STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145655	A. BUILDING _____ B. WING _____	C 03/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INTEGRITY HC OF WOOD RIVER	**393 EDWARDSVILLE ROAD WOOD RIVER, IL 62095**

(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) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint #1641281/IL00083911	F 000		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to timely provide medication as ordered in a timely manner for 1 of 3 (R2) residents reviewed for medication administration in the sample of 3. Findings include: On 3/11/16 at 9:05 AM, R2 stated "I had a problem that I didn't get my medicine a couple of	F 425		3/25/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 03/25/2016

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F 425	Continued From page 1	F 425		

weeks ago. She (E6, Registered Nurse, RN) did not give me my insulin shot and pills at lunch time. I usually get it (insulin) at every meal. (E6) is a nurse I have had a lot of trouble with in the past. She (E6) never knocks when she comes into my room and I think she missed my insulin on purpose."

R2's March 2016 Physician's Order Sheet documents (in part) diagnosis of Diabetes Mellitus and medication order for "Humalog (insulin) Sliding Scale and (fingerstick blood sugar) at 7:00 AM, 11:00 AM, 4:00 PM, and 8:00 PM, if (fingerstick blood sugar) 0-150 = 3 units, 151-200 = 6 units, 201-250= 9 units, 251-300 = 12 units, 301-350 = 15 units, 351-400 = 15 units, greater than 400 = 20 units and notify the medical doctor."

R2's progress notes, dated 3/2/16 at 2:45 PM, document, "Late Entry. MD (Medical Doctor) called for clarification on sliding scale insulin dosing time. Awaiting return call."

R2's progress notes, dated 3/2/16 at 3:45 PM, document, "2nd and 3rd call placed to reach doctor. (Z2, Nurse Practitioner) returned call. Order received and noted to give one time dose of 20 units of Humalog insulin and recheck blood sugar in 1 hour. Do not hold further insulin unless blood sugar is below 350. Continue to monitor blood sugars as ordered with (sliding scale insulin) and (fingerstick blood sugar). Call medical doctor if any changes. Bedtime (fingerstick blood sugar) if less than 200 hold sliding scale insulin. Monitor and check on him through night, (fingerstick blood sugar) as needed. Resident is aware of new orders and medication times."

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F 425	Continued From page 2	F 425		

R2's progress notes document on 3/2/16 at 9:31 PM "No signs or symptoms of hypoglycemia noted. Resident has no complaint at this time. 8:00 PM (fingerstick blood sugar) was 397."

On 3/11/16 at 10:18 AM, E6 stated "If a dose of medicine is missed depending on the time frame if it is longer than one hour, we have to make the doctor aware of the missed dose and proceed with his recommendation. I have not missed medicine, but I missed a fingerstick. Once the fingerstick was done, it guided to the (insulin) sliding scale dose. When the finger stick was gotten, I think (R2's) blood sugar was over 400. I think the order was to give 20 units Humalog insulin and inform the doctor. This happened about two weeks ago on a Monday. It was for the noon fingerstick which was supposed to be done at 11:00 AM. The fingerstick was done about two hours after. Someone else (E7, Director of Nursing, DON), then got it for me. I think I remembered about 1:30 PM. (R2) and I have had a couple of misunderstandings. I did not feel comfortable with him, so I had the nurse from hall 100 (E7) give him his morning medicines, because I didn't feel comfortable going in his room. The hall 100 nurse went into his room and got his fingerstick that morning, it was over 300. It caused (R2) some mental and emotional suffering, but not physical. I would never intentionally cause him any harm. I did get written up and warned about it. He (R2) might not have needed extra insulin if he had gotten the fingerstick before the meal. About 1:30 PM was when I realized the situation. (E7) went into his room and got his fingerstick and she gave him 20 units Humalog insulin. Then we called the doctor. By the time (Z1, Physician) called back I was

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F 425	Continued From page 3 gone, so I don't know if he got any more (insulin) or not." Medication Error Report, dated 3/2/16, documents at 11:00 AM "failed to get sliding scale glucose level. Insulin not provided in timely manner." The physician was notified at 2:45 PM on 3/2/16. "The effects of the medication error is unknown." The facility's Drug Administration - General Guidelines, dated 12/31/14, documents (in part), "2. Medications are administered in accordance with written orders of the attending physician. Includes (fingerstick blood sugar) /Insulin." It also documents, "9. Medications are administered within 60 minutes of scheduled time, except before or after meal orders, which are administered precisely as ordered."	F 425		