STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012553	A. BUILDING: _____ B. WING _____	C 12/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON OF SCHAUMBURG	675 SOUTH ROSELLE ROAD SCHAUMBURG, IL 60193

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S9999	Final Observations Statement of Licensure Violations; 300.610a) 300.1210d)1) 300.1610a)1) 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 300.1210 General Requirements for Nursing and Personal Care 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 300.1610 Medication Policies and Procedures	S9999		

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S9999	Continued From page 1 a) Development of Medication Policies 1) Every facility shall adopt written policies and procedures for properly and promptly obtaining, dispensing, administering, returning, and disposing of drugs and medications. These policies and procedures shall be consistent with the Act and this Part and shall be followed by the facility. These policies and procedures shall be in compliance with all applicable federal, State and local laws. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act) These Requirements are not met as evidenced by: Based on interview and record review, the facility failed to ensure the prescribed amount of insulin was added to TPN (Total Parenteral Nutrition) intravenous administration for 1 of 3 residents reviewed for medication administration. This medication error resulted in R1 having episodes of hypoglycemia and requiring emergent transfer to the hospital for evaluation and treatment. Findings include: E6 (Registered Nurse) said during interview (11.20.24, 6:56 p.m.-7:10 p.m., via telephone) she had to add 3 medications to R1's TPN prior to hanging, including insulin. She said she collected the necessary supplies including two 10	S9999		

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cc syringes (to withdraw infuvite and famotidine) and a 3 cc syringe to withdraw insulin. E6 said: "In general an insulin syringe should be used to withdraw insulin, however, an insulin syringe has a very small needle and doesn't go into the bag (TN), so I used a 3 cc syringe because it has a longer needle."

E6 said she left the facility "around 5:00 p.m." She said before she left the facility she heard a nurse saying that R1's blood sugar has dropped, she offered to call the Nursing Supervisor and after 5 minutes she left. E6 said she arrived home ("around 6:00 p.m.") and realized that she had used the wrong syringe to withdraw the insulin. She called E4 (Registered Nurse, Supervisor) and said: "I want you to stop the TPN."

E6 said this was the first time she had hung TPN and that she did not ask for help prior to hanging it. She also said, in retrospect, she "would have used the insulin syringe and taken my chances."

Review of E6's "Trigger Investigation Report" statement (signed and dated 11.14.2014) documents: "I called the supervisor to report that I had not used insulin syringe for insulin and I was in doubt that I had added more insulin than stated amount in TPN bag. I do not recall the exact amount of insulin drawn out."

E5 (Registered Nurse) said during interview (11.20.2014, 6:20 p.m.-6:32 p.m., via telephone) she "believed the incident happened on 11.13.2014 around 4:45 p.m." She said R1 was in bed with ongoing TPN (that the day shift had hung), was diaphoretic (cold and clammy), complained of not feeling well and her blood sugar was 25 mg/dl (normal range is 60 mg/dl-99 mg/dl). The facility's Diabetic Protocol was

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initiated, however, R1 continued to experience episodes of hypoglycemia despite these interventions.

E5 said that E6 was present when R1's blood sugar first dropped. She said E6 told her: "keep doing what you're doing and I'll call the supervisor" and that E6 never said that she might have given the wrong dose of insulin.

E4 confirmed during interview (11.20.2014, 4:30 p.m.-5:21 p.m. in the Welcome Room) that E6 had notified her (11.13.2013, at approximately 5:00 p.m.) of R1's multiple low blood sugars and that she later received a call from E6 stating that she was unsure how much insulin she had added to R1's TPN.

Z1 (Pharmacist) said during interview (12.02.2014, 1:25 p.m.-1:36 p.m. in the Welcome Room) an insulin syringe must be used to draw up insulin to ensure the proper dose because insulin is measured in units and other syringes don't have those markings. She also said if too much insulin is added to TPN "it's very dangerous."

Z2 (Physician) said during interview (12.02.2014, 2:06 p.m.-2:22 p.m. in the Welcome Room) that she was notified multiple times of R1's change in condition. When informed that E6 admitted to using a 3 cc syringe to draw up insulin, Z2 said the resident received the incorrect amount of insulin and a regular syringe shouldn't be used because insulin is measured in units and the dose wouldn't be correct. Z2 said if sustained, hypoglycemia is bad and could cause seizures and neurological deficits.

Review of R1's TPN order documents under

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S9999	Continued From page 4 "Nurse Additives," "Insulin Regular (NovolinR) 10 units." Per "Pearson Nurses Drug Guide" (copyright 2011, page 803, Insulin Regular), under Administration: "Use an insulin syringe." Review of the facility's Incident Report documents the following: "R1 presented with an episode of hypoglycemia approximately one and a half hours after her TPN began infusing. She was administered a glucagon x1 and glucose tabs by the PM Nurse while the day nurse observed and monitored. R1's blood sugar stabilized after treatment without incident. After about 30 minutes, patient bean to complain of feeling dizzy and nauseated in which another hypoglycemic episode occurred. Facility diabetic protocol initiated with MD and POA notification. While the PM Nurse was reassessing the patient, the facility received a call at approximately 6:30 p.m. from the previous shift nurse asking for the supervisor to discontinue R1's TPN as she couldn't recall the amount of insulin delivered to the TPN solution. This nurse stated she didn't use an insulin syringe because she felt the needle would be too small to inject in the TPN bag. Due to continued fluctuating blood sugars, probable medication variance, and use of TPN, MD gave order to sent patient to ER via 911. R1 was admitted with hypoglycemic reaction..." (B)	S9999		