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
	IL6004907	A. BUILDING: _____ B. WING _____	C 12/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JERSEYVILLE NSG & REHAB CENTER, INC	1001 SOUTH STATE STREET JERSEYVILLE, IL 62052

(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
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210b) 300.1210c) 300.1210d)1)2) 300.1630e) 300.3240a) 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, 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	S9999		

Attachment A Statement of Licensure Violations

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S9999	Continued From page 1 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 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: 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. Section 300.1630 Administration of Medication 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 Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.	S9999		

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S9999	Continued From page 2 These requirements are not met as evidenced by: Based on interview and record review, the facility neglected to follow facility policy and provide adequate care that included assessment and monitoring of blood glucose levels following a medication error for 1 of 3 (R1) residents reviewed for medication errors in a sample of 5. This failure resulted in R1 receiving the wrong insulin dose which was not according to his physician's order of Sliding Scale on 12/6/14 at 6:00 AM. Also, the facility failed to assess/monitor and intervene to prevent a serious medical condition/hypoglycemia following a medication error for one of 3 residents (R1) reviewed for sliding scale insulin in the sample of 5. These failures resulted in R1 exhibiting sweating, being cool to touch, and a blood sugar level of 22 on 12/6/14 at 11:10 am. R1 expired at 12:29 pm on 12/6/14. Findings Include: 1. The Admission Report documents R1 to have been admitted to the facility on 8/20/14 from the hospital with diagnoses of Stage IV lung Cancer, Diabetes, End Stage Renal Failure with Dialysis. R1's Physician's Orders Sheet (POS), dated December 2014, documents that R1 was to receive Novolog 100unit (u) /milliliters (ml) as directed subcuteneously 3 times per day before meals on a sliding scale basis. Parameters for the sliding scale per the physician's orders were as follows: 70-139 - no insulin, 140 - 175 - 2 units, 176 - 200 - 3 units, 201 - 250 - 4 units, 251-300 - 6 units, 301 -350 - 8 units, 351 - 400 - 10 units and notify physician, 401 - 500 12 units.	S9999		

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The Facility's Incident Report of 12/6/14 and the EMAR (Electronic Medication Administration Report), dated 12/6/14 at 6:00 AM, documented E3 Licensed Practical Nurse (LPN) did blood glucose monitoring on R1. At that time, R1's blood glucose level was 121. Per the documented Sliding Scale and Physician's Orders, R1 would have required no insulin. E3 documented on the EMAR that R1 received 25 units of Novolog 100u/ml.

R1's Progress Note dated 12/6/14 written by E4, LPN document that at 9:29 AM, R1 was unable to take morning medication due to lethargy, alert to verbal stimuli, skin was dry and warm to touch. At 10:36 AM, E4 documented in the Progress Note that she went to assess the patient and status was unchanged, skin warm and dry to touch, responded to verbal stimuli by opening and closing eyes when talked to. Neither the Progress notes or the EMAR document R1's blood sugars being monitored.

On 12/16/14, at 1:55 PM , E4, LPN, stated that she received report from E3 the morning of 12/6/14 at approximately 7:00 AM. E4 stated she had been told by E3 that R1 was to receive 100 Units of Insulin but thought that was too much given his decline in condition and she (E3) decided to give him 20 units instead. E4 stated she did not recheck for order or question the Insulin given R1 as she was unfamiliar with R1's care. E4 stated neither she nor E3 notified the physician of the insulin given adding that E3 seemed sure that R1's was suppose to get 100 units and she didn't appear to question the dose change. E4 stated she did not recheck R1's blood sugar that morning.

On 12/6/2014, at 11:10 AM, E4 documented in

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R1's Progress Note that R1's wife called her into the room because patient was cool to touch and sweating through gown and sheets. Blood sugar registered "L" (Low) on accu-check. R1's physician, Z1, was called and an order for Glucagon , along with sugar under the tongue was given in an effort to bring up the blood sugar. The Progress note continued that the blood sugar came up to 22 and that after the physician was informed, ordered Dextrose Intravenously (IV) STAT (Immediately.) The progress note documents EMT's (Emergency Medical Technician's) were called to start the IV with multiple attempts to get the IV started. E4 documented R1's time of death was 12:29 PM.

On 12/17/14 at 10:50 am, E4 stated that she had did not check the order until R1's wife asked how much insulin he had been given that morning at 11:10 AM when she was called to the room. E4 said when she checked the EMAR (Electronic Medication Administration Record), she saw that he should have not gotten any according to the sliding scale and that E3 actually documented 25 units given and not 20 as she had been told. E4 stated she told Z1 that R1 had received 25 units at 6:00 AM that morning when she called him at 11:10 am. E3 also stated she was told at 8:30 am that morning that R1 had not eaten any breakfast. E3 stated she did not do any glucose monitoring earlier that morning.

On 12/18/2014, at 10:00 AM , Z1 stated that he was not made aware of the Insulin error until later that morning when he ordered the Glucogon but had he known, he would have implemented hypoglycemic treatment. Z1 stated it was just a medication error and that R1 had Cancer, had decided to discontinue dialysis, had not had it in 4 days, and he had just signed orders for Hospice

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S9999	Continued From page 5 care that morning. Z1 stated R1 would soon have expired anyway adding that this "tipped him over the edge." The Facility's Policy entitled "Adverse Consequences and Medication Errors" documents that residents receiving any medication that has a potential for an adverse consequence will be monitored to ensure that any such consequences are promptly identified and reported. The policy continues to document that examples of medication errors to be monitored include wrong dose (e.g. Dilantin 12 ml ordered, Dilantin 2 ml given). The facility's policy entitle "Definitions of Abuse, Neglect, Involuntary Seclusion and Misappropriation of resident Property defines neglect as: The failure to provide adequate medical or personal care or maintenance, which failure results in physical mental injury to a resident or in the deterioration of a residents physical or mental condition." (A)	S9999		

F309 – 483.25 Quality of Care

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care

1. The corrective action for the alleged deficient practice has been achieved by the following:

   A. On 12-6-2014 all licensed staff was in-serviced by the Director of Nursing on Administering medication/ procedure to administer subcutaneous medication injections policy and procedure, including insulin administration, and following physician orders of administration of medications, including insulin.
   B. On 12-8-2014 all licensed staff was in-serviced again by Larry Henken, Pharmacist Consultant on Insulin Administration Procedure and training acknowledgement signed by all licensed staff. In-service included prescribing information for insulin agents commonly used to treat diabetes and highlighted: rapid acting, short-acting, intermediate-acting, combination intermediate-rapid acting, and long acting. In-service also addressed the administration of high risk medications.
   C. On 12-8-2014 Carrie Thurman, RN with Blue Strata in-serviced licensed nursing staff on insulin orders entry for sliding scale and provided education material on entering sliding scale orders to ensure consistency on eMar.
   D. On 12-8-2014 Beth Alford, RN, BSN, Nurse Consultant reviewed the policy and procedures on Administering Medications, Procedure to administer subcutaneous medications, and Adverse Consequences and Medication Errors.
   E. On 12-10-2014 a quality assurance audit and review was completed on all medication orders and Diabetic Monitoring to ensure accuracy and compliance.
   F. 12-17-2014 Beth Alford, RN, BSN, Nurse Consultant reviewed the policy and procedures on Change in a Resident's Condition or Status, Administering Medications, procedure to administer subcutaneous medications, and adverse consequences and medication errors.
   G. All licensed staff was in-serviced on 12-17-2014 by Beth Alford, RN, BSN, Nurse Consultant on the policy and procedures of following Physician orders and Changes in Resident's Condition or Status and medication errors to include the nurses responsibilities and prompt follow up to physician.

2. All residents have the potential to be affected by the alleged deficient practice. All residents were reviewed for change of conditions including residents on insulin sliding scales. Due to implementation of 1 A-G the alleged deficient practice will not reoccur.

3. The following systemic measures have been implemented to ensure the alleged deficient practice does not recur:

   A. The Director of Nursing/ Designee will make random checks of MAR to ensure documentation of medications administration according to Physician orders.

Attachment B IMPOSED PLAN OF CORRECTION

B. The Director of Nursing/Designee will review the 24 hour nursing report and check documentation to ensure prompt physician notification and orders are being transcribed and administered as ordered.
C. The Director of Nursing / Designee will make random medication pass observation.

4. The following Quality Assurance Programs have been implemented to ensure the alleged deficient practice does not recur:

A. The Director of Nursing / Designee will continue to review the 24 hour nursing report to ensure continued compliance.
B. The Director of Nursing/ Designee will continue to make random medication pass observation to ensure continued compliance.
C. The Director of Nursing will report concerns to the Administrator through the Quality Assurance process.

Completion Date: 12-19-2014 accepted