| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | IL6003750 | A. BUILDING: _____ B. WING _____ | 06/07/2018 |

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| S 000 | Initial Comments<br><br>Annual Health<br><br>Statement of Licensure Violations | S 000 | | |
| S9999 | Final Observations<br><br>300.610a)<br>300.1210b)<br>300.1620a)<br>300.1630c)<br>300.3240a)<br><br>Section 300.610 Resident Care Policies<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>Section 300.1210 General Requirements for Nursing and Personal Care<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 resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following | S9999 | **Attachment A**<br>**Statement of Licensure Violations** | |

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procedures:
Section 300.1620 Compliance with Licensed Prescriber's Orders
a) All medications shall be given only upon the written, facsimile or electronic order of a licensed prescriber.
Section 300.1630 Administration of Medication
c) Medications prescribed for one resident shall not be administered to another resident.
Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident

These requirements were not met as evidenced by:

Based on interview and record review the facility failed to ensure a resident was not administered a medication prescribed for another resident for one of one residents (R74) reviewed for significant medication errors in a sample of 22. This failure resulted in R74 receiving a diabetic medication meant for another resident which caused R74 to have severe low blood sugar levels, hypotension and seizures resulting in prolonged hospitalization.

Findings include:

A Pharmacy Policy and Procedure Manual dated April 24, 2017 page 37 states, "Medications are administrated as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication." Page 38 of the policy states, "Medications are administered in accordance with written orders of the attending physician. If a dose

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seems excessive considering the resident's age and condition or a medication order seems to be unrelated to the resident's current diagnoses or condition, the nurse calls the provider pharmacy for clarification prior to the administration of the medication. This interaction with the pharmacy and the resulting order clarification are documented in the nursing notes and elsewhere in the medical record as appropriate." Page 39 of the policy states, "The resident's MAR (Medication Administration Record) is initialed by the person administrating the medication, in the space provided under the date, and on the line for that specific medication dose administration."

A facility Medication Administration Policy dated March 2014 states, "19. The Medication Administration Record will be verified against the physician's orders. 20. Medications shall be recorded on the MAR promptly after each administration by the individual who administered the drug."

A current Glipizide drug disease interactions sheet from Drugs.com documents, Glipizide is a sulfonylureas classification and states, "patients with impaired liver and/or renal function treated with sulfonylureas may be exposed to higher serum drug concentrations, which can increase the potential for severe hypoglycemic episodes induced by these agents. Hypoglycemia, if it occurs during treatment, may be prolonged in these patients because of slow metabolism and/or excretion of the drugs."

R74's Face Sheet documents diagnoses which include: End Stage Renal Disease with dependence on Renal Dialysis and Chronic Kidney Disease. R74's Facesheet does not include a diagnosis of Diabetes.

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On 06/03/18 at 10:21 a.m., R74 stated on 4/28/18 R74 was having a seizure of some kind and had to be sent out to a hospital. R74 later found out it was actually due to low blood sugar from an incorrect medication given to R74 "that began with a G." R74 stated that 911 was called and he was taken to the hospital. R74 further stated that he was hospitalized from 4/28/18 through 5/14/18 at a local hospital in the intensive care unit (ICU). R74 stated that his blood sugar was as low as 20mg/dl (milligrams per deciliter) during his hospital stay.

Progress notes for R74 dated 4/28/18 at 8:42 a.m., states, "7:00 a.m. called to (R74's) room per C.N.A. (Certified Nurse Aide). (R74) was jerking, unresponsive. B/P 72/40 per palpitation. Diaphoretic at top of head. Blood sugar 48. (V14) physician called and ordered to send to (local ER Emergency Room). Ambulance called, wife and daughter were notified. 7:15 a.m., ambulance here. Ambulance started IV and was given medicine per IV. Blood sugar up to 125. Resident was arousing and stated felt like he was having a stroke. Ambulance wanted (V14) called to see if wanted resident still sent d/t was arousing. (V14) was called and ordered to send resident to ER due to this was unusual for resident; DON notified."

Progress notes dated 4/28/18 at 1:27 p.m., for R74 documents: "Resident being admitted to local hospital; diagnoses hypoglycemia, seizures, and mental status change."

A facility incident report dated 4/28/18 at 8:40 a.m., documents that R74 had been observed to be unresponsive with jerking movements, blood pressure 72/40 palpable, and blood glucose 48. A

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facility incident report form dated 4/30/18 at 8:30 a.m., documents that R74 was admitted to the hospital with a diagnoses of hypoglycemia.

R74's local hospital history and physical and emergency records dated 4/28/18 states "(R74) resides at a nursing home, apparently was recently started on glipizide. Blood sugars dropped down profoundly and (R74) was having apparently seizure-like activity and he was transferred to the ER, had to be started on a glucose drip and transferred to the ICU (intensive care unit). Assessment and Plan, 1) Refractory hypoglycemia, almost certainly secondary to Glipizide. ED Assessment: (R74) was brought in from his rehabilitation facility for altered mental status and hypoglycemic episodes. Given the high probability of a clinically significant life-threatening deterioration, (R74) required the highest level of care to intervene emergently. (R74) will be admitted to the ICU for the ongoing hypoglycemic episodes associated with seizure activity."

A local hospital discharge summary from V14 physician for R74's hospital stay of 4/28/18 through 5/14/18 states, "(R74) will be discharged to (previous facility) today. (R74) was dialyzed and stable, seen and examined, evaluated earlier today, See history and physical and follow up notes. (R74) came in with profound hypoglycemia. Sepsis at that time was ruled out. We did not think he had a depletion of glycogen stores. There was a question about receiving oral hypoglycemics. The issue is still in flux as the nursing home is convinced that even though the order got on the wrong chart, he was never given an oral hypoglycemic, but he certainly acted that way clinically as his sugar continued to go down repeatedly in spite of multiple amps of D50 (fluids

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given intravenously with dextrose) and he was started on D10. (R74) also was hypotensive, which is not new, but intermittently required intensive care management for close monitoring of his blood sugar and management of this blood pressure."

A letter (undated) from V17 Pharmacist of the prescribing pharmacy states "The dose pack for R74 for the dates of 4/27/18 and 4/28/18 was delivered to the facility on 4/26/18 late evening or just after midnight and contained Glipizide 10 mg along with two other medications Dialyvite 800-Ultra D and Fludrocortisone for 8:00 a.m. and 5:00 p.m. administration on 4/27/18."

On 6/5/18 at 10:30 a.m., V16 Pharmacist stated that an electronic order was received from the facility for resident R74 for Glipizide 10 mg and was processed and shipped on 4/26/18.

A medication error report dated 4/30/18 documents that a transcription error for Glipizide 10 mg was entered into Electronic Medical Record and added to the physician order report (POS) for R74 and the outcome to R74 was hypoglycemic, and admitted to hospital with hypoglycemia.

On 06/05/18 at 9:40 a.m., V13 Licensed Practical Nurse (LPN) stated, "I was instructed by V2, Director of Nursing (DON) to write the medication Glipizide on R74's medication administration record on 4/26/18 due to a new order that was transcribed by V2 from the Physician Order Report (POS)." V13 LPN stated that she did not clarify the order before putting in on the MAR even though the medication being ordered was diabetes medication. V13 further stated that R74 is not diabetic.

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| S9999 | Continued From page 6<br><br>On 6/5/18 at 10:03 a.m., V14 Physician stated that V14 has never given an order for Glipizide for R74.<br><br>On 6/5/18 at 2:45 p.m., V2 Director of Nursing stated that on 4/26/18 V2 transcribed a physician's order for Glipizide (Diabetic medication)10 milligrams (mg) twice a day 8:00 a.m. and 5:00 p.m. onto R74's chart accidentally. V2 stated, "The medication (Glipizide) was for a different resident."<br><br>(B) | S9999 | | |