the medication was not ordered by the facility. The recommendation went out to the facility on September 6, 2021, but the resident had already been transferred to the hospital."

On October 18, 2021 at 3:32 PM, V1 (Administrator) said, "When a new resident is admitted to the facility, the medication orders from the hospital are audited by a nursing manager. It would have been our post-acute manager who should have audited [R1's] hospital orders and clarified the insulin dosage. The post-acute manager is no longer working here."

On October 18, 2021 at 3:59 PM, V8 (Physician) said, "I was not aware [R1] was admitted to the hospital with DKA, or that she had sustained high blood sugars over the few days she was at the

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facility. I would have expected the facility to clarify the long-acting insulin dosage with me if they were unsure. I would have made sure she got the medication. Elevated blood sugars can be a result of not receiving insulin as ordered."

The facility's nursing care guidelines entitled Medication Reconciliation, dated May 5, 2018 shows: "The facility will accurately and completely review and reconcile all medications upon the resident's admission to the organization and with the involvement of the patient or responsible party as indicated and to communicate list of resident's medications to the next provider of services when referred or transferred to another setting, service, or level of care within or outside the organization. This reconciliation is done to avoid medication errors such as omissions, duplications, dosing errors, or drug interactions. Procedures or steps: 1) New Admission - the steps may include: a) Obtain, review, and verify medications orders from the hospital discharge summary/instructions and/or medication history. b) Verify orders with the attending physician. Clarify that the medications and dosages are appropriate. Reconcile and document any changes. c) Create/enter medication administration record."

2. On October 19, 2021 at 9:38 AM, V16 (Licensed Practical Nurse/LPN) administered multiple medications to R4, including Metoprolol Succinate ER (Extended-Release beta-blocker/cardiac medication) 25 mg to R4.

V16 documented R4's blood pressure on October 19, 2021 at the time of administration of the Metoprolol Succinate ER 25 mg. as 100/60, and heart rate as 60 beats per minute.

The EMR shows an order dated September 29,

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2021 for Metoprolol Succinate ER 25 mg tablet extended release 24-hour daily at 9:00 AM. The EMR shows the order was discontinued on October 4, 2021 "in order to crush medications."

The EMR shows a new order dated October 4, 2021 for Metoprolol Tartrate (beta blocker/cardiac medication) 12.5 mg orally, twice a day for atrial fibrillation. Hold if SBP (Systolic Blood Pressure) is less than 110 and/or HR (Heart Rate) is less than 60.

On October 19, 2021 at 1:00 PM, V16 was asked if the blood pressure of 100/60 was R4's blood pressure at the time of administration of the Metoprolol Succinate ER 25 mg. V16 said, "Yes." V16 could not give a reason why she administered the medication when the physician orders show to hold the medication for a systolic blood pressure less than 110. V16 confirmed she administered Metoprolol Succinate ER 25 mg, not the order shown in the EMR for Metoprolol Tartrate 12.5 mg. V16 said, "This is what we've been giving" and showed R4 had been receiving the Metoprolol Succinate ER 25 mg twice a day since October 4, 2021.

On October 19, 2021 at 12:26 PM, V11 (Pharmacy Technician) said, "On October 4, 2021 we received an order from the facility for [R4] for Metoprolol Tartrate 12.5 mg orally twice a day and an order to discontinue the Metoprolol Succinate ER 25 mg daily. The Metoprolol Tartrate 12.5 mg medication was never sent to the facility." During the same telephone interview, V17 (Pharmacist) said, "The Metoprolol Tartrate 12.5 mg was never sent to the facility. The Metoprolol Tartrate medication can be taken more often than the extended-release medication. The extended-release medication cannot be crushed,

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so that would be a reason to switch a resident from the extended-release to the Metoprolol Tartrate so the medication can be crushed. If the facility has been giving the extended-release Metoprolol to the resident twice a day, the side effects of the medication would increase, including lower heart rate and lower blood pressures."

On October 19, 2021 at 2:35 PM, V18 (Nurse Practitioner/NP) said, "The facility reported to me [R4] wasn't urinating much and her blood pressure was on the low side, so I ordered intravenous fluids for the resident. The resident receiving Metoprolol Succinate ER 25 mg twice a day would give her low blood pressure."

The EMR shows R4 was admitted to the facility on September 28, 2021 with multiple diagnoses including encephalopathy, osteoarthritis, aortic stenosis, hypertension, chronic pain, dysphagia, difficulty walking, lack of coordination, cognitive communication deficit, atrial fibrillation, and convulsions.

R4's MDS dated September 30, 2021 shows R4 has significant cognitive impairment, requires limited assistance with eating, and extensive assistance with all other ADLs (Activities of Daily Living).

R4's October 2021 MAR (Medication Administration Record) shows nursing documentation for administering Metoprolol Tartrate 12.5 mg by mouth twice a day starting October 4, 2021 at 5:00 PM, despite the fact the facility never received the medication from the pharmacy.

Nursing documentation shows R4 received the

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| S9999 | Continued From page 8<br><br>Metoprolol Succinate ER 25 mg tablets on the following days, despite the medication being discontinued by the physician:<br><br>10/4/2021 - one dose<br>10/5/2021 - one dose<br>10/6/2021 - one dose<br>10/7/2021 - (2 doses, 9:00 AM and 5:00 PM)<br>10/8/2021 - (2 doses),<br>10/9/2021 - (2 doses)<br>10/10/2021 - one dose<br>10/13/2021 - (2 doses)<br>10/14/2021 - (2 doses)<br>10/15/2021 - one dose<br>10/16/2021 - (2 doses)<br>10/17/2021 - one dose<br>10/18/2021 - one dose<br>10/19/2021 - one dose<br><br>Nursing documentation also shows R4 received Metoprolol Succinate ER 25 mg outside the physician-ordered SBP (Systolic Blood Pressure) parameters (hold for SBP less than 110) on the following days:<br><br>10/4/2021 at 5:00 PM 109/64<br>10/6/2021 at 5:00 PM 95/60<br>10/9/2021 at 5:00 PM 100/62<br>10/10/2021 at 9:00 AM 96/58<br>10/15/2021 at 5:00 PM 100/80<br>10/18/2021 at 5:00 PM 97/55<br>10/19/2021 at 9:00 AM 100/60<br><br>On October 11, 2021 at 7:29 PM, V19 (RN) documented intravenous fluids were started on R4. R4's blood pressure reading on October 11, 2021 at 9:00 AM was 96/70 and at 5:00 PM R4's blood pressure was 92/51.<br><br>On October 11, 2021, at 10:30 PM, V20 (LPN) | S9999 | | |

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documented, "This nurse went into resident's room to answer call light and noticed that resident pulled out her IV to Left arm. Blood noted on resident but denies pain at this time. BP 85/65 HR 82. Spoke with [V18] (NP) and was given orders to insert IV at 100ml/Hr."

On October 19, 2021 at 3:37 PM, V21 (Pharmacist) said, "The Metoprolol Tartrate 12.5 mg was never sent to the facility by the pharmacy. It was an error on the pharmacy's part that it did not get sent. If the resident was receiving the Metoprolol Succinate ER 25 mg twice a day, that would be double the dose of her prescribed medication, plus it was extended-release medication. If the facility was crushing the extended-release medication for the resident, the resident could potentially get too much medication too quickly. The resident should have been closely monitored for low blood pressure and low heart rate because those are the major side effects of getting too much Metoprolol. Also, the resident should not be given the medication if her blood pressure or heart rate is low or outside the parameters set up by the physician."

On October 20, 2021 at 3:23 PM, V1 (Administrator) provided the policy entitled, Physician Orders, revised July 28, 2021. The policy shows: "Policy Statement: It is the policy of this facility to ensure that all resident/patient medications, treatment and plan of care must be in accordance to the licensed physician orders. The facility shall ensure to follow physician orders as it is written in the POS (Physician Order Sheet). Procedures: Upon admission and readmission, the facility will verify transfer orders from the hospital with the resident's attending physician or physician on call. ...7. Medication

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| S9999 | Continued From page 10<br>orders entered in the POS shall be reflected accurately in the MAR (Medication Administration Record). In addition, wound treatment orders entered in the POS shall be reflected in the TAR (Treatment Administration Record)."<br><br>(A) | S9999 | | |