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
	IL6001010	A. BUILDING: _____ B. WING _____	C 01/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARCADIA CARE BLOOMINGTON	1509 NORTH CALHOUN STREET BLOOMINGTON, IL 61701

(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
S 000	Initial Comments Complaint Invesigation 22610134/IL154564	S 000		
S9999	Final Observations Statement of Licensure Violations (Violation 1 of 2) 300.610a) 300.1010h) 300.1210b) 300.1210d)1) 300.1210d)2) 300.1210d)3) 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 300.1010 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,	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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 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. 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 made by nursing staff and recorded in the	S9999		

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S9999	Continued From page 2 resident's medical record. These requirements were not met as evidenced by: This deficiency requires two deficient practice statements. A. Based on interview and record review the facility failed to obtain physician ordered laboratory values, failed to report critical level laboratory values to Physician and failed to report a change in condition timely to Physician for one (R2) resident out of three residents reviewed for change of condition on the sample of 17. These failures resulted in R2 experiencing poor fluid intake, delayed medical testing, experiencing critical labs then subsequently being hospitalized with lower leg cellulitis and pneumonia. B. Based on observation, interview and record review the facility failed to provide timely pain medication for a resident by not maintaining supply of R4's prescribed narcotic pain medication. This failure affects one (R4) resident out of three residents reviewed for change of condition on the sample of 17. R4 experienced severe unrelieved pain causing R4 to call for emergency services. Findings include: A. R2's Medical diagnoses include Right Lower Extremity (RLE) Cellulitis, Aspiration Pneumonia, Right Lower Leg (RLL) Deep Vein Thrombosis (DVT), COVID-19, Acute Lower Respiratory Infection, Cognitive Communication Deficit, Down Syndrome, Chronic Obstructive Pulmonary Disease (COPD), Morbid Obesity due to excess calories, Dysphagia and Difficulty Walking. R2's	S9999		

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S9999	Continued From page 3 Minimum Data Set (MDS) dated 11/25/22 documents R2 was moderately cognitively impaired. This same MDS documents R2 required extensive assistance of one person for bed mobility, dressing, eating, extensive assistance of two people for transfers and total assistance of one person for toileting and personal hygiene. R2's Physician Order Sheet (POS) dated November 1-30, 2022 documents a physician order dated 11/23/22 of "Please monitor over next 24 hours and encourage oral fluids at meals. If no improvement in oral fluid intake or increase in urinary output, please send to emergency department (ED) for further evaluation/treatment." This same POS documents a physician order dated 11/22/22 to obtain "Complete Blood Count (CBC) with Differential (diff), Comprehensive Metabolic Panel (CMP) or D-Dimer on 11/22/22. One time only." This same POS does not document a physician order for lab work on 11/29/22. R2's Documentation Survey Report dated November 1-30, 2022 documents intakes of: -11/23/22 R2 refused all food and fluids for breakfast, refused all food and drank 50 milliliters (ml) for lunch and refused all food and drank 480 ml for supper. -11/24/22 R2 refused all food and fluids for breakfast and lunch and refused all food for supper and drank 760 ml fluids. -11/25/22 R2 refused all food and fluids for breakfast and lunch and there were no entries documented for supper meal. -11/26/22 R2 refused all food and fluids for breakfast, there were no entries for lunch meal and refused all food and drank 120 ml for supper	S9999		

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S9999	Continued From page 4 meal. R2's Electronic Medical Record (EMR) does not document notification to (V20) physician of intakes from 11/23/22-11/26/22. R2's Physician Order Sheet (POS) dated December 1-31, 2022 documents a physician order dated 12/2/22 of "Please get labs as previously ordered stat. CBC with diff, CMP, D-dimer STAT." R2's EMR documents R2's weight as 148.5 pounds (lbs) on 11/2/22 and 139.0 lbs on 12/2/22. R2's Electronic Medical Record (EMR) does not document laboratory results for physician ordered Complete Blood Count (CBC), Comprehensive Metabolic Panel (CMP) or D-Dimer for 11/22/22 or 11/29/22. R2's Electronic Medical Record (EMR) documents the same labs were ordered STAT (immediately) on 12/2/22. R2's laboratory requisition dated 12/2/22 documents "can't get" as results of labs not obtained. R2's Laboratory Report dated specimen was obtained on 12/5/22. This same report documents R2's Complete Blood Count (CBC), Comprehensive Metabolic Panel (CMP) and D-Dimer results as follows: White Blood Cell (WBC) count result of 25.56 (high) with reference range of 4.0-12.0 10(3) cubic milliliter (mcL) of blood. D-Dimer result as >=20.00 (high) with a reference range of 0.50 micrograms (mg)/milliliter (ml) Fibrinogen Equivalent Unit (FEU).	S9999		

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S9999	Continued From page 5 Nurse Progress Notes document: -11/26/22 at 2:45 pm documents "Impaired balance noted. Weakness noted. Decreased sensation noted. (R2) has shortness of breath with exertion. (R2) has shortness of breath or difficulty breathing when lying flat." -11/27/22 at 6:45 AM documents (R2) has evidence of an acute change in mental status from (R2's) baseline noted. Decreased sensation noted." -11/29/22 at 3:05 PM V8 (Nurse Practitioner/NP) documents "NEXT LABS PENDING: Will reorder missing labs for 12/2/22 - CBC, CMP, D-dimer." -11/30/22 at 6:40 AM documents "(R2) has shortness of breath with exertion. (R2) has shortness of breath or difficulty breathing when sitting or at rest. Shortness of breath or difficulty breathing when lying flat. (R2's) Lung sounds diminished." -12/1/22 at 11:07 AM documents "(R2) has shortness of breath with exertion. (R2) has shortness of breath or difficulty breathing when lying flat." -12/2/22 at 9:05 AM document "(R2) has shortness of breath with exertion. (R2) has shortness of breath or difficulty breathing when lying flat." -12/3/22 at 9:05 AM documents "(R2) has shortness of breath with exertion. (R2) has shortness of breath or difficulty breathing when lying flat. (R2) lung sounds diminished." -12/4/22 at 9:05 AM documents "(R2) has shortness of breath with exertion. (R2) has shortness of breath or difficulty breathing when lying flat. (R2) lung sounds diminished" R2's Hospital Laboratory Report documents R2's 12/5/22 D-Dimer results were "called, results acknowledged and read back."	S9999		

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S9999	Continued From page 6 R2's EMR does not document receipt of abnormal lab values on 12/5/22 or 12/6/22. R2's Nurse Progress Note dated 12/7/22 at 1:45 PM documents "Resident noted to have a WBC of 25.56. (V8) NP ordered resident out to emergency room (ER) for evaluation." R2's Nurse Progress Note dated 12/7/22 at 2:04 PM (V8) NP documents "New Right Leg redness, swelling, post COVID-19. Onset-acute, first noticed one to two days ago, location Right Lower Extremity (RLE). (R2's) EMR shows nine pound weight loss within one month. Right Lower Leg edematous, erythematous, non-tender. Assessment/Plan: RLE redness, swelling; Leukocytosis, abnormal weight loss, send to emergency room for further evaluation to rule out Deep Vein Thrombosis (DVT), Leukocytosis." R2's hospital records dated 12/7/22 document admitting diagnoses as Right Lower Extremity (RLE) Cellulitis and Aspiration Pneumonia. R2's Ultrasound Right Duplex Lower Extremity Veins Result dated 12/8/22 documents "Impression: Deep Vein Thrombosis (DVT) in the visualized Common Femoral, Femoral, Popliteal, Posterior Tibial and Peroneal Veins." R2's Chest X-Ray Report dated 12/7/22 documents "Impression: Patchy opacity suspected at Left Lung base." R2's Ambulance Report dated 12/7/22 documents "Staff wanted (R2) evaluated in emergency room due to elevated White Blood Cell (WBC) count. Assessment revealed with vitals as documented with (R2) having redness in Right Lower Leg."	S9999		

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S9999	Continued From page 7 On 1/5/23 at 10:35 AM V2 (Director of Nursing/DON) stated the laboratory levels were never drawn on 11/22/22 or on 11/29/22. V2 stated the physician should have been notified but was not. The laboratory technician did come to facility on 12/2/22 but was unable to get blood collected due to R2 was not compliant. V2 stated the labs were finally obtained on 12/5/22 and physician was notified of the results on 12/7/22. V2 stated R2 was sent to the hospital on 12/7/22 for a decline in condition. On 1/6/23 at 11:00 AM V8 (previous NP) stated "(R2) had a productive cough with thick green mucous and generally did not look like he felt well." V8 stated "(R2) was not eating or drinking very well so on 11/23/22 I ordered the staff to monitor (R2's) fluid intake for 24 hours and send to the emergency room if not any better. They (staff) did not notify me of any changes in (R2's) condition including poor fluid intake, or I would have sent (R2) into the emergency room that day (11/24/22)." V8 stated attempted to review the labs that were ordered on 11/22/22 but the labs had not been completed. V8 stated "No one could tell me why the labs I ordered on 11/22/22 were not completed, but I was told that they would be completed and I would be notified of any abnormal values. I ordered the D-Dimer to rule out a possible Deep Vein Thrombosis (DVT) due to many patients I have seen with COVID-19 end up with DVTs. I saw (R2) again on 11/29/22 and realized then that the labs had not yet been drawn. I re-ordered them on 11/29/22. On 12/2/22 I ordered the labs to be drawn STAT due to the facility still had not obtained the labs that originally ordered on 11/22/22. (R2) refused to have blood drawn on 12/2/22 so I reordered them again for 12/5/22. On 12/7/22 I was able to review the lab	S9999		

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S9999	Continued From page 8	S9999		

results and saw that (R2) had a D-Dimer over 20 which is a critical level, and also the highest I have ever seen. (R2's) White Blood Cell (WBC) count was also at a critical level so at that point I gave the order to send (R2) to the emergency room. No one from the facility notified me of (R2's) critical lab values."

On 1/6/23 at 2:15 PM V21 (Laboratory (lab) Resolution Specialist) stated R2's CBC with Differential, CMP and D-Dimer were collected, received and processed on 12/5/22. V21 stated it is the policy of the laboratory to call the critical laboratory values to the facility as soon as they are realized by the lab. V21 stated "We (lab staff) called the abnormal values, especially the critical lab values such as in (R2's) case as soon as possible on 12/5/22. We (lab staff) call the lab values directly to the facility and ask for the nurse in charge of that patient. From there, I do not know what happens, but we (lab) call the labs to the patient's nurse, not the Physician."

On 1/6/23 at 1:00 PM V20 (Medical Director) stated resident laboratory values should be reported to Nurse Practitioner (NP) or Physician (MD) when they are received. V20 stated critical labs should always be reported immediately. V20 stated "In this case (R2) was hospitalized for something we could have treated more aggressively in the facility initially or have sent (R2) to the emergency room if applicable, but because the lab work was not done and then not reported (R2) subsequently ended up in the hospital." V20 stated V20 was made aware of R2's abnormal lab values on 1/6/23.

The facility policy titled 'Physician Notification of Laboratory/Radiology/Diagnostic Results' revised November 2019 documents the following:

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S9999	Continued From page 9 "Purpose: To assure physician ordered diagnostic tests are performed, and to assure test results are reported to the physician, so that prompt appropriate action may be taken if indicated for the resident's care. A requisition is to be completed and lab to be drawn on the next scheduled lab day unless "STAT" is ordered. A nurse is responsible for monitoring the receipt of test results. Test results should be reported to the physician or other practitioner who ordered them. All critical lab values unless other parameters are ordered by physician: White Blood Cell greater than 12000. The licensed nurse is responsible for documenting the results in the clinical record." B. R4's undated Face Sheet documents medical diagnoses of Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side, Dysphagia, Chronic Obstructive Pulmonary Disease (COPD), Chronic Respiratory Failure with Hypercapnia, Chronic Pain Syndrome, Dilated Cardiomyopathy, Congestive Heart Failure and Spondylosis Without Myopathy of Lumbar Region. R4's Minimum Data Set (MDS) dated 12/1/22 documents R4 is cognitively intact. This same MDS documents R4 as requiring extensive assistance of two people for bed mobility, dressing, toileting, personal hygiene and total dependence of two people for transfers. R4's Physician Order Sheet (POS) dated January 1-31, 2023 documents a physician order for Hydrocodone-Acetaminophen (Norco) 10-325 mg one tablet every four hours as needed for pain starting 12/6/22 and Norco 5-325 mg two tablets every four hours as needed for back pain starting 1/2/23.	S9999		

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S9999	Continued From page 10 R4's Medication Administration Record (MAR) dated January 1-31, 2023 documents Norco 10-325 mg was administered on 1/1/23 at 4:23 AM, 1/1/23 at 2:10 PM and 1/1/23 at 10:40 PM. This same MAR documents Norco 5-325 mg was administered on 1/2/23 at 2:31 PM. On 1/3/23 at 11:00 AM surveyor observed R4 laying in bed with tears in eyes. R4 stated "They (facility) let me go hours without my pain medication. I had to just lay here in bed for hours in pain. I was crying it hurt so bad. I asked to go to the emergency room and was told I had to wait because they (staff) were trying to get my pain medication. I got tired of waiting in pain so I sent myself to the emergency room (1/2/23) for pain because they (facility) would not send me. The emergency room gave me some pain medication and a new prescription, but the facility still did not give me any until later that day (1/2/23)." On 1/3/23 at 1:30 PM V2 (Director of Nurses/DON) stated R4 is an established patient at the local pain clinic. V2 stated R4 does have back pain and that is why R4 sees the pain clinic. V2 stated R4 can be 'very demanding' and have 'unreasonable expectations' of staff. V2 stated the pain clinic will send a prescription electronically (e-scribe) to the facility, the facility enters the order and then the pharmacy will send the new prescription. V2 stated "In the case of (R4), the pain clinic never sent the prescription. We (facility) should have followed up with that but did not. That is when we (facility) called the pain clinic and were told that they (pain clinic) never sent the prescription to our facility. So, that is why the pharmacy never sent any more Norco for (R4). (R4) asked me if we (facility) could send (R4) to the emergency room and I told him 'you have the right to go to the emergency room but we (facility)	S9999		

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S9999	Continued From page 11	S9999		

are working on getting you more pain medication. You just have to be patient.' I did not call 911 for (R4). (R4) could not wait for us (staff) to get his pain medication figured out so he called 911 himself. The hospital gave (R4) some pain medication and a new prescription for Norco 5-325 mg two tablets every four hours as needed. (R4) may have went a total of 8 or 10 hours without any pain medication. I did not know until today that the pain clinic sent (R4's) Norco prescription to a local chain pharmacy."

On 1/3/23 at 2:45 PM V12 (Pain Clinic Nurse Practitioner/NP) stated R4 is an established patient at local pain clinic. V12 stated R4 was given a computer tablet to enter any updated information on when R4 arrived at pain clinic appointment on 12/9/22. V12 stated R4 is alert and oriented and independently chose an outside pharmacy so that is where the Norco prescription was sent. V12 (NP) stated "The facility got (R4) to the appointment and we (pain clinic) got (R4) the medication needed. The facility should have asked (R4) about any new orders or called the pain clinic to inquire. I personally tried to call the facility multiple times because I knew (R4) lived in a long-term care setting and most of those use their own pharmacies. I could not get anyone to respond so we (pain clinic) sent the prescription to the local chain pharmacy that was listed in (R4's) chart."

On 1/4/23 at 10:05 AM V10 (Licensed Practical Nurse/LPN) stated "January 2, 2023 was the day we realized (R4) did not have any more Hydrocodone-Acetaminophen 10-325 milligrams (mg). I began calling the pharmacy. When I called the pharmacy, they said the order had been discontinued and would not be filled until a new prescription was obtained. So, that is when I

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S9999	Continued From page 12 called the pain clinic. I could not get ahold of them right away so (R4) decided to send himself to the hospital to get a new prescription. (R4) did not want to wait on us (facility)." The facility policy titled 'Physician Orders-Entering and Processing' revised January 2018 documents the following: "Purpose: To provide general guidelines when receiving, entering and confirming physician or prescriber's orders (a prescriber is noted as a physician, nurse practitioner, and a physician's assistant). Following a physician visit, a licensed nurse will check for any orders that require confirmation. The orders will be confirmed by the nurse and the instructions for the order will be completed. (A) (Violation 2 of 2) 300.610a) 300.1210b) 300.1210d)1) 300.1630b) 300.1630c) 300.1630d) 300.1630)e 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	S9999		

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	IL6001010	A. BUILDING: _____ B. WING _____	C 01/12/2023

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S9999	Continued From page 13 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. 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 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	S9999		

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S9999	Continued From page 14 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. c) Medications prescribed for one resident shall not be administered to another resident. 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. 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. These requirements were not met as evidenced by: Based on observation, interview and record review the facility failed to administer Lantus Insulin 85 units for one (R3) resident for a total of 25 days due to facility did not follow their own policy when reviewing a Physician order. This failure affects one (R3) of three residents reviewed for medication in the sample of 17. This failure caused R3 to experience a significant increase in R3's blood glucose levels resulting in R3 developing cellulitis requiring additional	S9999		

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S9999	Continued From page 15 antibiotic therapy, with a potential for sustained elevated blood glucose levels resulting in diabetic coma and/or death. Findings include: R3's Medical diagnoses include Type II Diabetes Mellitus Without Complications, Essential Hypertension, Respiratory Failure, Dementia with Behavioral Disturbances, Chronic Congestive Heart Failure, Venous Insufficiency, Difficulty in Walking and Chronic Obstructive Pulmonary Disease. R3's Minimum Data Set (MDS) dated 12/5/22 documents R3 as moderately cognitively impaired. This same MDS documents R3 as requiring extensive assistance of one person for bed mobility, dressing, toileting, personal hygiene and extensive assistance of two people for transfers. R3's Physician Order Sheet (POS) dated November 1-30,2022 documents a physician order for Lantus Insulin 85 units to be self-administered unsupervised daily in the morning from 11/12/22-11/30/22. This same POS documents an increase in R3's Humalog insulin to be administered subcutaneously with each meal on 11/30/22 from 4 units to 6 units. R3's Medication Administration Record (MAR) dated November 1-30, 2022 documents R3's Lantus Insulin was signed out as unsupervised self-administration (U-SA) for 11/12/22-11/30/22. This same MAR documents R3's blood glucose levels from 11/1/22-11/10/22 as ranging from mid 100's to high 200's and 11/11/22-11/30/22 as high 200's to high 300's with four entries in the low 400's.	S9999		

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S9999	Continued From page 16 R3's POS dated December 1-31, 2022 documents a physician order for Lantus Insulin 85 units to be self-administered unsupervised daily in the morning from 12/1/22-12/7/22. This same POS documents physician orders for Cephalexin 500 milligrams (mg) twice daily for Cellulitis starting 12/19/22 through 12/24/22. R3's Medication Administration Record (MAR) dated December 1-31, 2022 documents R3's Lantus Insulin was signed out as unsupervised self-administration (U-SA) for 12/1/22-12/7/22. This same MAR documents R3's blood glucose levels range from 12/1/22-12/7/22 as mid 200's to mid 300's and 12/7/22-12/31/22 as high 100's to mid 200's. On 1/3/23 at 11:15 AM Surveyor observed R3 did not have any Humalog Insulin on medication cart nor in nurses' storage refrigerator. On 1/3/23 at 11:20 AM V9 (Licensed Practical Nurse/LPN) confirmed R3 did not have any Humalog Insulin in the medication cart nor nursing storage refrigerator. V9 (LPN) stated "We (staff) have been using (R6's) Humalog since we are out. (R3) has been getting the insulin, just not from (R3's) own bottle. I will get it ordered today." On 1/3/23 at 2:00 PM V2 (Director of Nurses/DON) stated V2 was not aware that (R3's) Humalog Insulin was not in facility. V2 stated "All residents should have their own medication. The nurses should never borrow one resident's medication to give to another resident." On 1/3/23 at 2:30 PM V2 (DON) stated "The previous Nurse Practitioner (V8) ordered (R3's) Lantus Insulin 85 units every morning on	S9999		

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S9999	Continued From page 17 11/11/22. (V8) entered (R3's) Lantus order incorrectly. (V8) entered an order that read (R3) would self-administer the Lantus unsupervised. This was a mistake on (V8's) part. (R3) cannot safely self-administer any medications. Because of that, (R3) never received that medication from 11/12/22-12/7/22." V2 stated when the Electronic Medical Record (EMR) 'reads' that order, it is not digitally sent to the Medication Administration Record (MAR) that the nurse sees on their computer. So the nurses would never have seen that (R3) was supposed to be getting the 85 units of Lantus every morning. (V10) (LPN) reviewed and confirmed the order, but I am sure (V10) did not question the order since (V8) entered it." On 1/4/23 at 8:30 AM R3 stated "I did not have to go to the hospital or anything, but I sure didn't feel good most of those days." On 1/4/23 at 9:55 AM V8 (previous NP) stated "(R3) is a long time diabetic patient. I did enter an order for (R3's) Lantus 85 units daily to be administered in the morning on 11/12/22-12/12/22. I wrote that order for one month due to R3 has had multiple changes in (R3's) Insulin regimen. I did enter the Lantus order to be self-administered unsupervised. (R3) is not cleared to self-administer medications due to poor cognition. The facility policy was for the nurses to review all physician orders. (V2) (DON) called me on 12/7/22 to report the error. I told (V2) then to complete a medication error report. The original error in entering the order was my fault, but if the facility would have followed the facility policy to review the orders, (R3) would have only missed possibly one dose, not a month's worth of insulin. For (R3), not getting the insulin that was prescribed more than likely caused (R3) to have to take antibiotics for	S9999		

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S9999	Continued From page 18 bilateral lower leg cellulitis. (R3's) elevated blood sugars would have prevented healing. If (R3's) blood sugars had been better controlled with insulin, more than likely (R3) would not have been on those extra antibiotics. (R3) could have gone into a Diabetic coma due to dangerously elevated blood sugar levels. (R3) could have died. That is how serious this is." On 1/6/23 at 1:10 PM V20 (Medical Director) stated "I was unaware of any medication error concerning (R3). (R3) is a chronic diabetic patient that requires a significant amount of insulin in order to maintain consistent blood sugars. It sounds like (V8) Nurse Practitioner entered the Lantus Insulin order incorrectly and the facility also did not review the order to ensure (R3) would have the insulin administered by a nurse. (R3) was previously getting 84 units of Lantus daily, so I don't understand why the facility did not recognize that (R3) was not getting (R3's) daily insulin. (R3) could have had severe consequences from not getting the Lantus for 25 days. The ill effects show in (R3's) elevated blood glucose levels and having to be prescribed antibiotics for the cellulitis." The facility policy titled 'Physician Orders-Entering and Processing' revised January 2018 documents the following: "To provide general guidelines when receiving, entering and confirming physician or prescriber orders. (A prescriber is noted as Physician, Nurse Practitioner or Physician's Assistant). Following a physician visit, a licensed nurse will check for any orders that require confirmation. The orders will be confirmed by the nurse and the instructions for the order will be completed."	S9999		

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S9999	Continued From page 19 (B)	S9999		