| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | IL6003586 | A. BUILDING: _____ B. WING _____ | C 03/29/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| S 000 | Initial Comments<br><br>Complaint Investigations<br>2592359/IL188343 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations:<br><br>300.1010h)<br>300.1210b)<br>300.1210c)<br>300.1210d)3)<br><br>Section 300.1010 Medical Care Policies<br><br>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, 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.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>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. | S9999 | | |

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|---|---|---|---|---|
| S9999 | Continued From page 1 | S9999 | | |

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:

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.

Based on interview and record review, the facility failed to manage a resident with an insulin overdose in accordance with the standards of care for 1 of 4 residents (R1) reviewed for quality of care in the sample of 4. This failure resulted in a delayed transfer to the hospital, R1's wife summoning EMS (emergency medical services) and R1 being admitted to the ICU (intensive care unit) with an insulin overdose and hypoglycemia.

The findings include:

On 3/28/25 at 1:02 PM, V4, Registered Nurse (RN), said he found R1 to be groggy and sleepy at the end of his (night) shift (on 11/25/24). V4 said he checked R1's blood glucose (BG), all BG measurements in this citation are in milligrams/deciliter (mg/dl) and it was very low; in the 30s. V4 said he gave R1 glucagon (a medication used to treat severe low blood (sugar) glucose) which he got from the crash cart and R1 slowly regained his alertness. V4 said glucagon

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|---|---|---|---|---|
| S9999 | Continued From page 2 | S9999 | | |

should start working 15 to 30 minutes after administration. V4 said he then gave R1 some juice. V4 said R1 admitted that he was giving himself insulin but could not say how much insulin or when he had injected it, but he had used Lispro (a fast-acting insulin) and a long-acting insulin. V4 said R1's BG increased from the 30s to the 50s. V4 said he is not sure when he gave R1 a dose of glucagon, thinks it was around 6:00 AM. V4 said he should have charted in on the MAR (medication administration record), but he is not sure if he did. V4 said drowsiness, weakness, and slurred speech are all symptoms of low blood sugar. V4 said he would monitor for symptoms of low blood sugar (hypoglycemia) and if there were still symptoms and the BG was not at a normal level, he thinks it would be best to send the patient to the hospital.

On 3/28/25 at 11:55 AM, V3, Licensed Practical Nurse (LPN), said she does not remember R1, but in an emergency situation, one nurse will help another nurse manage a resident. After reviewing R1's medical record, V3 confirmed she had given R1 glucagon on 11/25/24 at 10:00 AM, and believes it is the only dose he received according to the documentation on the MAR. V3 said if a resident's BG is low, she gives them orange juice and they usually have glucagon ordered and she can give that too. If the resident is alert, she tries to get them to eat/drink. V3 said she would repeat the glucagon after 15 minutes if the BG continued to drop or if there was no improvement in their cognition. V3 said slurred speech is a symptom of hypoglycemia. V3 said she would feel like a resident was safe if their BG had increased greater than 100 or 125, the vital signs were OK, and the resident's cognition was back to their baseline. V3 said if R1 had been her patient, she would have insisted for the doctor to send him to

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|---|---|---|---|---|
| S9999 | Continued From page 3 | S9999 | | |

the hospital because he ate, glucagon was given, and he was still not responding to the treatment interventions.

On 3/28/25 at 12:30 PM, V6, RN, said night shift did not report having any problems with R1 to her during nurse-to-nurse report (on 11/25/24). R1 said she checked R1's BG as ordered that morning. R1 was a "very brittle diabetic" and at one point they found insulin vials and pens at his bedside. V6 said R1's wife admitted to administering insulin to R1 while in the facility. V6 said R1's wife was screaming at her saying no one was taking care of her husband. V6 said the morning R1 went to the hospital (11/25/24), R1 was lethargic and had slurred speech. V6 said R1's BG was, "a little bit low." V6 said she had no idea how much, when, or what type of insulin R1 or his wife administered to R1. V6 said she does not remember R1's BG level, but it was low enough that the other nurse working that day administered glucagon to R1. V6 said glucagon starts working in less than five minutes. V6 said she did not call R1's provider about R1's BG. V6 said she would be concerned about any BG less than 70. V6 said she would check the BG again less than five minutes after glucagon is given to see if it was increasing and if it was still low, she would send a resident to the hospital immediately. V6 said she would consider a resident stable if their mental status was at baseline, the BG was between 70 and 100, and their vital signs were stable. V6 said R1's wife called the ambulance and demanded he be sent to the hospital.

On 3/28/25 at 1:47 PM, V2, Director of Nursing, said standards of care would consider a BG less than 70 as low. The doctor would need to be notified and nursing would follow their instructions. V2 said he would recheck a

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|---|---|---|---|---|
| S9999 | Continued From page 4 | S9999 | | |

resident's BG in 10 to 15 minutes after administering glucagon and if it was still low, he would administer a second dose of glucagon. V2 said he would err on the side of a resident's BG going too high rather than too low and risk a permanent medical condition from hypoglycemia. V2 said nurses document their medications on the electronic MAR as well as the BG checks. V2 said if something is not documented, then it was not done. V2 said nurses can use nursing judgment and critical thinking to determine if a patient needs to go to the hospital, they do not require a physician's order.

On 3/29/25 at 10:20 AM, V10, R1's physician, said he knows R1 very well and he did not have slurred speech at his baseline. V10 said slurred speech is a sign of hypoglycemia or stroke. V10 said R1 was using insulin without permission. V10 said if the BG was less than 60, they should try giving glucagon and if able, feed the patient, and monitor the BG closely, especially with R1 as he had kidney issues which alone can cause hypoglycemia. V10 said an unknown quantity, type and time of insulin was given, so he could not say when it would peak or how long it would last. V10 said if large amounts of insulin were administered, even glucagon could not bring up the BG effectively. V10 easily needed to be closely monitored for 12-24 hours after the insulin overdose. V10 said if a patient's care or safety was compromised, he would send them to the hospital. V10 said if R1's speech remained slurred, he would try to give the glucagon once and if he did not return to baseline, he would send him to hospital. V10 said he would expect a BG to go to the 200s after receiving glucagon. V10 said a BG of 37, 58, or even 60 is not ok. V10 said he would not consider a BG to be stable in the range of 37 to 60. V10 said if the facility called and told

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|---|---|---|---|---|
| S9999 | Continued From page 5 | S9999 | | |

him R1's BG did not go up to a normal range and he still had slurred speech despite being given glucagon and having eaten, he would have told them to send him to the hospital.

On 3/29/25 at 11:20 AM, V11, R1's Nurse Practitioner, said R1's speech was not slurred, nor was he lethargic or groggy at his baseline. V11 said R1 was an alert and oriented, brittle patient who was noncompliant and difficult to work with. V11 said she was informed after the incident that R1 had been given insulin, but no one knows what type, when, or how much insulin was given. V11 said she could not even estimate how long the insulin would last. V11 said she would have given glucagon, and if R1 was not responding, she would have sent him to the hospital. V11 said someone cannot survive with a BG of 37. V11 said a BG of 37 to 60 is not stable; it's not safe for a person. V11 said a normal range for a BG is 60 to 100. V11 said the BG should be checked and repeated if it's not above 60 within 10-15 minutes. V11 said if she had been informed that R1's speech became slurred and his BG never recovered to a normal range, she would have sent him to the hospital. Then V11 said, based on how R1 was as a patient, she would have sent him to the hospital anyway; he was noncompliant, not easy, and nothing good could have come out of this situation. V11 said she feels like patient safety is the most important thing. The nurses have a lot of patients on that floor that are very critical, and R1 could have probably died. V11 said the standards of care after an insulin overdose support that R1 should have been sent out to the hospital right away.

R1's Admission Record dated 3/28/25 shows R1 was admitted to the facility on 10/29/24. R1's diagnoses include, but are not limited to, left

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|---|---|---|---|---|
| S9999 | Continued From page 6 | S9999 | | |

ankle and foot osteomyelitis, type 2 diabetes with foot ulcer, non-pressure chronic ulcer of other part of left foot, cellulitis of left lower limb, hypertensive heart and chronic kidney disease with heart failure, congestive heart failure, peripheral vascular disease, atherosclerosis of native arteries of extremities, paroxysmal atrial fibrillation, atherosclerotic heart disease of native coronary artery, hyperlipidemia, gout, diabetic polyneuropathy, obstructive sleep apnea, gastroesophageal reflux disease, anemia, muscle wasting and atrophy, abnormal posture, hyperparathyroidism, vitamin D deficiency, depression, left eye cataract, urinary incontinence and long term use of anticoagulants.

R1's Minimum Data Set dated 11/5/24 shows R1's speech clarity is clear with distinct intelligible words.

R1's MAR for 11/1/24 to 11/30/24 shows one dose of Glucagon Emergency Injection Kit 1 milligram (mg) was administered to R1 on 11/25/24 at 10:00 AM.

R1's Weights and Vitals Summary dated 3/28/25 shows R1's BG was 37 at 7:01 AM on 11/25/24, 60 at 7:54 AM on 11/25/24, and 57 at 10:05 AM on 11/25/24. R1's BG averaged 163.55 between 11/19/24 and 11/24/24; it was never below 89 during that time span.

R1's Progress Notes show his BG was 37 when it was checked at 7:04 AM on 11/25/24 and R1 was awake and alert with three insulin pens/needles at the bedside. R1 admitted to self-administering insulin. The same note shows a recheck BG was 54. R1's Progress Notes show on 11/25/24 at 7:05 AM, R1 was responsive and "appeared to be responding to treatment." On 11/25/24 at 7:54

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|---|---|---|---|---|
| S9999 | Continued From page 7 | S9999 | | |

AM, R1's Progress Notes show his speech was slurred. On 11/25/24 at 8:30 AM, R1's progress notes show he was eating breakfast, but his speech remained slurred. On 11/25/24 at 9:03 AM, R1's Progress Notes show R1's wife was updated on R1's status. On 11/25/24 at 9:05 AM, R1's Progress Notes show he spoke to his wife on the phone with slurred speech. On 11/25/24 at 9:55 AM, R1's Progress Notes show R1's wife was at the bedside, R1 was staring ahead, blinking his eyes and not answering questions. On 11/25/24 at 9:59 AM, R1's Progress Notes show R1's wife called 911. On 11/15/24 at 10:15 AM, R1's Progress Notes show R1 was being transported via 911 to the hospital Emergency Room.

R1's Care Plan initiated on 10/30/24 shows R1 has potential for fluctuating blood glucose levels related to type 2 diabetes and his BG levels will be maintained within the parameters set forth by his physician. Signs and symptoms of hypoglycemia include a BG less than 70 and BG monitoring will be provided as ordered and as needed.

R1's hospital records dated 11/25/24 show the Emergency Physician documented that R1 presented to the hospital with an insulin overdose. EMS found a "low" blood sugar on arrival and started R1 on an intravenous dextrose solution infusion. R1's initial BG at the hospital was 107, but later dropped into the 50 range. The Triage Note shows R1 "was found catatonic upon EMS arrival" with an BG check reading "low." R1 was admitted to the ICU with diagnoses including, but not limited to insulin overdose and hypoglycemia.

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