Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000335	A. BUILDING: ______ B. WING ______	C 06/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMONT MANOR HLTH & RHB	512 EAST OGDEN AVENUE WESTMONT, IL 60559

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S 000	Initial Comments Complaint 2173945/IL134705	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.1210b) 300.1210d)1) 300.1630e) 300.3240a) 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. 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 300.1630 Administration of Medication e) Medication errors and drug reactions shall be immediately reported to the resident's	S9999	Attachment A Statement of Licensure Violations	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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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.

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 interview and record review, the facility failed to ensure that ordered medications were administered to a resident who is on insulin and antianxiety medications. The facility also failed to administer pain medication as scheduled for a resident.

This applies to 2 of 6 (R16 and R17) reviewed for medication administration in the sample of 21.

This failure resulted in R17 not receiving ordered Insulin for blood sugar control and anti anxiety medication as prescribed. This resulted in R17 suffering from increased anxiety while at the facility and promoting R17 to leave the facility AMA (Against Medical Advice).

This failure also resulted in R16 having discomfort during dialysis session because prescribed medications were not provided prior to dialysis.

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The findings include:

1. Review of R17's EHR (Electronic Health Record) showed R17 was admitted to the facility 6/3/21 at 6:45 P.M. R17's progress dated 6/4/21 showed R17 signed out (AMA) against medical advice on 6/4/21 at 4:00 P.M. R17's face sheet showed the resident was admitted with diagnoses that included end stage renal disease, dysfunction of the bladder, dependence on renal dialysis, diabetic retinopathy, blindness left eye, diabetes mellitus, hypertensive heart, hyperkalemia. Review of R17's POS (Physician Order Sheet) showed R17's medications were profiled on 6/4/21. Review of R17's observation detail list report dated 6/4/21 showed R 17 was alert on admission to the facility. The observation detail list showed R17 with blood pressure 127/72mm/Hg, temperature 97.3 degrees, blood sugar 164mg/dl on 6/3/21 at 7:15 P.M.

Review of R17's hospital transfer and medication form dated 6/3/21 showed the next time her medications were due to be administered:
(1). Dicyclomine 20mg oral tablet 1 tablet 4 times a day due 6/3/21 at 9PM.
(2). Torsemide 10mg oral tablet 2 tablets oral daily due 6/3/21.
(3). Sevelamer 800mg 3 tablets oral three times a day. Next dose 6/4/21 at 8AM.
(4). Pantoprazole 40mg oral delayed release tablet 1 tablet oral two times a day. Next dose 6/3/21.
(5). Metoclopramide 10mg oral tablet 1 tablet oral daily. Next dose 6/4/21.
(6). Atorvastatin 40mg 1 tablet oral daily next dose due 6/4/21.
(7). Insulin glargine (Basaglar kwikpen 100units/ml subcutenous solution) 15units subcutaneous every morning. Take once or twice

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daily in various doses from 4-10units depending on how much she eats and her blood sugar. Next dose 6/4/21.
(8). Insulin lispro (Insulin Lispro kwikpen 100units/ml injectable solution). 1 unit subcutaneous three times a day before meals as needed blood sugar. Next dose 6/4/21.
(9). Alprazolam 2mg 1 tablet oral two times a day as needed for anxiety. Next dose as needed.
R17's remaining medications on the transfer form showed medication that should be given as needed.

Review of R17's POS (Physician Order Sheet) dated 5/10/21 through 6/10/21 showed R17 with the following medication orders:
(1). Alprazolam 2mg 1 tablet oral twice a day as needed.
(2). Lokelma 10gram 1 packet once a day due at 09:00
(3). Atorvastatin 40mg 1 tablet oral once a day due at 09:00
(4). Basaglar Kwikpen U-100 insulin, 15units subcutaneous three times a day before meals due 06:00 A.M., 11:00 A.M., 04:00 P.M.
(5). Ducosate sodium 100mg 1 capsule oral once a day as needed.
(6). Insulin lispro 100 unit/ml, 1 unit subcutaneous three times a day before meals at 06:00 A.M., 11:00 A.M., 04:00 P.M.
(7). Melatonin 3mg 1 tablet oral at bedtime as needed.
(8). Metoclopramide Hcl 10mg 1 tablet oral once a day at 09:00 A.M.
(9). Midodrine 5mg 2 tablets oral. special instructions: Give for SBP less than 90 three times a day at 06:00 A.M., 02:00 P.M., 10:00 P.M.
(10). Pantoprazole 40mg 1 tablet oral twice a day at 09:00 A.M. and 05:00 P.M.

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(11). Polyethylene glycol 3350 powder 17 grams oral once a day at 09:00 A.M.
(12). Sevelamer carbonate 800mg 3 tablets oral, special instruction: Give with meals three times a day; 06:00 A.M., 12:00 A.M., 04:00 P.M.
(13). Torsemide 10mg 2 tablets oral once a day at 09:00 A.M.
(14). Relistor 8mg/0.4ml; give 0.3ml subcutaneous once a day every other day due at 09:00 A.M.
(15). Hydrocodone-acetaminophen 10-325mg 1 tablet oral every four hours as needed.

Review of facility's convenience box medication list titled "Westmont Manor CAPSA contents" showed three of R17's prescribed medications were available and they include:
(1). Insulin lispro (Humalog) 100units/ml is available in the convenience box cassette D, bin B6 and cell C4.
(2). Xanax 0.25mg (Alprazolam) tab 0.25mg available in the convenience box cassette A, bin (controlled) and cell C1.
(3). Midodrine 2.5mg tab available in the convenience box cassette C, bin B5 and cell C2.

The dialysis list on the unit showed R17 was scheduled for dialysis on 6/4/21 6:00 A.M. Review of R17's MAR (Medication Administration Record) dated 6/01/21 through 6/10/21 showed the above listed medications were either documented as "Not Administered: Drug/Item unavailable" or "Not Administered: Resident unavailable."

Review of R17's progress note dated 6/4/21 at 2:18 P.M., showed R17 was seen by the nurse practitioner at the facility. The note also showed R17's medications were reviewed and faxed to pharmacy.

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S9999	Continued From page 5 On 6/14/21 at 12:43 P.M., V32 (Nurse Practitioner) stated on 6/3/21 she went over the medication reconciliation with the nurse. V32 stated she briefly had an encounter with R17 on 6/4/21. V32 stated she was never informed R17 was unable to receive any of her medications at the facility. V32 stated if she was informed, she would have ordered the medications as stat orders to be given. V32 stated it was a concern that R17 did not receive any of her prescribed medications throughout her short stay at the facility. V32 stated she expected medications to be given as ordered. On 6/10/21 at 8:20 A.M., V1 (Administrator) stated she was informed by nursing staff that R17 signed out AMA because she wanted her Xanax which was not available and was not allowed to smoke. On 6/14/21 at 10:37 A.M., V27 (Agency Nurse) stated she worked evening and night shifts on 6/3/21. V27 stated she received R17 from the hospital. V27 stated she obtained the hospital transfer form from the paramedic staff. V27 stated she checked R17's vital signs, did a skin assessment and performed blood glucose check because R17 had an order to check the blood glucose four times a day. V27 stated she called the nurse practitioner for R17's medication reconciliation over the phone. V27 stated she is an agency nurse and was not familiar with the facility's EHS (Electronic Health System) and how to enter R17 into the facility's EHR as a new admission. V27 stated on 6/3/21 when R17 was admitted, she could not add R17 into the system, so she was unable to send R17's medications to the pharmacy for processing. V27 stated that was her first admission at the facility and she did not	S9999		

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have access to the convenience box otherwise she could have given R17 some of her medications. V27 stated she should have notified the DON (Director of Nursing) of the issues. V27 stated she later informed the DON the following morning. V27 stated she did not give R27 any medications throughout her shift including coverage for the blood glucose test she obtained from R17.

On 6/14/21 at 11:20 A.M., V29 (Nurse) stated on 6/4/21, she worked on the evening shift and cared for R17. V29 stated when she first approached R17, the resident was crying, anxious and very agitated. V29 stated R17 wanted to speak with V28 (Former Social Service). V29 stated V28 came upstairs to talk with R17. V29 stated she was not aware R17 was yet to receive any medications at the facility. V29 stated she would have gotten R17 medications from the convenience box. V29 stated she did not give R17 any medications because R17 was ready to leave the facility.

On 6/10/21 at 9:32 A.M., V2 (Director of Nursing) stated she was made aware R17 left the facility AMA on 6/5/21. V2 stated she was informed R17's name could not be entered into the system which prevented nursing staff from documenting the initial assessment and faxing her orders to pharmacy. V2 stated some of R17's medications could have been retrieved from the convenience box but she believed staff could not do that because R17's name was not in the system. V2 stated she visited R17 in her room in the morning of 6/4/21. V2 stated she found R17 curled herself up in a fetal position in bed and informed her she suffers from social anxiety and wanted her medication. V2 further stated R17 was seen by V32 (Nurse Practitioner) and her medications was

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faxed to pharmacy. V2 stated she was not aware R17 did not receive any of her ordered medications before signing out AMA on 6/4/21.

On 6/10/21 at 3:23 P.M., V3 ADON (Assistant Director of Nursing) stated she notified V32 that R17 complained she needed her anxiety medication and she was a new admit. V3 stated V32 saw R17 that morning after R17 had received dialysis. V3 stated she faxed the orders to pharmacy but was not aware R17 did not receive any of her ordered medications.

2. On 6/9/21 at 10:10 A.M., R16 stated she attends dialysis Monday, Tuesday, Thursday and Friday from 6:30 A.M., through 10:30 A.M. R16 stated depending on the nurse on duty, she does not receive her medication before been taken down for dialysis. R16 stated on 6/8/21 for instance, she did not receive her early morning medications for pain and her stomach issues.

Review of R16's MDS (Minimum Data Sets) dated 3/16/21 showed R16 with BIMS (Brief Interview for Mental Status) of 15 which indicated an intact cognition. Review of R16's POS showed an order dated 5/25/21 for: Acetaminophen 500mg 2 tablets oral, special instructions: for pain , resident requests first dose to be at 05:00 because she leaves early for HD (Hemodialysis).

Review of R16's MAR dated 6/8/21 -6/8/21 showed R16 was scheduled to receive: (1). Acetaminophen 500mg 2 tablets. Special instructions: For pain, resident requests first dose to be at 05:00 A.M., because she leaves early for dialysis. (2). Omeprazole capsule delayed release 20mg once every morning at 06:00 A.M. R16's MAR dated 6/8/21 showed that R16 did not receive either of these medications prior to

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S9999	Continued From page 8 dialysis. (B)	S9999		