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least monthly and, based on their clinical experience and judgment, and Section 300.Appendix F, determine if there are irregularities that may cause potential adverse reactions, allergies, contraindications, medication errors, or ineffectiveness. This review shall be done at the facility and shall be documented in the clinical record. Any irregularities noted shall be reported to the attending physician, the advisory physician, the director of nursing and the administrator, and shall be acted upon.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These requirements were not met as evidenced by:

Based on observation, record review and interview, the Facility failed to assess and adequately monitor the necessary needs of a known insulin dependent resident with Type II diabetes for one of four residents (R2) reviewed for a change in condition in the sample of 4. This neglect resulted in R2 not receiving daily blood glucose monitoring and medication intervention to reduce R2's blood glucose levels from 3/01/2015 through 3/15/2015. As result of this neglect, R2 was hospitalized for treatment of a severely elevated blood glucose level and a low serum potassium level with diagnoses of hyperosmolar non-ketotic coma with dehydration.

Findings include:

The Physician's Order Sheets (POS) for March

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2015 documents diagnoses for R2, in part, as Respiratory Failure, Anoxic Brain Injury, Diabetes Mellitus-Type II, Renal Insufficiency, Seizures, Coronary Artery Disease, Tracheotomy and Persistant Vegetative State.

R2's Admission POS for 12/2014 documents an admission date of 12/23/2014 with medication orders, in part, as "Lantus insulin 30 units SQ (subcutaneously) at HS (bedtime), Humalog insulin SQ per sliding scale at 12:00 AM, 6:00 AM, 12:00 PM and 6:00 PM. Physician must contact consultant as needed for blood glucose less than 70."

R2's POS for 1/2015 documents, in part, "Glucagon Hydrochloride 1 mg (milligram) SQ PRN (as needed) for hypoglycemia (low blood glucose), Lantus insulin 30 units SQ at bedtime, (glucometer) check every 6 hours with sliding scale Humalog and Dextrose 50 % 50 ml (milliliter) intravenous injection PRN."

R2's POS for 2/2015 documents, in part, "Lantus 30 units SQ at bedtime, (Glucometer) check, sliding scale every 6 hours, 140-175=2 units, 176-200=3 units, 201-250=5 units, 251-300=7 units, 301-350=9 units, Dextrose 50 %-50 ml intravenous injection PRN, Glucagon Hydrochloride 1 mg SQ PRN-Hypoglycemia."

R2's Physician's Order (PO), dated 2/18/2015, documents, in part, "Please send patient to the hospital for surgical evaluation and debridement of coccyx wound."

The Discharge Medication Instructions from the local hospital sent to the Facility, dated 3/01/2015, have no PO's for any medication to treat and control R2's blood sugar levels or any

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orders for the blood glucose monitoring for a daily assessment for her insulin needs.

The Facility's POS for R2, dated 3/01/2015, have no PO's documented to treat R2's diabetes at all.

The medical information about R2 sent to the local hospital on 2/18/2105 include the Admission Record (that includes a diagnosis of Diabetes Mellitus, Type II"), copies of the POS for R2 in 2/2015, and a Patient Transfer Form dated 2/28/2015 completed by E8, Licensed Practical Nurse (LPN). The Patient Transfer Form includes a diagnosis of Diabetes Mellitus, Type II. The copies of R2's POS sent to the hospital fail to include any insulin orders or sliding scale orders for elevated blood glucose levels.

On 3/24/2015 at 3:35 PM, E8 reported she was the task nurse the evening R2 was sent to the local hospital on 2/28/2015. E8 reported she could not remember exactly what she filled out or sent to the hospital with R2 and the ambulance staff. E8 stated, "I just can't remember." E8 confirmed R2 is diabetic.

The Discharge Summary for R2 from the local hospital, dated 3/01/2015 documents, in part, "During the ten days, her only two issues were elevated blood pressures and elevated glucose readings. For her glucose readings, she was initially brought in without any need for insulin, however, her glucose levels remained high initially. We titrated insulin up slowly from initially using Lantus 5 mg and low dose sliding scale to end with Lantus 25 mg every HS and Mid dose sliding scale. She tolerated this well."

A History and Physical (H&P) from Z2, Physician documents R2 was seen for a witnessed seizure

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and a follow up of an infection with a MDRO (multi-drug resistant organism). There is no documentation from Z2 included in the H&P to address R2's diabetes at all or if R2's medications at that time were reviewed.

A Nurses Note, dated 3/02/2015 at 5:00 PM, written by E7, LPN documents speaking with Z2 to clarify R2's medications and status. No orders for insulin or daily glucometer checks were documented as received at that time.

On 3/24/2105, at 4:20 PM, E7 confirmed she faxed R2's medication orders to the pharmacy and to Z2 on 3/02/2015. E7 stated, "Me personally, I don't work with (R2) on a regular basis, so when the transfer papers came from the hospital, I didn't question them. I didn't know she was diabetic. I have been here 7 months and never gave her insulin."

The Nurses Note For R2, dated 3/15/2015 at 5:30 PM, written by E5, LPN, documents, "Check (glucometer) reading 'HI', above 600 (normal =70 to 99). Called (Z8, Physician) at 5:35 PM. New order to send to ER (emergency room) for further evaluation. Called (ambulance) at 5:40 (PM) and (ambulance) arrived at 5:43 (PM). Called (local hospital) to give report. Family here with resident and aware. Left via stretcher at 6:00 PM."

The Nurses Note for R2, dated 3/16/2015 at 6:30 AM, written by E14, LPN documents, "Admitted with diagnosis of hypermolar non-ketotic state, in patient with Type II."

The diabetes.org website documents, in part, "Hyperosmolar Hyperglycemic Nonketotic Syndrome, or HHNS, can happen to people with either type 1 or type 2 diabetes that is not being

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controlled properly, but it occurs more often in people with type 2. If HHNS continues, the severe dehydration will lead to seizures, coma and eventually death. Warning Signs: blood sugar level over 600 mg/dl (milligrams per deciliter), dry parched mouth, extreme thirst, high fever, sleepiness or confusion, loss of vision, hallucinations, weakness on one side of the body."

On 3/25/2105 at 1:15 PM, E5, LPN reported she works PRN at the Facility, but had checked R2's blood glucose levels before and had given her Novolog insulin. E5 reported when she entered R2's room on 3/15/2015, she was carrying the glucometer machine to check R2's blood glucose as she had done previously. E5 reported Z7, family member was with R2 and asked her what her previous blood sugar levels had been. E5 reported when she left the room to check R2's chart, she discovered there was no PO for daily blood sugar levels or insulin ordered for R2. E5 reported Z7 then asked her to check R2's blood glucose level and the level was over 600. E5 reported she called Z2, but Z8 responded with an order to send R2 to the hospital. E5 reported she called the local hospital with a report of R2's vital signs and blood glucose level and sent R2 by ambulance to the hospital.

The H&P for R22 from the local hospital, dated 3/15/2105, documents, in part, "Suspect 2/2 lack of insulin for two weeks, and dehydration. Glucose 737-high. Potassium-2.5 (normal=3.5-5.0) Hyperglycemia hyperosmolar state due to lack of insulin for two weeks, and inability to increase fluid intake. Dehydration with acute kidney injury likely due to this. Marked hypokalemia. Hydration with normal saline at 250 ml's (milliters) per hour. Control glucose levels

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with IV (intravenous) insulin drip. Supplemental potassium via IV route. Cardiac monitoring until potassium level better."

On 3/26/2105, at 8:00 AM, Z7 reported when she visited R2 on 3/15/2105 she felt R2 "did not look right." Z7 reported R2 was sleeping a lot. Z7 reported, "Normally at her best, she would open her eyes and look at you. I asked (E5), the nurse to check her meds (medications) for me, and (E5) told me (R2) hadn't gotten any insulin from 3/01 through 3/15/2015. She has been hospitalized three times since she has been at the Facility." Z7 reported R2 has been diabetic for some time.

On 3/24/2105 at 3:15 PM, Z2 stated, "I see quite a few patients. I would assume the nurses would look through the old charts to see what they (residents) are on. This is a significant medication error by the hospital and the nursing home. With the number of hires and fires, I don't know how they would remember what a patient takes. It should be a standard to look through the old orders. They shouldn't clean out the old history and progress notes. They have a lot of issues with documentation at the Facility. I am glad you (the Department) are here. It is quite frustrating and risky for patient's because of it. It is basic nursing to make sure diabetic residents are on the right regimen."

On 3/25/2105 at 1:38 PM, E13, LPN reported R2 is a known diabetic since admission. E13 stated, "I have given her insulin and done glucometer checks. Recently when (R2) returned from the hospital, she had no insulin orders or orders for a glucometer. It never crossed my mind to wonder. I get moved around a lot."

On 3/25/2015, at 1:05 PM, Z5, Pharmacist

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reported he normally does the monthly medication reviews for the Facility, but has been having Z3, Pharmacist doing them for the Facility in March 20125. Z5 stated, "I would normally look at the hospital discharge orders as well as the current medications, and the meds they were on prior to leaving the Facility." Z5 reported he was unaware of any problems related to the pharmacy that the Facility was having or had had in the past.

On 3/25/2105 at 10:40 AM, Z3 was asked if he routinely monitors the medications for resident with Type II Diabetes Mellitus. Z3 stated, "I just don't know. For me, when I would look at that and knew a patient went into the hospital with a change in condition and came back with no order for insulin, I would think the hospital took them off the insulin or diabetic meds." Z3 reported Z5 usually does the monthly pharmacy reviews for the Facility, but Z3 was filling in for March 2015.

On 3/20/2015, at 1:40 PM, E1, Administrator stated, "We had a resident (R2) in the hospital who just came back. The hospital paperwork addressed the issue that we weren't giving her insulin. (E3, Assistant Director of Nursing) checked that out. What happened was when (R2) was discharged from the hospital, they failed to give discharge orders for insulin. I don't know how long she went without insulin."

On 3/25/2015, at 2:43 PM, E11, LPN reported she works the same hall where R2 resides and was aware R2 was diabetic. E11 stated, "She is non responsive, a g-tube (gastrostomy tube) and is diabetic. I have given her insulin before. The last time she was readmitted, I didn't give her insulin. I didn't question it. Typically, I would question if they are sent out with an insulin order and came

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S9999	Continued From page 8 back without one. I would check it out." On 3/24/2105 at 12:00 PM, R2 was in bed with a tracheotomy collar with tubing attached to a liquid oxygen tank. R2 had an indwelling urinary catheter and was receiving an enteral feeding through a gastrostomy tube, via a mechanical pump. R2 was non responsive to verbal stimuli, but would periodically open her eyes with no visual tracking of a voice or sound. E4, LPN was preparing to administer medication via the gastrostomy tube. E4 reported she is the nurse who often takes care of R2. E4 was asked if R2 had always received insulin, and E4 stated, "I can't say she was always on insulin before. I don't know really." R2's Care Plan, dated 12/29/2014 and updated 3/06/2015 documents, in part, "(R2) requires PROM (passive range of motion) as evidenced by the following limitations and potential contributing diagnoses of anoxic brain damage, cardiac arrest, acute respiratory failure, Diabetes Mellitus, Type II and febrile convulsions." The revised Care Plan, dated 3/06/2105, documents, in part, (R2) requires tube feedings to maintain daily nutritional requirements and weight and receives diuretic medication daily. (R2) has diagnosis of diabetes, but is not receiving medication to treat at this time." Interventions include; "Monitor/document/report to MD (medical doctor) PRN signs and symptoms of hyperglycemia: increased thirst and appetite, frequent urination, weight loss, fatigue, dry skin, poor wound healing, muscle cramps, abdominal pain, Kussmaul breathing, acetone breath (smells fruity) stupor, coma." On 3/24/2015 at 2:55 PM, E9, Corporate Registered Nurse (RN) was asked why R2 had	S9999		

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S9999	Continued From page 9 no intake and output (I&O) records for March 2015 to monitor her urinary output for increased or decreased output as a symptom of hyper or hypoglycemia. E9 stated, "One wasn't restarted when she came back from the hospital." No I&O records were documented in R2's clinical record. The Facility's Consultant Pharmacy Services Provider Agreement, updated 1/27/2104, documents in part, "The Consultant Pharmacist, or adjunctive licensed pharmacy personnel under the control of the Consultant Pharmacist provides consultant pharmacist services, including but not limited to the following: Reviewing the medication regimen of each resident at least monthly, utilizing federally mandated standards of care in addition to (company's name) applicable standards, and documenting the review and finding in the resident's medical record. Participating in the preparation of the resident care plan for each new resident or current resident with a change of status by reviewing the following information in collaboration with the operational pharmacist. The following examples of information may be reviewed to determine any potential problems related to the medication therapy of the resident, including the presence of a diagnosis to support the medications prescribed: Complete orders, including diagnosis, resident information, including height, weight, age, and gender, a copy of the resident's recent history and physical, and a description of the significant change in the resident's status if this is the reason for the assessment." (A) 300.610a)	S9999		

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3001210b)
300.1620a)
300.1620c)
300.1620f)
300.1630d)
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 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.
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

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S9999	Continued From page 11 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 prescriber and at the designated time. c) Review of medication orders: The staff pharmacist or consultant pharmacist shall review the medical record, including licensed prescribers' orders and laboratory test results, at least monthly and, based on their clinical experience and judgment, and Section 300.Appendix F, determine if there are irregularities that may cause potential adverse reactions, allergies, contraindications, medication errors, or ineffectiveness. This review shall be done at the facility and shall be documented in the clinical record. Any irregularities noted shall be reported to the attending physician, the advisory physician, the director of nursing and the administrator, and shall be acted upon. f) The licensed prescriber shall approve the release of any medications to the resident, or person responsible for the resident's care, at the time of discharge or when the resident is going to be temporarily out of the facility at medication time. Disposition of the medications shall be noted in the resident's clinical record. . Section 300.1630 Administration of Medication d) If, for any reason, a licensed prescriber's medication order cannot be followed, the licensed prescriber shall be notified as soon as is reasonable, depending upon the situation, and a notation made in the resident's record. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These requirements are not met as evidenced by:	S9999		

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Based on record review and interview, the Facility failed to adequately assess for pain, monitor the effectiveness of pain medication and provide narcotic pain medication when necessary for one of four residents (R1) reviewed for pain in the sample of 4.

Findings include:

Nurses notes document R1 was admitted to the Facility on 3/9/15 at 5:28 PM. The Daily Skilled Nurses Notes, dated 3/9/15, document R1 being alert, oriented to person, place and time with unclear speech and voicing no pain at the time. Admitting orders included Norco 5/325 1 tab via g-tube every 4 hours as needed, and Tylenol 650 mg every 6 hours as needed for pain.

The Pain Assessment, dated 3/9/15, signed by E5, LPN, is incomplete. The Assessment failed to document R1's description of pain, intensity, duration, effectiveness of medication, and what increases pain. It documents R1 had no pain at the time of the assessment. The section for General information has Decubitus Ulcer Back written in form the resident describing cause of pain and checks resident does not verbalize pain. Under "Relief of Pain," medication is checked as what relieves pain, no adverse consequences of interventions is checked, and resident's acceptable pain level is documented as a "3." The Assessment lists the PRN Hydrocodone/APAP (Norco) 5/325 1-2 tabs every 4 hours PRN which directly conflicts with the admitting order that clearly documents one tab every 4 hours as needed not 2. The Assessment's conclusion is also blank.

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The Controlled Drug Receipt /Record/Disposition Form documents Norco 30 tabs were received on 3/10/15, the day after admission, with the first dose given at 2:30 PM on 3/10/15. This was 21 hours after R1's admission to the Facility. In addition, R1's Medication Administration Record (MAR) has no documentation that Tylenol was given to R1 during this time. R1's March 2015 MAR documents that R1 received the Norco 13 times with no pain scale assessed while the Controlled Drug Form documents the Norco was given 26 times also with no assessment of pain at the time it was given/requested. The Controlled Drug Form documents R1 was given two tabs of Norco, instead of the ordered one tab, on 3/12/15 and three times on 3/16/15 at midnight, 6 AM and 10 AM. The Controlled Drug Form also documents that the 10 AM dose was the last available Norco. Later that same day, 3/16/15 at 1 PM, the Nurses Notes document that R1 was "very anxious this shift et (and) constantly requesting Norco even after given." The Nurses Notes fail to consistently and routinely assessed R1 for pain management even though he was taking Norco regularly when it was available.

On 3/17/15 at 2 AM, R1's Nurses Notes document "upset he is out of Norco. This nurse spoke c (with) pharmacy + he is out of refills. Pharmacy states will fax notification for Dr." Again, no pain intensity and no assessment is documented. At 10:35 AM, the Nurses Notes document R1 "was given Tylenol for complaints of pain" and they are "waiting for script (prescription)." The March 2015 MAR documents 4 doses of Tylenol given from 3/16 and 3/17 with only one documented at 10 AM on 3/17/15 on the back of the MAR in the Nurse's Medication Notes section with reason given and response to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001341	A. BUILDING: _____ B. WING _____	C 03/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST REHAB & RESPIRATORY	727 NORTH 17TH STREET BELLEVILLE, IL 62226

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 14	S9999		

medication. The Nurse's Medication Notes documents "3/17 10 AM Tylenol 650 gen (general) pain," but no pain intensity assessment (scale information) or response documented. At 7:30 PM on 3/17/15, R1 was sent to the emergency room following a chest x-ray and admitted with respiratory failure and skin ulcer. The Controlled Drug Form, dated 3/17/15, documents the Facility received 60 Norco at 11 PM on 3/17/15 after R1 left the Facility.

On 3/25/15 at 2 PM, Z6 stated R1 informed her that he did not have the Norco available until the second day of his stay. Z6 also said R1 described the pain on the last two days before discharge as a "8" on a scale of 1-10 with 10 being the worst. R1 told Z6 that the Facility did give him Tylenol, but that he gets no relief from Tylenol. Z6 stated E1 Administrator was aware of the facility not getting the Norco timely upon admission and voiced to Z6 that it was unacceptable.

On 3/25/15 at 1:15 PM, E5, LPN, stated she remembered R1 and that she had admitted him to the Facility. E5 described R1 as very intelligent, had unclear speech but could make all his needs known by writing them either on a pad of paper or with his communication board. E5 stated his communication board did not work the first night he was here, but did after that. E5 stated R1 denied pain the first night when she admitted him.

On 3/24/15 at 3:26 PM, Z2, Medical Director stated R1 had a radical throat surgery and would need the Norco for pain management. Z2 described R1 as alert/oriented times three being fully capable of making his needs known. Z2 stated that having the medication unavailable as

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	IL6001341	A. BUILDING: _____ B. WING _____	C 03/26/2015

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S9999	Continued From page 15 ordered was a significant error given R1's diagnoses and his need for adequate pain management. The Facility's Pain Management Policy, revised 2015, documents the purpose of the policy is to "help the staff identify pain in the resident, and to develop interventions that are consistent with the resident's goals and needs and that address the underlying causes of pain." The policy documents that pain management is a multidisciplinary care process that includes the following "a) assessing potential for pain, b) effectively recognizing the presence of pain, c) developing and implementing approaches to pain management, d) identifying and using different strategies for pain management, and e) modifying approaches as necessary." The policy continues to document that "During PRN pain medication administration, at a minimum, the location and intensity characteristics are to be gathered prior to administration of the as needed pain medication." (B)	S9999		

300.610a)
300.1210b)
300.1620c)
300.3240a)

1. ***Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?***

   R2 no longer resides at the facility.

2. ***How will you identify other residents having the potential to be affected by the same deficient practice?***

   Residents who are dependent on insulin have the potential to be affected by this alleged deficient practice.

3. ***What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?***

   Licensed staff will be educated on the facility Abuse Prevention Program Policy which includes an understanding of neglect as defined by the Department.

   Licensed staff will be educated on the proper procedures for Documentation of Transfers/Discharges Policy as well as Admission/Readmission procedures.

   Physician order sheets will be clarified upon admission and readmission to the facility.

   Readmitted residents **new** medication lists will be reviewed against their medication list that was current at discharge to check for changes and discrepancies.

4. ***How will you monitor the corrective action(s) to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?***

   The DON/Designee will review each admission and readmission for accuracy of physician orders, medication list and treatment.

   The DON/Designee will review each hospital transfer record to assure documentation compliance for 6 weeks then random reviews will be done quarterly.

   Results of these reviews will be discussed weekly for 8 weeks and at the Quarterly QA Meetings for 3 quarters. Educational needs will be discussed and education will be provide as needed.

COMPLETION DATE: 4-24-15 accepted

Attachment B
Imposed Plan of Correction