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| S 000 | Initial Comments<br><br>Complaint Investigation: 2293705/IL146821 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations<br><br>300.610a)<br>300.1210b)<br>300.1210d)3)<br>300.1010h)<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 plan. Adequate and properly supervised nursing care and personal care shall be provided to each | S9999 | **Attachment A**<br>**Statement of Licensure Violations** | |

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| S9999 | Continued From page 1<br>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>3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.<br><br>Section 300.1010 Medical Care Policies<br><br>h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.<br><br>These Requirements were NOT MET as evidenced by:<br><br>Based on interview and record review, the facility failed to follow their policy and failed to report critical kidney function level labs to the nurse practitioner or physician for approximately one week for one (R2) resident reviewed for abnormal labs out of four residents in a total sample of seven. This failure resulted in R2's sent to the | S9999 | | |

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| S9999 | Continued From page 2 | S9999 | | |

local hospital with kidney function worsening causing acute renal failure, and R2 needing to be admitted to the intensive care unit in the hospital where emergent dialysis was performed.

Findings Include:

R2 is a 59 year old with the following diagnosis: chronic respiratory failure with encounter for a tracheostomy, dependent on ventilator status, type 2 diabetes, pressure ulcer to the sacral region, and chronic heart failure. R2 admitted to the facility on 02/07/22 and discharged on 03/01/22.

The Chemistry Lab Report dated 2/9/22 documents the following levels: blood urea nitrogen (BUN) of 22 mg/dL and creatinine of 0.6 mg/dL. These are kidney functioning labs to tell how well the kidneys are waste from the blood. Both the BUN and creatinine are within a normal range on this day. Normal range for BUN is 7 to 20 mg/dL, and normal range for creatinine is 0.6 mg/dL to 1.3 mg/dL.

The Laboratory Report dated 2/23/22 documents the blood specimen was collected on 5:50 AM, the blood specimen was received at 2:10 PM, and the final results were reported at 5:49 PM. This report documents the following levels: sodium of 164, potassium of 5.5, BUN of 141 (this is considered a critical level, anything higher than this would also be considered critical), and creatinine of 3.3.

The Laboratory Report dated 2/24/22 documents the blood specimen was collected at 5:45 PM, the blood specimen was received at 7:25 PM, and the final results were reported at 9:41 PM. This report documents the following levels: sodium of

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| S9999 | Continued From page 3<br>162, BUN of 146, Creatinine of 3.3.<br><br>There is no documentation in any notes that the critical lab levels were reported to a nurse practitioner or physician on 02/23/22 or 02/24/22.<br><br>A Nursing note dated 2/24/22 documents R2's pulse rate is elevated to 118. The nurse practitioner was notified and a new order was given for a blood pressure machine medication and stat complete blood count and complete metabolic panel (lab work).<br><br>A Nurse Practitioner note dated 2/25/22 documents the nurse practitioner assessed R2 on this day. No acute distress was noted. R2 was resting comfortably in bed. There is no mention of any abnormal lab work in this note.<br><br>A Nurse Practitioner note dated 3/1/22 documents R2 was seen and examined today for follow up abnormal lab values. R2 is not in any acute distress. R2 has critically high lab values noted on 2/24, ordered IV hydration but unable to insert IV due to edema in both arms. It will take hours to wait for midline insertion and repeat of lab exams. R2 was transferred to the hospital for IV hydration and further treatment. These lab results were done on 2/24 but was reported only today by the nurse. Per nursing, the results were in "unmatched lab" section of the chart.<br><br>A Lab note dated 3/1/22 documents the nurse relayed lab results to the nurse practitioner. A new order for intravenous fluids were ordered due to high level of creatinine, BUN, and sodium. An IV was attempted to be inserted but was an able to find a vein. The nurse practitioner order to send R2 to the hospital. | S9999 | | |

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| S9999 | Continued From page 4<br><br>The Nursing Home to Hospital Transfer Form dated 3/1/22 documents the reason for transfer as abnormal lab values - BUN 146, creatinine 3.3, and sodium 162.<br><br>The Hospital Records dated 3/1/22 document R2 arrived to the emergency room for electrolyte abnormalities. The labs from the nursing home showed a sodium level of 162 (normal is 135-145 mmol/L). R2 is at baseline with a history of anoxic brain injury, chronic trach, and G-tube. Lab work was ordered in the emergency room and showed the following: sodium of 150, potassium of 9.2 (normal 3.4-5.1 mmol/L), BUN of 288 (normal is 6-20 mg/dL), creatinine of 7.43 (normal is 0.67-1.17 mg/dL). R2 has multiple electrolyte derangements and chemistry shows acute renal failure. Nephrology was consulted for emergent dialysis. R2 was admitted to the intensive care unit given the critical nature of R2's condition. R2's emergency room diagnoses are acute renal failure, hyperkalemia, anemia, and hyponatremia.<br><br>On 05/27/22 at 11:10AM, V6 (Nurse) stated, "I do work doubles on Wednesdays so if my name is documented as taking R2's vital signs that I probably did work with R2 that day. When you get an order for a lab then you call the lab to schedule the draw. They come and they do the lab draw and send it back to the lab. We wait for the results and when they call with the results you relayed them to the doctor. If they are normal then you normally don't call but if they are abnormal you do call. The results are automatically uploaded into the computer so the doctors can take a look at them too. They will know that they're there even if we don't call them. I don't recall any call or results from the lab for that resident. With results that critical, it should be reported to the doctor immediately." This was the | S9999 | | |

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| S9999 | Continued From page 5<br>scheduled nurse working with R2 on 2/23/22 when the lab worked was documented as being reported.<br><br>On 05/27/22 at 11:27AM, V7 (Nurse) stated, "If a resident has a lab draw and the results are in then we relay them to the nurse practitioner or the doctor. You always call the nurse practitioner or doctor with critical results and document that you called them. You should always call them. There is not a reason that they should not be called." V7 denied remembering sending R2 out to the hospital for critical lab values.<br><br>On 05/27/22 at 2:50PM, V13 (Nurse Practitioner) stated, "I cannot tell you the exact days that I ordered the labs on but if they were done on those days then I probably told the nurses to do them. I know we tried to IV fluids on R2 but we ended up having to send R2 out the same day. I know that R2's BUN and other kidney function levels were critically high. When they are that high and not treated it, can lead to a need for dialysis due to renal failure. The longer you wait to treat something like that the more damage that is done to the kidneys and it is harder for them to get back to prior functioning. I know that with all R2's other comorbidities and with R2's wound that is where R2 could've been losing the hydration from. R2 only gets R2's nutrition and hydration through the G-tube so it is likely that with that worsening R2 was losing more fluid through that. If the nurses didn't tell me about the critical level then I likely would not have put in an order to address them. I've mainly relied on the nurses to tell me the critical level of the resident. I have six nursing homes that I oversee patients with so I understand when something like this could have been missed. I now make sure that it is a team effort and then I go in and I check all | S9999 | | |

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the labs for my residents. It is the expectation that the nurses still call either me or the doctor of the critical level."

On 05/31/22 at 1:54PM, V16 (Nurse) stated, "I normally work the night shift so if I have lab values that are called in I usually wait until morning unless they are critical. If they're a critical level then I will call the doctor immediately. We getting reports there was a lab draw and we know to watch out for the call or to check back to see if they were entered in. You always call when they're critical. I don't know why this one was not called in. I do not remember."

The Admission Hospital Records dated 2/7/22 document R2 presented to the hospital in November for unresponsiveness and was found in cardiac arrest. Lab work on 2/4/22 document a creatinine of 0.6 mg/dL and a BUN of 28 mg/dL. There is no documentation of concerns with kidney function upon discharge.

The Physician Order Sheet was reviewed and did not document any new orders addressing R2's critical kidney function levels until 03/01/22.

The Minimum Data Set (MDS) Section I dated 2/14/22 documents R2 does not have any renal failure or end-stage renal diagnoses. There is no care plan related to any renal concerns for R2.

The policy titled, "Physician-Family Notification-Change in Condition," dated 11/13/18 documents, "Purpose: to ensure that medical care problems are communicated to the attending physician or authorized designee in family/responsible party in a timely, efficient, and effective manner. Responsibility: license nursing personnel/social services. Guidelines: the facility won't inform the

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| S9999 | Continued From page 7<br>resident; consult with the residence physician or authorized designee such as nurse practitioner; and if known, notify the residence legal representative or an interested family member when there is: (A) an accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the residence physical, mental, or psychosocial status (i.e., A deterioration in health, mental, or cycle social status in either life-threatening conditions or clinical complications); ... (C) I need to alter treatment significantly (i.e., I need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); o A need to alter treatment "significantly" means a need to stop a form of treatment because of adverse consequences (e.g., an adverse drug reaction), or commence a new form of treatment to deal with a problem (e.g., do use of any medical procedure, or therapy that has not been used on that resident before)."<br><br>The policy titled, "Physician Notification of Laboratory/Radiology/Diagnostic Results," dated 3/14/18 documents, "Purpose: to assure physician order diagnostic tests are performed, and to assure test results are reported to the physician so that prompt, appropriate action may be taken if indicated for the residence care. Guidelines: a licensed nurse is responsible for ensuring the laboratory is notified of physician's orders for testing. A requisition is to be completed and lab to be drawn on the next scheduled lab draw unless "stat" or "same-day order" is received .... A nurse is responsible for monitoring the receipt of test results. Test results should be reported to the physician or other practitioner who ordered them. Guidelines for Reporting Abnormal | S9999 | | |

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| S9999 | Continued From page 8<br>Results: ... In the event the physician does not respond promptly to attempts to convey critical laboratory results, the alternate physician or medical Director will be notified. Promptly may be defined based on the clinical condition of the resident and the judgment of the nurse in each individual situation ... should the alternate physician or medical director not respond, the director of nursing will be notified. The director of nursing intervention should include: assessment of the residence clinical condition (in person or by phone); further attempt to contact the physician, alternate physician, or Medical Director; an emergency transfer based on clinical judgment. Unless other parameters are ordered by physician: ... sodium <130 or >145, potassium <3.0 or >1.5, blood sugars <64 > 400 in diabetes, BUN > 60 ..."<br><br>(A) | S9999 | | |