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S 000	Initial Comments Complaint Investigation: 2358028/IL164831	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210a) 300.1210b) 300.1210d)3) 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 300.1010 Medical Care Policies 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 notification. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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 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: 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	S9999		

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S9999	Continued From page 2 further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure care and services were provided in accordance with professional standards of practice for the treatment of Type II Diabetes Mellitus for 3 (R3, R19, R20) of 4 residents reviewed for labs in the sample of 21. This failure resulted in abnormal lab values not being immediately communicated with the physician and R3 experiencing altered mental status requiring transport to the Emergency Department where a blood glucose level of 819 was found. Findings Include: 1. Review of R3's "Admission Record" documented his initial admission date to the facility as 9/16/21. R3's Primary Physician is listed as V13 (Physician) and Power of Attorney for care is V5 (Family Member). R3's "Cumulative Diagnosis Log" includes but is not limited to the following diagnoses: coronary artery disease; Dementia; Chronic Kidney Disease, Stage 3; Peripheral Neuropathy; Hypertension; Diabetes Mellitus II, with the "date identified" listed as 12/8/22. Facility policy titled, "(company) Notification for	S9999		

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S9999	Continued From page 3 Change in Resident Condition or Status" with an issue date of 7/1/12 documents, "The facility and/or facility staff shall promptly notify appropriate individuals (i.e., Administrator, DON (Director of Nursing), Physician, Guardian, HCPOA (Health Care Power of Attorney, etc.) of changes in the resident's medical/mental condition and/or status." The procedures stated, "1. The nurse supervisor/charge nurse will notify the resident's attending physician or on-call physician when there has been: ...m. Abnormal lab findings ...3. Except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in the resident's medical/mental condition or status ...5. The nurse supervisor/charge nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status." Facility policy titled, "(company) Laboratory Tests" with a reviewed date of 9/27/17 documents the facility policy as, "Appropriate laboratory monitoring of disease processes and medications requires consideration of many factors including concomitant disease(s) and medications(s), wishes of the resident and family and current standards of practice." A pharmacy consultation report dated 1/27/23 stated, "(Name) R3 has diabetes and does not receive medications, but an A1c (Glycated Hemoglobin) is not available in the medical record in the past 6 months. Fasting blood sugar on 11/16/22 was 213." Recommended was, "Please monitor A1c on the next convenient lab day." V13 (Physician) is documented on this form as accepting these recommendations, and labs will be drawn on 2/8/23 as well as an additional order given for an A1c to be drawn in July 2023.	S9999		

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S9999	Continued From page 4 R3's lab results documented a specimen collection date of 2/8/23, with a "H" (high) Hemoglobin A1c result of 9.9. The normal reference range of 4.8 % - 5.6 % is listed on this same document. The lab documented R3's estimated average glucose level to be 237, correlating with these A1c results. This lab document noted a handwritten comment of "faxed 2-8-23." These labs are documented as being faxed to the facility from the local hospital on 2/8/23 at 12:42 PM as evidenced by the fax server time stamp. R3's Physician Progress note made by V13 (Physician), dated 2/8/23 documented he was seeing R3 for a routine evaluation. V13 documented R3's blood sugar levels as being controlled, running about 150. V13 documented the last A1c level was on 11/16/22 with a value of 7.3. V13 gave no new orders regarding this evaluation and does not note lab results from 2/8/23. The first documented communication with V13 regarding the 2/8/23 A1c level is on 3/20/23. Review of R3's 3/20/23 Physician Progress note made by V13 documented R3 was a diabetic with his A1c being "a little high at 9.9." V13 documented R3 is post-covid, and he will look at R3 when he is well. The "Disposition" listed on this same note documented R3 ordered a chest x-ray and labs, which included an A1c and complete metabolic panel (CMP). R3's lab results documented a specimen collection date of 3/22/23, with a "H" A1c level of 10.3. The normal reference range of 4.8% - 5.6% is listed on this same document. The lab documented R3's estimated average glucose	S9999		

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S9999	Continued From page 5	S9999		

level to be 249, correlating with these A1c results. This lab document noted a handwritten comment of "faxed (V19 (Registered Nurse) initials)." Additional lab results with a collection date of 3/22/23, document an actual glucose level of 259. The normal range listed for this lab value is (70-100)." The A1c lab is documented as being faxed to the facility from the local hospital on 3/22/23 at 11:08 AM as evidenced by the fax server time stamp. The glucose lab is documented as being faxed to the facility on 3/22/23 at 8:01 AM as evidenced by the fax server time stamp.

No definitive documented communication can be confirmed that V13 was ever notified of these results. R3's Physician Progress note made by V13 on 4/3/23 documents, "We looked at the laboratory ..." although specific labs review is not noted. No new orders were documented on this progress note. R3's "Skilled Progress Note" dated 3/22/23 made by V19, documented communication with V13 regarding an abnormal chest x-ray result, but no mention of labs.

"Nurse's Notes" dated 5/15/23 at 6:00 PM documented, "Resident (R3) very confused and not himself. Was reported that he was unable to feed self and dumped 2 glasses of water r/t (related to) unable to grasp items. Resident incontinent at this time. Resident unable to form sentences and speaking garbled words. Vitals obtained and blood sugar. Blood sugar reading "HI" >600. (Name) V13 notified and send to hospital order given. (relationship/name) V5 notified. Ambulance service called. Report called and given to ER (Emergency Room) dept. (department). Awaiting ambulance at this time." The next Nurse's Note is dated 5/15/23 at 6:50 PM, "Ambulance service here along with

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S9999	Continued From page 6 (name/relationship) V5. Resident put on transport cart without difficulty. Both (all) departed at 7:05 PM. Will follow up with ER dept." R3's document titled, "ED (Emergency Department) Events" dated 5/15/23 documented the first provider evaluation was done by V23 (APRN-CNP/Advanced Practice Registered Nurse - Certified Nurse Practitioner) at 7:18 PM. Chief complaint is listed as "altered mental status." V23 documented, R3 presented to the ED with EMS (Emergency Medical Services). EMS reported upon their arrival they found R3 appearing sedated and confused with some slurred speech. V23 also documented, "Last known normal is unclear, as staff at the nursing home report he has been progressively more confused over the past couple of days." R3's initial labs listed in this same document note R3's Glucose level as 819 HH (extremely high). The reference range listed for the glucose level is 70 - 100 mg/dL (milligrams per deciliter). The "Clinical Impressions" as of 5/16/23 at 1:44 AM are listed as: Altered Mental Status, unspecified altered mental status type; Type 2 Diabetes Mellitus with hyperglycemia, without long-term current use of insulin; Dehydration. The "Plan" documents an insulin drip was initiated, and glycemic control was achieved. V23 noted review of R3's clinical chart documented an A1c level of greater than 7 for the past year, most recently 10.3 on 3/22/23, with no initiation of diabetic medications. R3 is documented as being admitted to hospital for continued glycemic monitoring and initiation of diabetic medications prior to discharge back to the nursing home. R3 is documented as now being conversant and oriented to person, place, time, and situation once glycemic control was achieved.	S9999		

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S9999	Continued From page 7 R3's "Medicine Discharge Summary" documented an admit date to the local hospital for R3 as 5/15/23 and discharge date of 5/20/23. R3's Admission and Discharge Diagnosis include the diagnosis of "Uncontrolled diabetes mellitus with hyperglycemia." The "Hospital Course" documents R3 was transported to the ED with a workup completed for a possible stroke, but no acute intercranial problems were discovered. R3's Glucose level was found to be 819, and includes the notation of, "Looking back at the nursing home patient had hemoglobin A1c done 2 months ago was 10.3 which gives an average of 249. The patient was not started on medications." R3's A1c listed as being completed in the hospital on 5/16/23 at 5:17 AM document a A1c level of then 13.8. Discharge medications include the addition of subcutaneous use of insulin glargine and insulin lispro. R3's Progress Note dated 6/5/23 documented V13 (Physician) was examining R3 on this date due to a hospitalization when "his blood sugar went to 800." The note goes on to say, "Let me look at his sugars. We are going to go back and find out what his sugars are. We have a hemoglobin A1c too high. It is 10.3 and this was on 3/22 .... So, hemoglobin A1c is too high. Now, let's look at blood sugars. Now, we are going to the computer. I assume some electronic medical records. We are having trouble finding the sugars. They have totally thinned the charts getting ready for electronic medical record. They are not here. So, we are still searching. They are bound to be some place." The "disposition" listed in this note included new lab orders, one being an A1c. Lab results documented a specimen collection	S9999		

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date of 6/14/23, with a "H" A1c level of 10.5. The normal reference range of 4.8% - 5.6% is listed on this same document. The lab documented R3's estimated average glucose level to be 255, correlating with these A1c results. This lab document noted a handwritten comment of "faxed (V19 (Registered Nurse) initials)." Additional lab results with a collection date of 3/22/23, document an actual glucose level of 130. The normal range listed for this lab value is (70-100).

Review of R3's Clinical Record documented V13 was notified of the 6/14/23 lab results on 6/15/23, with medication order changes given.

Lab results document a specimen collection date of 7/12/23, with a "H" A1c level of 7.9. The normal reference range of 4.8% - 5.6% is listed on this same document. The lab documented R3's estimated average glucose level to be 180, correlating with these A1c results. This lab document noted a handwritten comment of "faxed." The A1c lab is documented as being faxed to the facility from the local hospital on 7/12/23 at 7:40 AM as evidenced by the fax server time stamp.

The first documented communication with V13 regarding the 7/12/23 A1c level is on 8/7/23. V13 had no new orders at this time.

On 10/3/23 at 9:54 AM, V13 stated he doesn't recall being notified of R3's 3/22/23 A1c level of 10.3 or glucose level of 259. V13 stated he cares for a lot of people though, so the facility should document their communication with him. V13 stated that those levels would have been results he would have had further orders for, at minimum, repeat orders. V13 was notified of his

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S9999	Continued From page 9 4/3/23 progress note in which he stated he reviewed lab but does not specify which ones. V13 stated it can be suggested the 3/22/23 labs were not presented to him, given there were no new orders. V13 stated at any rate, he would expect to be notified of abnormal lab results immediately. V13 stated that uncontrolled blood sugar can lead to complications and even possible death, although he states it would have to be severe and may be a stretch. V13 confirms that a glucose level of 819 is critical and would require immediate intervention. V13 also stated he has no nurse practitioner who works with him and completes resident examinations himself. V13 stated that labs listed in the disposition section of his notes are orders he is giving. On 10/3/23 at 10:23 AM, V9 (Licensed Practical Nurse/LPN) stated the process for labs is that all labs are faxed to the physician, and if they are abnormal a call is made to notify the physician of the level. V9 stated if the labs are normal, they are placed in the resident's record after being faxed for the physician review the next time they are in the facility. V9 stated that V13 is easy to get a hold of and a good communicator with the facility. V9 stated that R3 was not having his glucose monitored except for via labs prior to his May 2023 hospitalization. On 10/3/23 at 10:59 AM, V2 (Director of Nursing) stated that the local hospital is the only entity the facility utilized for lab testing. V2 stated the process for labs in the facility is that once labs are ordered the labs are obtained as indicated. V2 stated the hospital will fax the results of the labs to the facility. V2 stated that a nurse on duty should then fax the lab results to the physician and call the physician if the lab results are	S9999		

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abnormal. V2 stated that the labs are always faxed to the physician so that the physician can keep a copy in their record too. V2 stated that routine labs with normal values would be placed in the resident's record for the physician to review during the next time they make rounds in the facility. V2 stated that abnormal lab values that are phoned to physician would have that communication documented in the progress notes. V2 stated that she believes it was just an error on the nurse's part that communication with the physician regarding R3's abnormal glucose/A1c labs was not documented. V2 stated that V13 is good about responding and communicating with the facility. V2 stated that glucose readings obtained by finger prick in the facility are documented on the MAR (Medication Administration Record). V2 stated that no concerns had been brought to her attention which may suggest R3 was experiencing hyperglycemia prior to his May ER visit and hospitalization. V2 confirms it is her expectation that the facility immediately contacts the physician regarding any abnormal labs or change in resident status and document such communication. V2 confirmed that lab samples obtained are obtained in a fasting nature, as they are sure to have them drawn before breakfast.

On 10/3/23 at 11:35 AM, V19 (Registered Nurse/RN) stated when a physician orders labs, they are obtained, and the physician is called if the results come back abnormal. V19 stated if the results are normal, they are placed in the resident's chart for review the next time the physician is in. V19 stated that all lab results are faxed to the physician office once the facility receives them so the physician can have a copy in their records. V19 stated that "generally" a note should be made in the resident's progress

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S9999	Continued From page 11 notes that the physician has been notified of any abnormal labs and any new orders, "but you know how life goes." V19 stated prior to R3's hospitalization she cannot say R3 was experiencing any signs of hyperglycemia specifically due to his intermittent confusion making it hard to tell. On 10/3/23 at 11:46 AM, V20 (RN) stated that she was the staff member who sent R3 to the hospital in May for altered mental status. V20 stated the something was just off and R3 wasn't himself. V20 stated that she was doing an evaluation trying to figure out if there was something she could note being wrong. V20 stated R3's vital signs were normal, but a finger prick glucose test was taken and just read high. V20 stated that she repeated the test, again receiving the reading of high. V20 stated she notified V13 who gave orders to send R3 to the hospital for evaluation. V20 stated that when the hospital faxes the facility lab results from specimen draws, the nurse on duty reviews the labs and faxes all the labs to the physician. V20 stated if something is an abnormal level, the physician is notified immediately by phone. V20 stated that staff are "suppose to" make a progress note, documenting the physician communication. On 10/3/23 at 12:47 PM, V21 (Health Information at out-of-town hospital) stated that she is one staff member who worked with V13's office. V21 stated in reviewing R3's records they received from the nursing home, she can see where an A1c level dated 2/8/23 was faxed to V13's office. V21 stated the only lab values V13's office received from the facility dated 3/22/23 was a	S9999		

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S9999	Continued From page 12 Vitamin B12 level. On 10/3/23 at 11:59 AM, V1 (Administrator) stated that a change in resident status or abnormal lab results should be communicated to the physician immediately with the communication documented in the progress notes of the resident record. V1 confirms that although requested, the facility is unable to provide communication with V13 immediately upon the receipt of R3's abnormal lab values from 2/8/23, 3/22/23, and 7/12/23. On 10/4/23 at 11:26 AM, V18 (Certified Nurse Assistant) stated she worked with R3 the day he was sent to the ED. V18 stated she recalls R3 urinating a lot that day and just being "out of it." V18 stated that nursing staff were aware and were monitoring him. V18 stated she had taken his Vital Signs a couple times, and they were fine. R3's Clinical Record via paper and Electronic Health Record documented no immediate communication with V13 regarding the abnormal lab results from the 2/8/23, 3/22/23, and 7/12/23 specimens. R3's Medication Administration Record via paper and Electronic Health Record documented R3 was not having his glucose monitored via fingerstick, nor receiving any medication therapy for diabetes from 2/1/23 until 5/20/23, when R3 returned from the hospital. R3's current "Active Orders" as of 9/28/23 documented R3 receives blood glucose monitoring four times a day. R3 is documented as receiving subcutaneous insulin glargine and insulin aspart medications for treatment of diabetes mellitus.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003172	A. BUILDING: _____ B. WING _____	C 10/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 13 R3's "Care Plan" documented a problem area of Diabetes with an initiation date of 12/8/22. Interventions include obtaining labs as ordered, and physician notification as needed. 2. R19's admission record documents an admission date of 12/10/21. This same document includes the following diagnosis Type 2 Diabetes Mellitus. R19 has labs dated 8/23/23 with abnormal values compared to the reference range. These labs include an elevated glucose. At the bottom of the page an unsigned note written in 'faxed' and dated 8/23/23. No further documentation is found in the chart regarding following up with the physician to ensure labs were received and if any new orders are to be carried out. 3. R20's admission record documents an admission date as 6/26/22. This same document includes the following diagnosis: type 2 diabetes mellitus. R20's lab result dated 5/10/23 includes labs with abnormal ranges. These abnormal labs include an elevated glucose level. The lab results are dated 5/10/23 by V9 (LPN) as "faxed to V13". On 10/5/23 at 11:30 AM, V9 stated that prior to 10/5/23 the policy was to just fax the lab results to the physician's office and no further documentation was done. "A"	S9999		