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	IL6009336	A. BUILDING: _____ B. WING _____	C 05/29/2024

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S 000	Initial Comments Complaint Investigation: 2444065/IL173535	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210a) 300.1210b) 300.1210c) 300.1210d)2)3) Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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		

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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.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

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.

These requirements were not met as evidenced by:

Based on interview and record review, the facility failed to monitor and treat a resident with the diagnoses of Diabetes Type 2 for one of 3 residents (R10) reviewed for quality of care, in the sample of 12. This failure resulted in R10 being hospitalized with Uncontrolled Diabetes Mellitus with an initial blood glucose of 614 in the Emergency Room (ER).

Findings include:

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R10's Hospital Emergency Room (ER) Records, dated 5/22/24, documented that he had a history of insulin dependent diabetes mellitus and that he was admitted to the hospital on that date with the diagnoses of Acute on Chronic Renal Failure and Uncontrolled Diabetes Mellitus. Per the hospital records, R10's blood glucose level was 614 when he was in the ER.

R10's Face Sheet, printed 5/23/24, documented that he was admitted to the facility on 9/9/21 with a diagnosis of Type 2 Diabetes Mellitus without complications.

R10's Minimum Data Set (MDS) dated 2/6/24 documents he is moderately cognitively impaired and is dependent on staff for Activities of Daily Living (ADLs).

R10's Care Plan, dated 9/26/21, documented, "(R10) has Diabetes Mellitus." The goal for this care plan was, "(R10) will have no complications related to diabetes through the next review date of 5/19/24." Interventions for this care plan included, "Check all of body for breaks in skin and treat promptly as ordered by doctor. Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness. Dietary consult for nutritional regiment and ongoing monitoring. Discuss mealtimes, portion sizes, dietary restrictions, snacks allowed in daily nutritional plan, compliance with nutritional regimen. Don't use over the counter remedies for corns and calluses, refer to podiatrist to treat. Educate regarding medications and importance of compliance. Have resident verbally state an understanding. Educate resident/family/caregiver: Diabetes is a chronic disease, and that compliance is essential to prevent complications of the disease. Review

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complications and prevention with the resident/family/caregiver. Elicit a verbal understanding from the resident/family/caregiver, that nails should always be cut straight across, never cut corners. File rough edges with emery board. " R10's Care Plan did not address monitoring blood glucose levels or signs and symptoms of hyper or hypoglycemia.

R10's Care Plan, dated 9/26/21 and revised on 5/23/24, documented, "(R10) has actual impairment to skin integrity related to (r/t) Diabetes, decreased mobility and urinary incontinence. (R10) had a pressure ulcer to the right trochanter, coccyx and right ischium, diabetic ulcer to left foot dorsal, and 2 arterial ulcers to RLE (right lower extremity)." The goal for this care plan documented, "(R10's) diabetic, pressure and arterial ulcers will show s/s (signs and symptoms) of healing through next review date of 5/19/24."

R10's lab result, dated 5/8/24 at 7:05 AM documented that his blood glucose of 374, which is high, with normal limits being 74 to 106.

R10's most recent Order Summary Report, dated 5/24/24 with order date range from 5/1/24 to 5/31/24, documented an order, dated 5/9/24, "Draw TIBC (Total Iron Binding Capacity), Iron, Folate, A1C, Occult Stool x 3 one time only for 1 day. No A1C result was found for that date (5/9/24) in R10's Electronic Medical Record (EMR).

R10's lab result, dated 3/7/24, documented his HGB A1C as 9.4, which was high, with the goal being less than 7 if a resident is diabetic. There was no documentation in R10's EMR that his physician was notified of this abnormal lab.

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R10's Physician Order Summaries were reviewed for April 2024, March 2024, February 2024, January 2024, December 2023, November 2023, October 2023 and September 2023. Review of these physician order summaries documented R10 was receiving both Humalog Insulin (Order dated 9/26/23: Humalog (Insulin Lispro) 15 units (u) subcutaneously (SQ) before meals for diabetes and Insulin Glargine 20 u SQ one time a day for diabetes). R10 continued to receive these medications with blood glucose monitoring before meals and at bedtime until he was hospitalized on 11/29/24. R10's December 2023 physician order summary documented that he was readmitted to the facility on 12/7/23. The December physician order summary documented the order dated 12/13/23: May obtain blood sugar prn (as needed) for signs and symptoms of hyper/hypoglycemia as needed. If blood sugar is less than 70 and able to swallow, administer food or juice. Recheck blood sugar in 15 minutes and notify MD as needed. If blood sugar remains less than 70 and able to swallow, administer glucose gel orally. Recheck blood sugar in 15 minutes. If blood sugar remains less than 70 and unable to swallow, administer Glucagon per manufacturer's instruction. Obtain from EDK (Emergency Drug Kit). Recheck blood sugar in 15 minutes. If blood sugar remains less than 70, notify MD as needed. R10 did not have an order to resume scheduled blood glucose monitoring. On 2/25/24 R10 received an order for Metformin 500 mg one tab in the morning and 2 tabs at bedtime. There was no order for routine blood glucose monitoring after R10 returned from the hospital on 12/7/23.

R10's Hospital Discharge Instructions, dated 12/7/24, documented, "Discharge Follow Up Appointments- Endocrinology, Call office for

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appointment in 3-5 days. We were not able to confirm if he takes insulin and he largely refused a lot of things in the hospital including blood draws. Blood sugars remained well controlled on Metformin 500 mg BID (twice a day). Please reassess. The discharge instructions did document that R10 was to stop taking Insulin Glargine and Insulin Lispro but did not address if R10 was to continue to have blood glucose monitored routinely as he had prior to hospitalization. No documentation was found in R10's EMR regarding notification of his MD for reassessment of blood glucose monitoring and if insulin should be resumed.

On 5/24/24 at 11:07 AM V21, Licensed Practical Nurse (LPN), during phone interview, stated that she was R10's nurse on the day he was sent to the hospital. She stated he was having a change in condition since she saw him the previous week, as she only works prn. She stated the previous week R10 had some shortness of breath, and his pulse ox was a little low and she called his doctor, and a chest x-ray was ordered, and he was started on antibiotics. She stated when she saw him the next week, he was not any better and he had just finished his antibiotics. She stated that R10 was holding his pills in his mouth when she gave them to him and then started chewing them which was not normal for him. She stated R10 was normally grouchy and yelling at people and on that day, he was not talking. He was not being able to cough up his phlegm and was still drooling some of the chocolate health shake with little bits of his medication mixed in. V21 stated that she did not do an accucheck on R10 because she didn't think his change in condition had anything to do with his blood sugar.

On 5/24/24 at 1:55 PM, V23, Registered Nurse

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(RN) in R10's Primary Care Physician's (V24's) office, stated that she couldn't find in R10's records at the physician's office that they ever received notification of R10's A1C result of 9.4 that was done on 3/7/24. V23 also stated that they would have definitely ordered accuchecks to be done if his A1C was 9.4, and probably would have started something else to treat his diabetes. She stated that R10's glucose level on 5/8/24 was 347 and V24 ordered an A1C to be done but they have not received those results yet.

On 5/24/24 at 2:37 PM V25, MD, Hospitalist, stated that he has seen R10 during this hospitalization. He stated that R10's blood glucose was 614 when he first came to the Emergency Room, and it continued to be high for a while. He stated R10 should have been getting routine accuchecks to keep an eye on his diabetes. He stated that if R10 was on insulin, he would expect accuchecks to be done at least a couple of times a day and if not on insulin, he should have been receiving accuchecks at least once a day to monitor his diabetic status because of his history of diabetes. V25 also stated that he does think it would have made a difference if R10's blood glucose levels had been monitored and his high blood glucose levels had been caught and treated in that it would have helped prevent his hospitalization, infections and poor wound healing. V25 stated that he reviewed R10's medical records and they indicated R10 should have been taking insulin. He also stated it would have been appropriate to be checking R10's blood glucose levels to see if he needed to be back on insulin.

On 5/24/24 at 3:12 PM, V2, Director of Nursing, stated that she has the fax confirmation page showing that the lab did fax R10's A1C result

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S9999	Continued From page 7 from 3/7/24 to the physician's office, but she does not think the facility followed up to make sure V24 saw it. She stated that going forward, the facility has educated the nurses to compare previous orders prior to hospitalization, or home medications to current or hospital discharge orders to check for any differences, and then notify the MD to see if he wants any previous orders, including accuchecks, resumed upon readmit to the facility. She also stated she just started this process about a month ago, so it probably did not happen when R10 was readmitted to the facility on 12/7/23. V2 also stated R10's A1C was not drawn as ordered on 5/9/24 because he had one done within the last 3 months, so they will draw it in June. V2 stated that the facility does not have a specific policy regarding diabetic management, and stated they just treat according to physician's orders. (A)	S9999		