Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005193	A. BUILDING: ______ B. WING ______	C 06/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDEN LAKELAND REHAB & HCC	820 WEST LAWRENCE CHICAGO, IL 60640

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S 000	Initial Comments Complaint Investigations: #2384066/IL159912 #2384042/IL159878	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)1) Section 300.610 Resident Care Policies 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. Section 300.1210 General Requirements for Nursing and Personal Care 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	S9999	Attachment A Statement of Licensure Violations	

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care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

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:

1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.

These requirements are not met as evidenced by:

Based on interview and record review, the facility failed to ensure that one resident (R1) was free from a significant medication error in which insulin was administered instead of heparin to a non-diabetic resident (R1). This failure resulted in R1 needing hospitalization for blood sugar monitoring and administration of intravenous dextrose for a severely low blood sugar reading of 34 mg/dL (milligrams/deciliter) recorded in the emergency department.

Findings include:

R1's Admission Record documents diagnoses including but not limited to hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, chronic pain syndrome, peripheral vascular disease, and long term (current) use of anticoagulants.

R1's 5/16/23 BIMS (Brief Interview for Mental Status) determined a score of 15, indicating that R1's cognition is intact.

On 5/30/23 at 12:25 PM, R1 stated that on May

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9th, 2023, around 4 pm, after V9 (Agency LPN/Licensed Practical Nurse) gave R1 an injection, "Like a half hour later she (V9) came back and said, 'I (V9) made a mistake. I (V9) gave you insulin instead of heparin.' I (R1) said I'm not a diabetic." R1 stated that his (R1) blood sugar dropped to 51 mg/dL, and he (R1) was sent out to the hospital. R1 added, "I (R1) was scared, and knowing I (R1) got all that insulin, I (R1) didn't know what would happen." R1 stated that since then, he (R1) is very skeptical and requires the nurse to show him (R1) the heparin vial with his (R1) label on it as well as draw up the syringe in front of him (R1).

On 5/30/23 at 3:16 PM, V9 stated that after administering R1's injection, she (V9) walked back to her (V9) medication cart and noticed a vial of insulin sitting on top of the cart. V9 stated, "I don't know if I put the heparin vial back in the cart. All these thoughts start going through my mind. It's too great of a risk to not say anything if he (R1) was given that (insulin)." V9 asserted that she (V9) did have the eMAR (electronic Medication Administration Record) open and verified the medication at the time she (V9) was preparing R1's injection. V9 added that R1's initial blood sugar was 60 mg/dL upon assessment after the alleged medication error and physician orders were received to send R1 to the hospital. V9 described using a TB (Tuberculin needle) to inject 1 ml (milliliter) of medication into R1's arm.

On 5/30/23 at 2:47 PM, V3 (ADON/Assistant Director of Nursing) affirmed that V9 notified him (V3) that she (V9) may have given insulin instead of heparin because when she (V9) came back to her (V9) cart, she (V9) saw the insulin bottle, so she (V9) wasn't sure if she had drawn insulin lispro (fast-acting insulin).

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On 5/31/23 at 1:41 PM, V2 (Interim DON/Director of Nursing) stated that the expectation with medication administration is to administer medications as prescribed by the physician. V2 added that the process for medication administration is to confirm the order, make sure it's the right medication, right patient, right time, and right dose. V2 stated there is a risk of a medication error occurring if this process is not followed. V2 stated that the risks of a medication error involving insulin include but are not limited to, "Hypoglycemia (low blood sugar), altered mental status, or change in condition."

On 5/31/23 at 3:18 PM, V18 (Medical Doctor/R1's Primary Care Physician) confirmed that she (V18) was notified of the potential medication error. V18 also confirmed that R1 is not diabetic and was supposed to receive heparin. V18 stated, "I knew his (R1) sugar was going to drop. I (V18) told them to send him (R1) to the hospital immediately."

R1's 5/9/23 at 8:42 PM "ED (Emergency Department) Note Nursing" documents, in part, "Accucheck (blood sugar monitoring) 34. ER (Emergency Room) MD (Medical Doctor) notified. Amp (ampule) D50 (50% Dextrose injection) administered per order. Pt (patient) provided with Dr. Pepper and brownie."

R1's Hospital Discharge Summary authored by V18 documents, in part, "Chief Complaint and History of Present Illness...Patient was injected accidentally 100 units of insulin by nursing staff at SNF (Skilled Nursing Facility), called EMS (Emergency Medical Services) and who injected glucagon (emergency medication used to treat very low blood sugar). Patient became mildly

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altered, blood pressure went down to 60 (systolic)/30 (diastolic) and became better after glucagon injection. Patient was brought to ED (Emergency Department), was started on D10W (intravenous fluids containing dextrose), admitted for close observation of hypoglycemia (low blood sugar) and further treatment..."

R1's Order Summary Report lists a physician order for Heparin Sodium (Porcine) Injection Solution 5000 unit/ml (milliliter). Inject 1 ml subcutaneously every 8 hours for DVT (Deep Vein Thrombosis) prophylaxis related to peripheral vascular disease. R1 does not have a physician order for insulin.

The facility "Medication Correction Form" filled out by V9 (Agency LPN) documents, in part, "Describe the error: Administration of wrong medication. Insulin given. 1. State medication and dosage (if any) should have been given: Heparin 5000 unit/ml 2. What medication was given: insulin lispro ... 2. What act contributed most to giving a wrong medication? Insulin and heparin stored in close proximeter (proximity)."

The facility 3/2021 "Medication Administration: General Guidelines" documents, in part, "Policy: To ensure that medications are administered safely as prescribed ... Procedure: ... 3. Medications are prepared and administered by the same authorized staff. Administration should occur at the time of preparation. 4. Prior to administration, the authorized staff must verify medications and orders by comparing the medication label with the physician's order on the MAR/eMAR. Any discrepancies must be followed up by checking the original physician's order ... 7. Medications prescribed for one resident shall not be administered to another resident."

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S9999	Continued From page 5 The CDC (Centers for Disease Control and Prevention) online article titled "Low Blood Sugar (Hypoglycemia)" documents, in part, "Blood sugar levels change often during the day. When they drop below 70 mg/dL, this is called having low blood sugar. At this level, you need to take action to bring it back up ...Causes of low blood sugar: There are many reasons why you may have low blood sugar, including: Taking too much insulin ... Severe low blood sugar: As your low blood sugar gets worse, you may experience more serious symptoms, including: Feeling weak, having difficulty walking or seeing clearly, acting strange or feeling confused, having seizures. Severe low blood sugar is below 54 mg/dL. Blood sugar this low may make you faint (pass out). Often, you'll need someone to help you treat severe low blood sugar." (https://www.cdc.gov/diabetes/basics/low-blood-sugar.html) (A)	S9999		