STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007496	A. BUILDING: _____ B. WING _____	C 06/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLLINSVILLE REHABILITATION & HEALTH C	614 NORTH SUMMIT COLLINSVILLE, IL 62234

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S9999	Final Observations Statement of Licensure Violation: 300.610a) 300.1210b) 300.1210d)1)2) 300.1620a) 300.3240a) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. 2) All treatments and procedures shall be administered as ordered by the physician. 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. The facsimile or electronic order of a licensed prescriber shall be authenticated by the licensed prescriber within 10 calendar days, in accordance with Section 300.1810. All such orders shall have the handwritten signature (or unique identifier) of the licensed prescriber. (Rubber stamp signatures are not acceptable.) These medications shall be administered as ordered-by the licensed	S9999		

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S9999	Continued From page 2 prescriber and at the designated time. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act) These Requirements are not met as evidenced by: Based on interview and record review, the facility failed to provide and administer insulin medication and failed to monitor blood glucose levels for 1 of 3 residents (R3) reviewed for change in condition in the sample of 6. This failure resulted in R3 being sent to the hospital and admitted to the Intensive Care Unit for Diabetic Ketoacidosis. Findings include: R3's Admission Physician Order Sheet (POS) dated 6/9/17 documents admitting diagnoses significant for Diabetic Ketoacidosis and Diabetes Mellitus. The POS further documents, " Insulin Lispro 100 units/ milliliter (ml) Sliding Scale before meals, and Insulin Levemir 25 units subcutaneously q (at) hs (bedtime)." R3's Medication Administration Record (MAR) dated 6/2017 documents R3's blood glucose	S9999		

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reading on 6/10/17 at 6:00AM was 400 milligram/deciliter (mg/dl) and was administered 12 units of Insulin Lispro. The MAR also documents R3's blood glucose levels at 6AM on 6/10/17, 6/11/17, and 6/12/17 but there were no blood glucose levels documented at 11 AM and 4PM on the same dates. The MAR documents, "Insulin Levemir inject 25 units subq (subcutaneously) at hs (bedtime)," with initials circled on 6/9/17, 6/10/17 and 6/11/17.

R3's Care Plan Master Listing dated 6/9/17, documents, "Resident admitted with diagnosis of Diabetes Mellitus and Diabetic Ketoacidosis and needs monitoring for Hypoglycemia/Hyperglycemia. Approach: Close monitoring of blood sugar and give SSI (sliding scale insulin) as ordered and daily insulin as ordered."

R3's Nurses Notes dated 6/12/17 at 8:30AM, documents, "Resident was found in room during breakfast having increased respirations and difficulty being aroused. Due to patient being diabetic, she was sent to (city hospital) via paramedics, staff waited for paramedics." " Vital signs: 105/85, 97.3, 22, 110. Blood sugar was checked 3 times before paramedics arrived and read 'high' all times."

R3's Emergency Room Care Physician Documentation dated 6/12/17 at 9:30AM, documents, in part, "Patient is a 69 y/o Caucasian female, with past medical history of Diabetes Mellitus, Diabetes and Schizophrenia, who presents to the Emergency Dept, with complaints of elevated Blood Sugar. Per EMS (Emergency Medical Services) report, the patient did not receive any insulin over the weekend, patient's blood sugar was >600 upon EMS arrival."

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R3's Hospital Discharge Summary dated 6/16/17 documents, in part, "Admitting Diagnosis: DKA Diabetic Ketoacidosis (resolved). Was sent to the ER with elevated blood sugar was found to have DKA was admitted to ICU (Intensive Care Unit) and treated with insulin infusion."

On 6/20/17 at 9:42AM, E4, Licensed Practical Nurse (LPN), stated she admitted R3 around 2:30PM on 6/9/17, did the initial admission and filled out the MAR and faxed the POS to the pharmacy. E4 stated she reported to the oncoming nurse what she did.

On 6/20/17 at 12:40PM, E7, LPN, stated she worked on 6/9/17 from 6PM-6AM and received report from E4 that E4 did as much as she could with R3's admission, but not specifically that the POS was faxed to the pharmacy. E7 stated she recalled R3 was on sliding scale insulin and she did Accuchecks and gave R3 insulin that night that she borrowed from stock. E7 stated there was no delivery of insulin for R3 that night.

On 6/19/17 at 2:17PM, E6, LPN, stated she took care of R3 on the night shift of 6/10/17 and 6/11/17 and monitored R3's blood sugar levels in the MAR. E6 stated she does not recall giving any bedtime insulin to R3. E6 stated when she came in to work on 6/11/17, R3's supper tray was still on the table, and R3 was moving around in her room and to the bathroom with assist. E6 stated R3 did not have any insulin. E6 stated she was told R3's medications were ordered and were coming. E6 stated no medication was delivered for R3 on 6/10/17 and 6/11/17 and she reported it to the oncoming day shift nurse, E5, who was the oncoming nurse at both dates.

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On 6/19/17 at 2:02PM, E5, LPN, stated she took care of R3 during the 6AM-6PM shift on 6/11/17 and 6/12/17. E5 stated she did not give any insulin to R3 and did not receive R3's insulin from pharmacy. E5 stated she did not follow up with pharmacy and realized she should have followed up with pharmacy. E5 stated that on 6/12/17 she received report from E6 that R3's Accucheck was 155 mg/dl. E5 stated that on 6/12/17 at 8 AM during breakfast R3 was hard to arouse and having increased respirations. E5 stated she checked R3's blood sugar reading 3 times which read 'high' and called Z1, R3's Physician, and R3 was sent to the hospital.

On 6/19/17 at 2:30PM, E2, Interim Director of Nursing (IDON), stated she expected the nurses to make sure any medications faxed to pharmacy came in and new admission medication orders are carried out. E2 stated she expected the nurses to have R3's insulin delivered on E-run for the time required.

On 6/20/17 at 10:18AM, E1, Administrator, stated E5 told her on Monday morning on 6/12/17, that R3 did not get any insulin and that R3's insulin did not get in the facility and had orders to transfer to the hospital due to high blood sugar levels.

On 6/20/17 at 9:43AM, E3, Regional Nurse, stated the facility does not have a policy that is specific on time frames for admitting medication orders. E3 stated she expected nurses to have communication with pharmacy with physician orders to make sure delivery of resident medication.

On 6/20/17 at 9:24AM, Z1, Medical Director and R3's Physician, stated it is obvious that R3's not receiving insulin over the weekend was a

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S9999	Continued From page 6 contributing factor to R3's diabetic Ketoacidosis but there are multiple components to it, like on the resident's part, what they eat or do not eat, family members bring them food. Z1 further stated, on the other hand, it is the responsibility of the facility for providing insulin and administering insulin and in this case, there was a breakdown in communication among nurses. Z1 stated if the admitting nurse did not get the ordered medication, they should call pharmacy to follow up or call physician on call for substitution. The Facility Policy on Medication Administration revised 7/3/13, documents, "Procedure: 21. If the medication is not available for a resident, call the pharmacy and notify the physician when the drug is expected to be available. Medications are not to be "Borrowed" from one resident for another. 22. Notify the physician as soon as practical when a scheduled dose of a medication has not been administered for any reason." (A)	S9999		