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	IL6007306	A. BUILDING: _____ B. WING _____	C 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHARON HEALTH CARE ELMS	3611 NORTH ROCHELLE PEORIA, IL 61604

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S 000	Initial Comments Complaint Investigation #2324277/IL160173	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)2) 300.1210d)3) 300.1620c) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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: 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 resident's medical record Section 300.1620 Compliance with Licensed Prescriber's Orders 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 documented in the clinical record. Portions of this review may be done outside the facility. 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. These requirements are not meet as evidenced	S9999		

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S9999	Continued From page 2 by: A. Based on interview and record review, the facility failed to act on and obtain a physician response to a Pharmacist's Drug Regimen Review which documented a clinically significant medication issue for one of four residents (R1) reviewed for physician orders in the sample of four. This failure resulted in R1 incorrectly receiving extra doses of an anti-diabetic medication. R1 was found unresponsive, hypoglycemic and required transfer to the hospital via ambulance. B. Based on interview and record review, the facility failed to accurately transcribe physician orders resulting in a significant medication error of an anti-diabetic medication and failed to order and administer an emergency glucose replacement when a resident's blood glucose levels were critically low for one of four residents (R1) reviewed for physician orders in the sample of four. These failures resulted in R1 incorrectly receiving extra doses of an anti-diabetic medication. R1 was found lethargic, unresponsive and with critically low blood glucose levels. R1 was transferred to the local area hospital via ambulance. Findings include: The facility's "Medication Regimen Review" Policy, undated, states, "The consultant pharmacist performs a comprehensive review of each resident's medication regimen and clinical record at least monthly. The Medication Regimen Review (MRR) includes evaluating the resident's response to medication therapy to determine that the resident maintains the highest practicable level of functioning and preventing or minimizing	S9999		

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S9999	Continued From page 3 adverse consequences related to medication therapy. The MRR also involves a thorough review of the resident records and may include collaboration with other members of the interdisciplinary team, collaboration with the resident, family members or other resident representatives. The MRR also involves reporting of findings with recommendations for improvement. All findings and recommendations are reported to the Director of Nursing and the Attending Physician, the Medical Director and Administrator. Procedure: 2. The consultant pharmacist reviews the medication regimen of each resident at least monthly. a. A more frequent review may be deemed necessary i.e., if the medication regimen is thought to contribute to an acute change in status or adverse consequence, or the resident is not expected to stay 30 days. b. Upon admission or re-admission to the facility, the consultant pharmacist performs a MRR in accordance with CMS (Centers for Medicare and Medicaid Services)-N2001. The consultant pharmacist will provide a notice of the MRR having been performed with a Code 0 (no discrepancy) or Code 1 (discrepancy noted), along with a clinical recommendation for each discrepancy noted on admission or re-admission." "6. Resident-specific irregularities and/or clinically significant risks resulting from or associated with medications are documented and reported to the director of nursing, medical director, and prescriber as appropriate. 7. Recommendations are acted upon and documented by the facility staff and/or the prescriber." The facility's "Medication Pass Guidelines", dated 3/00, states, "Purpose: To assure the most complete and accurate implementation of physicians' medication orders and to optimize	S9999		

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S9999	Continued From page 4	S9999		

drug therapy for each resident by providing for administration of drugs in an accurate, safe, timely, and sanitary manner." "Physician's Orders-Medications are administered in accordance with written orders of the attending physician." "The nurse who receives the order is responsible for transcribing to the chart."

The facility's "Ordering and Receiving Medications" Policy, dated 3/00, states, "Purpose: To ensure that medications are available for administration at the correct time, in the correct form and quantity." "Procedure: New Orders 1. All new orders must be written on a physician's order sheet. 2. Transcribe written physician orders appropriately to the Medication Administration Record (MAR) and treatment sheets."

R1's Facesheet documents R1 admitted to the facility on 5/5/23 with a diagnosis of Type 2 Diabetes Mellitus.

R1's Census Report documents R1 admitted to the facility on 5/5/23 and was discharged to the hospital on 5/8/23.

R1's After Visit Summary (AVS) documents R1 was being discharged to the facility after an inpatient hospital stay from 4/15/23-5/5/23. This AVS documents the following: "Discharge Medications" with an order for "Glipizide 2.5 mg/milligram tab (tablet)-sr/sustained release-24 hr/hour. Commonly known as Glucotrol XL (Extended Release). Take two tablets by mouth daily." and "Recommendations for your Diabetes: Follow directions for your medicine, meals and exercise, Check your blood sugars often, Stay within your safe blood sugar levels; Treat a low blood sugar right away, and Tell all doctors about your diabetes."

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S9999	Continued From page 5 R1's Order Summary Report, 5/5/23-5/8/23, documents an order for "Glipizide ER (Extended Release) Oral Tablet Extended Release 24 hour 2.5 mg/milligrams. Give two tablets by mouth two times a day related to Type 2 Diabetes Mellitus without complications" with a start date of 5/6/23. R1's admission date to the facility as 5/5/23; and V11 as R1's Physician. R1's Drug Regimen Review/DRR from the facility's Pharmacy Company states, "Attention Required: Discrepancies Noted. CMS (Centers for Medicare and Medicaid Services) N2001: Drug Regimen Review" This form states, "In compliance with CMS-N2001: Drug Regimen Review, upon admission/readmission, the resident's medication regimen was reviewed for clinically significant medication issues. After clinical review, the following was noted: Hospital paperwork showed patient (R1) is using Glipizide 2.5 mg 2 (two) tabs (tablets) daily. Order needs to be reviewed and updated per (name of electronic charting system) says 2 (two) tabs (tablets) BID (twice a day)." This DRR documents R1's admission date to the facility as 5/5/23 and documents V11 as R1's Physician. The "physician/prescriber response" section is blank. This form states, "In accordance with CMS-N2001, prescriber response must be received by midnight the next calendar day." R1's CMS-N2001 Drug Regimen Review, dated 5/6/23 by V13 (Pharmacist) states, "In compliance with CMS-N2001: Drug Regimen Review, upon admission/readmission the resident's medication regimen was reviewed to assess whether any clinically signification medication issues were present. After review it was noted that: Code One, Yes. One or more clinically significant medication issues were	S9999		

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S9999	Continued From page 6	S9999		

identified during the DRR" This DRR is electronically signed and dated by V13 (Pharmacist) on 5/6/23 at 11:49 AM. DRR "Conversation Records" documents the DRR communication was faxed to the facility's nursing station, emailed to V2 (Director of Nursing) and emailed to V12 (Care Plan Coordinator) on 5/6/23 at 11:58 AM and was re-faxed to the facility's nursing station on 5/8/23 at 1:30 PM. On 5/9/23 at 1:27 PM, V13 documents R1 is back at the hospital.

R1's Medication Administration Record (MAR) dated 5/1/23-5/31/23 documents an order for "Glipizide ER (Extended Release) Oral Tablet Extended Release 24 hour 2.5 mg/milligrams. Give two tablets by mouth two times a day related to Type 2 Diabetes Mellitus without complications." This same MAR documents two Glipizide ER 2.5 mg tablets were given two times a day on 5/6/23 and 5/7/23 at 9:00 am and 5:00 PM. Another dose of two Glipizide ER 2.5 mg tablets is documented as being given again on 5/8/23 at 9:00 AM, 16 hours after the previous dose.

R1's Nursing Note on 5/8/2023 at 4:35 PM, signed by V4 (Licensed Practical Nurse) states, (R1) presents as lethargic. Upon assessment bs (Blood Sugar) 46, unable to arouse. (R1) sent to (name of local area hospital) for eval (evaluation) and treat (treatment). All appropriate parties notified."

The facility's "Packing Slip" from the Pharmacy, dated 5/5/23, documents Glipizide ER 5 mg tablets were delivered for R1.

R1's Skilled Nursing Facility to Hospital Transfer Form, signed by V4 documents on 5/8/23, R1

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S9999	Continued From page 7 was transferred to the local area hospital with lethargy and low blood sugar. On 5/25/23 at 11:27 AM, V10 (Pharmacist) stated that after a review of R1's admission medications were completed a discrepancy noted R1's Glipizide order was entered as 2.5 mg ER two tabs two times a day and the hospital order was ordered for only once a day. V10 stated requests for a clarification were sent to V2 and V12 via electronic mail and a request was sent to the facility nursing station fax number as well on 5/6/23. V10 stated a fax was sent to the nursing station fax number again on 5/8/23. V10 stated no response was received from the facility regarding the discrepancy. V10 stated R1's extra doses of Glipizide could have caused R1's hypoglycemia. On 5/25/23 at 3:51 PM, V2 (Director of Nursing) stated, "The minute the nurses got the fax (R1's Drug Regimen Review), it should have been addressed. The faxes are not supposed to sit. We are still investigating this to see what happened." V2 stated since it was a weekend, V2 did not see the electronic mail correspondence from the pharmacy. On 5/25/23 at 3:29 PM, V11 (R1's Physician) stated V11 does not recall receiving notification regarding pharmacy's request for clarification regarding R1's Glipizide medication order. V11 stated that V2 (Director of Nursing) made V11 aware today (5/25/23) that the Glipizide order was ordered incorrectly and that R1 had received more than the ordered dose. V11 stated R1's hypoglycemia on 5/8/23 could have been from the extra doses of Glipizide that was given. On 5/26/23 at 12:10 PM, V9 (Assistant Director of	S9999		

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S9999	Continued From page 8 Nursing) stated R1's Drug Regimen Review fax that indicated there were issues with R1's medication orders should have immediately been addressed by the nurses when it was pulled from the fax. V9 stated, "Addressing this right away could have prevented a medication error from occurring." V9 stated all nurses are going to be re-educated on the fax machine and the importance of responding to received faxes at huddle at shift change today." As of 5/26/23, R1's medical record did not document a physician response to V13's Drug Regimen Review. V11's (R1's Physician) Standing Orders and "Guidelines for Patient Care and Reasonable Expected Reviewer's Criteria", signed and dated by V11 on 1/21/16, states, "VI. Emergency e. If a known diabetic patient becomes lethargic or shows signs and symptoms of Insulin reaction or hypoglycemia, BGM (Blood Glucose Monitor) the patient. If below 60 and symptomatic, give 1 (one) cc (cubic centimeter/one milliliter) Glucagon and send notification." "If unable to BGM patient and symptomatic, give 1 cc Glucagon and send to Emergency Room." The facility's "First-Dose and Emergency Medication Kit" Policy, undated, states, "Policy: Emergency needs for medication are met by using the facility's approved emergency medication supply or by special order from (name of the facility's Pharmacy)." The facility's "(Name of Automated Dispensing System) Item List" documents Glucagon 1 mg (One Milligram) Kit is contained inside. The facility's Registered Nurse/Licensed Practical	S9999		

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S9999	Continued From page 9 Nurse Job Description, undated, states, "Position Purpose: Provide Nursing Care to residents in accordance with clinically accepted practice, governmental regulations, accreditation standards, and consumer wishes and needs." "Responsibilities: Requires the ability to apply general nursing techniques and practices, Requires the ability to maintain accurate records, charts and report observations, Requires the ability to follow and give oral and written directions in exact detail and to administer therapeutic prescriptions." "Provides routine nursing care in accordance with the physician's orders in conformance with recognized nursing techniques and procedures established standards, and the administrative policy of the facility to which assigned. Maintains clinical charts; reports on the conditions of residents; accepts appropriate telephone communications with the physicians. Assists residents with nursing care problems." (A)	S9999		