

Illinois Department of Public Health

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6000343 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 07/21/2023 |
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| NAME OF PROVIDER OR SUPPLIER ALIYA OF OAK LAWN | STREET ADDRESS, CITY, STATE, ZIP CODE 6300 WEST 95TH STREET OAK LAWN, IL 60453 |
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| S 000 | Initial Comments Complaint Investigations: 2392715/IL158244 2391978/IL157346 2391894/IL157203 Facility Reported Incident of 5-10-23/IL16007 Facility Reported Incident of 3-1-23/IL157647 Facility Reported Incident of 1-23-23/IL157311 | S 000 | | |
| S9999 | Final Observations Statement of Licensure Violations: Violation 1 of 3 300.1010h) 300.1210a) 300.1210b) 300.1210d)2)3)5) 300.3210a) 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 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 | S9999 | Attachment A Statement of Licensure Violations | |

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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| S9999 | Continued From page 1 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. Restorative measures shall include, at a minimum, the following procedures: 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: 2) All treatments and procedures shall be administered as ordered by the physician. 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 | S9999 | | | |

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| S9999 | <p>Continued From page 2</p> <p>made by nursing staff and recorded in the resident's medical record.</p> <p>5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.</p> <p>Section 300.3210 General</p> <p>a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of his or her status as a resident of a facility. (Section 2-101 of the Act)</p> <p>These requirements were not met as evidenced by:</p> <p>Based on interviews and record reviews, the facility failed to re-evaluate a resident's discharge plan and modify this plan when a resident had a change in condition to include elevated temperature, elevated white blood cell count and a deteriorating stage 4 pressure sore. This affected 1 of 3 residents (R9) reviewed for change in condition on the sample list of 36. This failure resulted in R9 going to the hospital 48 hours post discharge and being admitted with an</p> | S9999 | | |

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| S9999 | <p>Continued From page 3</p> <p>infected sacral pressure ulcer, osteomyelitis (bone infection) in wound, low blood pressure (73/63), elevated heart rate (101 beats/minute), increased respirations (24/minute), and diminished responsiveness to stimuli.</p> <p>Findings include:</p> <p>On 7/18/23 at 3:30pm, R9's family member stated that V17 (social services) telephoned him on 6/7/23 at 4:30pm to inform him R9 needed to be discharged the following day because insurance coverage was ending on 6/9/23. R9's family member stated that he does not recall being informed that he could appeal R9's discharge due to R9's sacral wound. R9's family member stated that he was not informed of R9's elevated temperature or elevated white blood cell count on 6/9/23 or that R9's sacral wound was infected.</p> <p>On 7/18/2023 at 10:15am, V20 (social services director) stated that social services, skilled therapy, nursing, and the resident's insurance make up the IDT (interdisciplinary team) involved in discharge planning. V20 stated that R9's family member was advised to come in for wound care training on 6/10/23. V20 stated that she believes R9's family member came in for this training. V20 stated that R9's family member did not express any concerns related to R9's discharge. V20 stated that she thought R9's family was okay with taking R9 home with a stage 4 sacral pressure ulcer. V20 did not follow up with R9's family member to ensure safe discharge home. V20 stated that IDT meet once a week to set discharge dates for residents. V20 stated that she relies on the nurses and nurse practitioners to inform her of a resident's wound status. V20 stated I'm sure that the clinical staff</p> | S9999 | | |

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| S9999 | <p>Continued From page 4</p> <p>review wound care notes, but she doesn't review wound notes or speak with wound care team. V20 unable to articulate reason the wound care team is not involved with the discharge planning process. V20 stated that V20 set up for R9 to have a wheelchair provided for home use by an outside DME (durable medical equipment) company. V20 was informed that this surveyor contacted this DME company and there is no record of V20 contacting this company to request any medical equipment. V20 stated that she did not follow-up with the home health agency and confirm start date for daily wound care treatments.</p> <p>On 7/11/23 at 12:13pm, V67 (representative at DME company) stated that she could not find any referral for DME for R9. V67 stated that she checked their computer system four different ways to see if any requests were made, using R9's name, date of birth, phone number, and address. V67 stated that she is unable to find any requests made between 5/23/23 and 6/10/23 for R9.</p> <p>On 7/11/23 at 12:30pm, V68 (home health nurse) stated that the home health agency received a referral on 6/9/23. V68 stated that this agency was waiting for insurance approval for services. V68 stated that after received insurance authorization, R9's family member was contacted to set up first visit and she was informed that R9 was in the hospital with an infected sacral pressure ulcer.</p> <p>V20 presented an order form for R9's wheelchair request. This form does not note the name of the DME company request was made. There are no delivery or product request notes documented on this form. V20 was unable to present any</p> | S9999 | | |

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| S9999 | <p>Continued From page 5</p> <p>documentation of the response to referrals sent to the home health agency and the DME company.</p> <p>On 7/18/23 at 11:00am, V51 (wound care physician) stated that he was not involved in R9's discharge planning process. V51 stated that he was not made aware of R9's elevated temperature or elevated WBC (white blood cell - increases due to infection or inflammation) results on 6/9/23. V51 stated that R9 was last seen on 6/6/23 when R9's sacral wound was observed to be deteriorating. V51 stated that he is present once a week for wound care rounds and to monitor wound progress. V51 stated that he was not aware R9 was being discharged to home on 6/10/23. V51 stated that he did not speak with V61 (attending physician) prior to R9's discharge but his notes are readily available in R9's electronic medical record for V61 to review.</p> <p>V51 (wound care physician) documentation, dated 5/30/23, noted R9's unstageable sacral pressure ulcer measured 6.7cm x 7.7cm x 0.2cm, 70% eschar (dead tissue), 10% slough, and 20% skin, moderate blood tinged drainage. On 6/6, R9's wound was reclassified as a stage 4 sacral pressure ulcer. Wound measured 11.8cm x 8.3cm x 0.6cm, 70% eschar, 10% slough, and 20% skin, moderate blood tinged drainage; wound deteriorating.</p> <p>On 7/18/23 at 2:30pm, V61 (attending physician) stated that V61 does not recall being notified of R9's abnormal laboratory results that were ordered urgently on 6/9/23. V61 stated that he does not think anyone contacted him. V61 stated that V61 expects communication from the nursing staff regarding any changes in a resident's</p> | S9999 | | |

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| S9999 | <p>Continued From page 6</p> <p>medical condition. V61 stated that V51 (wound care physician) should notify V61 if V51 has any concerns with discharging a resident with wounds. V61 stated that V61 did not speak with V51 regarding R9's deteriorating stage 4 sacral pressure ulcer. V61 stated that V61 was aware of R9's temperature 101 degrees on 6/9/23, but temperature normalized after receiving fever reducing medication. When questioned if R9's discharge to home would have been postponed if V61 was made aware of R9's WBC (white blood cell count) had increased to 16.7 on 6/9, V61 responded it is hard to say because he would have to look at the whole clinical picture. V61 stated that he could have held R9's discharge to further evaluate reason for elevated WBC. V61 stated that the home health agency could have assessed R9's sacral wound and done further work-up regarding elevated WBC. V61 was informed that R9 did not receive any home health services due to being hospitalized after discharge from this facility with an infected sacral pressure ulcer. V61 stated that R9's transition to home would have been better if home health services had been done.</p> <p>Review of R9's medical record, dated 5/29/23, notes V20 (social services director) and representative from therapy had a care conference with R9 and R9's family member. R9 and R9's family member were provided with an update on how R9 has been doing in therapy and the recommendations for home.</p> <p>Review of R9's medical record, dated 6/9/23, notes V60 (nurse) notified V50 NP (nurse practitioner) that R9 is scheduled for discharge in the morning and was noted to have an elevated temperature of 101 degrees. New orders received for urgent complete blood count.</p> | S9999 | | |

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| S9999 | <p>Continued From page 7</p> <p>There is no documentation found noting V60 notified R9's family member or V51 (wound care physician) of R9's change in condition on 6/9/23.</p> <p>There is no documentation found in R9's medical record noting V61 (attending physician) or V51 were notified of R9's abnormal laboratory results.</p> <p>(B)</p> <p>Violation 2 of 3 300.610a) 300.1210a) 300.1210b)5) 300.1210c) 300.1210d)6)</p> <p>Section 300.610 Resident Care Policies</p> <p>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.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> | S9999 | | |

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| S9999 | <p>Continued From page 8</p> <p>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)</p> <p>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. Restorative measures shall include, at a minimum, the following procedures:</p> <p>5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.</p> <p>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.</p> | S9999 | | |

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| S9999 | <p>Continued From page 9</p> <p>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:</p> <p>6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.</p> <p>These requirements were not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to follow their fall prevention and management policy to include developing and implementing fall prevention plan of care, failing to utilize two person assistance for toileting/bed mobility and transfers for three of three residents (R16, R15, and R20) reviewed for falls on the sample list of 36. This failure resulted in R15 falling from the bed, while receiving care from facility staff, and sustaining a laceration requiring three staples and a left parietal subdural hemorrhage.</p> <p>Findings include:</p> <p>1) R16 was admitted to the facility on 2/20/23 with a diagnosis of repeated falls, unsteadiness on feet, dementia, osteoarthritis, major depressive disorder and hypertension.</p> <p>R16 facility reportable dated 3/1/23 documents: R16 was in pain at a scale of 8. R16 reported he had a fall during the early morning. Swelling and guarding was noted to right knee and R16</p> | S9999 | | |

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| S9999 | <p>Continued From page 10</p> <p>complained of pain to the front and back of his right leg. Unwitnessed fall occurred in resident's bathroom and R16 did not notify staff of incident. Resident admitted to local hospital with diagnosis of fracture of right femur.</p> <p>R16's pre admission documents dated 2/20/23 documents under safety: decreased awareness of need for assistance and decreased awareness of need for safety. Under history and physical documents: R16 presented to emergency room for frequent falls. Upon discussion with patient, he notes he has been falling more recently as much as two times today. Thinks falls are mechanical in nature states he does not always use his walker when going around the house.</p> <p>R16's hospital record dated 3/1/23 documents under CT of lower extremity right: acute basicervical femoral neck/intertrochanteric proximal femur fracture. Under history documents: He was discharged to rehab facility and coming today for a new mechanical fall that resulted in fracture. Per patient he was trying to go the bathroom and fell, and lied on the floor for at least 30 minutes.</p> <p>R16 medical record documents only on fall risk evaluation dated 3/1/23 which documents a score of 22 which indicates resident is at high risk for falls. There were no other fall risk evaluations in the medical record.</p> <p>R16's admission evaluation dated 2/20/23 under fall risk factors documents: none of the above. Under proceed to care plan there is nothing checked or documents for fall interventions.</p> <p>R16's plan of care alteration in musculoskeletal status related to weakness date initiated 2/21/23</p> | S9999 | | |

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| S9999 | <p>Continued From page 12</p> <p>indicates cognitively intact.</p> <p>R15 minimum data set (MDS) under functional status dated 1/16/23 documents for bed mobility a score of 3 for self-performance which indicates extensive assistance and a score of 3 under support which indicates two plus persons for physical assist. For toilet use a score of a score of 3 for self-performance which indicates extensive assistance and a score of 3 under support which indicates two plus persons for physical assist. Under bladder and bowel documents under urinary incontinence care 2 frequently incontinent.</p> <p>R15's fall risk factors on admission dated 10/28/22 documents under fall history none of the above.</p> <p>R15's care plan dated 1/11/23 documents under Activities of daily living (ADL) Self care deficit as evidenced by physical deficits related to recent hospitalization due to shortness of breath and generalized weakness noted with diabetic ketoacidosis, hyperlipidemia, hypothyroidism, multiple myeloma and chronic kidney disease. Interventions: ADL assist: usually transfers with mechanical lift and two person assist.</p> <p>Facility final reportable dated 1/24/23 documents under summary of events: On 1/22/23 patient as sent to Emergency room following an incident at facility resulting in scalp laceration. Records reports staples were applied to head laceration. Under type of injuries documents: scalp laceration and 0.8 cm left partial hemorrhage. Under timeline documents: on 1/22/23 while facility staff were providing assistance with incontinence care, patient started rolling out of the bed and staff were unable to stop her from</p> | S9999 | | |

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| S9999 | <p>Continued From page 13</p> <p>rolling out of the bed. Witness statement dated 1/23/23 for V16(certified nursing aide, CNA) documents: I was doing rounds around 9:00 PM-9:15 PM. I went to change the resident after I had gathered the supplies. I took off the incontinence brief and washed her private area. I turned toward the door and she started to roll. I tried to stop her but she fell out of bed on the floor.</p> <p>R15's hospital record dated 1/22/23 documents under diagnosis laceration of scalp, closed head injury, hyperglycemia. Under CT head documents left parietal subdural 0.8 cm hemorrhage; scalp hematoma. Under history documents: Patient states she was at rehab center, she was getting changed when she rolled over and fell out of bed hitting her head. Patient has a scalp laceration received 3 staples in emergency room.</p> <p>R15's transfer notification progress note dated 1/22/23 documents: Patient was being changed by facility staff and accidentally fell out of the bed hitting her head. This injury resulted in significant bleeding from the head.</p> <p>On 7/12/23 at 2:41 PM, V15 (Nurse) who was identified as the nurse working with R15 at time of fall said V16(CNA) reported to him that she was changing R15's incontinence product, when she turned R15, she rolled off the bed. V15 said the bed was at waist level and there were no other staff in the room at time of incident.</p> <p>On 7/12/23 at 12:50 PM, V29 (Minimum data set, MDS nurse) said under section G functional status is determined by staff point of care charting. A score of 3 under supports indicates the patient required 2 or more person assist with the task.</p> | S9999 | | |

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| S9999 | <p>Continued From page 14</p> <p>3) R20 was diagnosis with Dementia, Cognitive communication deficit, unsteadiness on feet and history of falls with injury. R20 required extensive assistance with two plus person physical assist with bed mobility and transfers. R20 required limited assist with one person physical assist for eating. R20 had lower extremity impairment on one side. Fast track report dated 4/17/23 documents: R20 was at risk for falls. Progress note dated 5/6/23 documents: Writer was called into room by aide for assistance. Upon arrival into the room, writer noticed resident (R20) was on the floor on her left side laying on a pillow with a small bowl close to her face. Resident not able to tell what happened due to cognitive impairment. Incident report dated 5/6/23 documents: Left eyebrow began to swell. Discharge to hospital. Predisposing Physiological Factors: confused, incontinent, weakness/fainted, gait imbalance and impaired memory. Predisposing situation factor documents: recent room change.</p> <p>On 7/11/23 at 2:49PM, V2 (DON) said, R20 was noted lying on the floor on her face. R20 rolled out of bed. R20 had some redness and bruising on her face. R20's fall interventions were to kept bed in the low position, to minimal risk just in case R20 happen to fall. I guess they felt like the intervention was a good one moment.</p> <p>On 7/12/23 at 12:54PM, V29 (MDS) said, R20 required one person physical assist with eating and two plus person physical assist with turning and repositioning which mean staff has to and will turn the resident for bed mobility.</p> <p>On 7/12/23 at 1:23PM, V18 (physical therapy) said, R20 was not able to roll from lying on her back to a side lying position. R20 was low level in</p> | S9999 | | |

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| S9999 | <p>Continued From page 15</p> <p>cognition and physical function. R20 did not initiated any movements. R20 was maximum assist for bed mobility. R20 required ninety percent of staff assistance to turn and reposition in bed.</p> <p>Care plan initiated 4/26/23 documents: R20 was at risk for falls due to impaired balance/poor coordination, potential medication side effect, unsteady gait, history of falls and weakness. Interventions: bed in low position, encourage to transfer and change position slowly, provide assist to transfer and ambulated as needed and implement use of preventive device: non-skid socks.</p> <p>Rehabilitation evaluation status post functional decline dated 5/3/23 documents: R20 was referred for skilled therapy related to a noted functional decline, decrease in strength, transfers, ambulation and the ability to perform self-care ADL's. Past medical history: falls with a left femur fracture. Orientation: alert and orient to person, confused. Positive for generalized weakness and bilateral upper tremors. High fall risk: follow all facility fall precaution.</p> <p>Witness statement by V27 (cna) dated 5/7/23 documents: While during rounds and collecting lunch trays. I walked into R20's room at 1:20PM. R20 was noted on the floor on her left side with a pillow near her head.</p> <p>Hospital record dated 5/6/23 documents: R20 had an unwitnessed mechanical fall sustaining ecchymosis to left forehead.</p> <p>Fall Prevention and Management policy dated 1/2023 documents: The facility will identify and evaluate those residents at risk for fall, plan for</p> | S9999 | | | |

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| S9999 | <p>Continued From page 16</p> <p>prevention strategies, and facilitate as safe an environment as possible.</p> <p>(A)</p> <p>Violation 3 of 3 300.610a) 300.1210a) 300.1210b) 300.1210d)1) 300.1610a)1) 300.1630b) 300.1630e)</p> <p>Section 300.610 Resident Care Policies</p> <p>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.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>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</p> | S9999 | | |

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| S9999 | Continued From page 17 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. Restorative measures shall include, at a minimum, the following procedures: 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 Section 300.1610 Medication Policies and Procedures a) Development of Medication Policies 1) Every facility shall adopt written policies | S9999 | | |

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| S9999 | <p>Continued From page 18</p> <p>and procedures for properly and promptly obtaining, dispensing, administering, returning, and disposing of drugs and medications. These policies and procedures shall be consistent with the Act and this Part and shall be followed by the facility. These policies and procedures shall be in compliance with all applicable federal, State and local laws.</p> <p>Section 300.1630 Administration of Medication</p> <p>b) The facility shall have medication records that shall be used and checked against the licensed prescriber's orders to assure proper administration of medicine to each resident. Medication records shall include or be accompanied by recent photographs or other means of easy, accurate resident identification. Medication records shall contain the resident's name, diagnoses, known allergies, current medications, dosages, directions for use, and, if available, a history of prescription and non-prescription medications taken by the resident during the 30 days prior to admission to the facility.</p> <p>e) Medication errors and drug reactions shall be immediately reported to the resident's physician, licensed prescriber if other than a physician, the consulting pharmacist and the dispensing pharmacist (if the consulting pharmacist and dispensing pharmacist are not associated with the same pharmacy). An entry shall be made in the resident's clinical record, and the error or reaction shall also be described in an incident report.</p> <p>These requirements were not met as evidenced by:</p> | S9999 | | |

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| S9999 | <p>Continued From page 19</p> <p>Based on observation, interview and record review, the facility failed to follow physician order blood glucose parameters for the administration of insulin. This affected one of three (R35) residents reviewed significant medication error on the sample list of 36. This failure resulted in the facility administering 5 units of insulin to R35, whose blood glucose levels were not within physician ordered parameters, subsequently R35 was found verbally unresponsive, hard to arouse and hospitalized with the diagnosis of hypoglycemia.</p> <p>Findings Include:</p> <p>On 7/13/23 at 12:59PM, code blue was called to R35's room. R35's skin was observed pale and pasty. R35 was moaning with mouth opened wide while staff was doing the sternum rub. Emergency medical technician (EMT) service arrived and checked R35's blood glucose level which resulted at 44mg/dL (milligrams per deciliter) (normal range 70-100mg/dL).</p> <p>On 7/13/23 at 1:27PM, V44 (nurse) said, I took R35's blood glucose this morning. The result was 119mg/dL. V44 could not recall the exact time R35's blood glucose was taken or when insulin was given. I administered five units of insulin per R35's physician order. R35 was found unresponsive around lunch. I re-checked R35's blood glucose which resulted at 50 mg/dL. I administered two amples of glucagon which raised R35's blood glucose the mid to high fifties low sixties.</p> <p>On 7/13/23 at 3:55PM, V47 (R35's family) said, R35 was given too much insulin. R35's blood glucose was 44mg/dL. R35 doesn't eat much food. R35 had to be discharge to the hospital for</p> | S9999 | | |

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| S9999 | <p>Continued From page 20</p> <p>medical evaluation.</p> <p>On 7/14/23 at 11:32AM, V2 (Director of Nursing) said, R35's incident yesterday was a reportable event and a medication error.</p> <p>Physician order sheet dated 7/11/23 documents: HumuLIN R Injection Solution 100 UNIT/ML. Inject five units subcutaneously one time a day for diabetes once daily if glucose > (greater than) 200.</p> <p>Medication administration record dated 7/13/23 at 10:07AM documents: V44 administered Insulin subcutaneously to R35's right upper quadrant (RUQ/abdomen).</p> <p>Progress note dated 7/13/23 documents: 9am Received patient (R35) in bed, blood sugar checked at 119 mg/dL. Five (5) units of Humulin R injection solution 100 unit/ml given subcutaneously in her RUQ abdomen. At 1:01pm while rounding noted (R35) verbally unresponsive and hard to arouse. Blood sugar/glucose checked at 50 mg/dL. Called Code Blue and 911. Glucagon 1mg/1ml (milligrams/milliliter) administered via subcutaneous to her right back of arm. Recheck blood glucose at 56 mg/dL. R35 was drowsy but aroused to sternal rub, open eyes, and mumbled words. Administered another dose of glucagon 1mg/1ml subcutaneous via left lower quadrant. Rechecked blood glucose at 62 mg/dl. R35 more awake and alert and verbally responsive. Oral dose of glucagon gel given by a fellow nurse. Sternal rub continued to keep patient aroused. Patient verbally responding.</p> <p>Hospital paperwork dated 7/13/23 documents; Patient (R35) alert and oriented times four brought to ED (emergency department) from the</p> | S9999 | | |

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| S9999 | <p>Continued From page 21</p> <p>nursing home with complaints of hypoglycemia. Per emergency medical service (EMS) registered nurse (RN) might have given the R35 too much insulin causing her blood glucose to be forty-four. R35 states that she had no preceding symptoms, felt well this morning, no light headiness, chest pain, syncope, shortness of breath, fever, nausea, vomiting or any other symptoms preceding receiving insulin. Emergency Department (ED) diagnosis: Hypoglycemia (low blood sugar) secondary to wrong insulin dose.</p> <p>Employee report dated 7/13/23 documents: V44 did not follow medication order as written.</p> <p>Diabetes Management date 1/2023 documents: To provide guideline for the management residents: Guideline: Residents with a diagnosis of diabetes with be managed per physician's orders.</p> <p>(A)</p> | S9999 | | |