STATE OF ILLINOIS
DEPARTMENT OF PUBLIC HEALTH
STATEMENT OF VIOLATIONS AND PLAN OF CORRECTION

WOODSTOCK RESIDENCE	0038653
Facility Name	I.D. Number
309 MCHENRY AVENUE, WOODSTOCK,ILLINOIS 60098	
Address, City, State, Zip	
02648	APRIL 7, 2008
Reviewed By	Date of Survey
COMPLAINT 0674232, 0870179	02486, 02490, 02493, 02534, 02579, 02631, 11270, 13240, 14208, 15477
Type of Survey	Surveyed By

As a result of a survey conducted by representative(s) of the department, it has been determined the following violations occurred.

IMPORTANT NOTICE: THE STATE AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED UNDER PUBLIC ACT 83-1530. DISCLOSURE OF THIS INFORMATION IS MANDATORY. THE FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

"A" VIOLATION(S):

300.610a)
300.1210a)
300.1210b)1)
300.1220b)6)
300.3240a)

Section 300.610 Resident Care Policies

a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting.

Section 300.1210 General Requirements for Nursing and Personal Care

a) The facility must 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 assessment and plan of care. 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. Restorative measures shall include at a minimum the following procedures:

b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven-day a week basis:

CONT.

1) Medications including oral, rectal, hypodermic, intravenous and intramuscular shall be properly administered.

Section 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

6) Developing and maintaining nursing service objectives, standards of nursing practice, written policies and procedures, and written job descriptions for each level of nursing personnel.

Section 300.3240 Abuse and Neglect

a) *An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.* (Section 2-107 of the Act)

These regulations are not met, as evidenced by the following:

Based on interview and record review the facility neglected to:

- Initiate and conduct a complete and thorough investigation after allegations were made against a staff nurse working at the facility (E14, LPN) on 4/3/06;
- Protect other residents from possible injury/abuse related to the misuse of Morphine Sulfate during end of life care;
- Assess the need for, and monitor residents receiving Morphine Sulfate on a PRN basis (as needed) during end of life care;
- Ensure that there is an accurate account of all controlled medications to identify loss or diversion of controlled medications;
- Notify local law enforcement of possible criminal activity involving the potential miss-use of narcotic medications by (E14 LPN);
- Ensure that medications administered to residents timely and have been ordered by a physician.

This systemic neglect began on 4/3/06 when E13 (LPN) made E2 (DON) aware of E14's use of liquid Morphine Sulfate in the death of R27 on 4/2/06. Between 4/8/06 and 9/18/06 there were four other deaths related to the use of Morphine Sulfate (R28, R29, R30 and R31). There were approximately five months between the time E13 reported her concerns about E14 (LPN) to E2 (DON) and R29's death on 9/18/06. On 9/30/06 during

CONT.

the day shift E14 gave R32 an undetermined amount of Ativan without a physician's order along with the scheduled PM dose of Seroquel 25 mg. On 9/30/06 R32 fell out of his wheel chair and sustained abrasions to his face and head on the evening shift. R32 was sent to the hospital for evaluation and treatment.

These areas of neglect apply to 5 of 6 residents receiving end of life care (R27, R28, R29, R30, and 31) and one resident who was administered a medication without a physician's order (R32).

Findings include:

1. R27, a 56 year old male, had diagnoses of Down's Syndrome, Seizure Disorder, Dysphagia, Parkinson's Disease, Depression and Shy Drager Syndrome per the facility's Administration Face Sheet dated 3/28/06. R27's Doctor's Telephone Orders dated 3/28/06 state, "Admit to Hospice, add Roxianol 5 - 10 mg PO (Morphine Sulfate By Mouth) PRN (As Needed), Ativan 0.5 mg every 4 - 6 hours PRN for restlessness." R27 died at the facility on 4/2/06. Nurse's Notes dated 4/2/06 at 11:50 AM, document that R27 was observed to be without pulse or respirations.

On 2/22/08 at 12:40 PM E13 (LPN) stated, "I told E2 (Director of Nursing) and E3 (Assistant Director of Nursing) on 4/3/06 about my concerns with E14's (LPN) administration of liquid Morphine to R27 on 4/2/06. I know I went to them at least three times with my concerns." E13 confirmed that she was never questioned by E1 (Administrator), E2 (Director of Nursing), or E3 (Assistant Director of Nursing) about her concerns. E13 said that she was never asked to write a statement documenting her concerns about E14. E13 said that after another resident, R30, died on 9/18/06 she went to them (E1 and E2) a third time and voiced her concerns.

The Illinois State Police Investigative Report dated 10/30/06 documents an interview with E6 (LPN). E6 also reported that E14 (LPN) said, "Those people aren't meant to live that long. They are meant to die in their teens and I'm going to help him along." The report further states, "E6 recalled that approximately forty-five minutes later, she observed E14 leaving R27's room. E6 thought this was odd because R27 should not have been given any Morphine for at least another hour and a half....E6 said that she compared the narcotics book with R27's Morphine bottle. E6 explained that the amount remaining in a morphine bottle could be determined by lines along the bottle. E6 put forth that she discovered that 160 mg of Morphine were missing."

The Illinois State Police Investigative Summary (Synopsis) dated 12/12/06 documents that between 4/8/06 and 9/18/06 four other residents died in the facility while receiving liquid Morphine Sulfate (R28, R29, R30, and R31).

CONT.

Facility Incident Investigation Reports from 2006 to present were reviewed on 2/20/06. There was no documentation of investigations being conducted concerning the alleged abuse of liquid Morphine in the deaths of R27, R28, R29, R30, and R31.

Interviews conducted from 2/20/08 to 2/28/08 confirmed that E6 (LPN), E7 (RN), E8 (LPN), E9 (LPN), E10 (CNA), and E12 (LPN) were never questioned about E14's use of Morphine for residents during end of life care. All said that they were never asked about missing Morphine Sulfate or how it was to be administered to residents near end of life. E6, E9, E12, and E13 said that they talked to E1, E2, or E3 numerous times between 4/3/06 and 9/18/06 about concerns with E4's administration of liquid Morphine Sulfate to residents.

On 2/21/08 at 11:20 AM, E1 (Administrator) said that she was never made aware of any staff suspicions concerning E14 overdosing residents with liquid Morphine. E1 confirmed that no investigations were ever conducted concerning E14's alleged misuse of Morphine. E1 denied having any knowledge of E14's alleged misuse of Morphine Sulfate until 10/31/06 when the State Police entered the building. E1 confirmed that E14 was allowed to work in the facility as a nurse until 10/31/06.

On 2/26/08, E6 confirmed her interview with the ISP was accurate and restated that at 6:30 a.m. she had given R27 10 mg of Morphine. She said that she told E14 this on report during the shift change and that she specified the time the Morphine was given to E14. After the report, she went to the other unit and came back after 30 minutes and saw E14 coming out of R27's room with a bottle of Morphine in her hand. E6 stated that before she left, R27 was breathing normally without difficulty with respirations.

The Nurse's Note on 4-2-06 at 7:00 am by E14 states, "Resident observed with rapid resp. abd. (Abdominal) Resident was very congested. PO2 86 on 4 liter O2 per mask Morphine given."

With R27 displaying identified congestion and low PO2 while on Oxygen, E14 gave the Morphine. The Morphine was ordered to be given every two hours for pain or Dyspnea and E14 gave another dose 30 minutes after a dose was given. E14 was fully aware of this as E6 said that she emphasized this in her report.

On 2/22/08 at 12:40 PM, E13 confirmed that the events of 4/8/06 and 8/14/06 as documented on the Illinois State Police Investigative Report were accurate. E13 also stated that E14 would boast making statements like, "I will make sure they get enough medications to be gone, I will take care of it. E13 said that she made E2 (DON) and E3 (ADON) aware of her concerns about E14's care of R27 on 4/3/06. E13 stated, "When I told E2 (DON) she giggled. She then went to E14 and said I do not care if you play the angel of death just don't let me know about it." E14 (LPN) was allowed to work in the

CONT.

facility as a nurse until 10/31/06.

2. R28, a 78 year old female, had diagnoses of Cardiac Dysrhythmia, Atrial Fibrillation, Hypertension, Hypotension, and Dementia per the Medication Administration Record for September 2006.

The Illinois State Police Investigative Report dated 10/30/06 documents an interview with E6 (LPN). The report states, "E6 recalled R28 suffered from Dementia, was easily agitated, and would often hit people. E6 stated she came to the facility on Saturday, and had a conversation with E14 (LPN) in the smoking area. According to E6, E14 told her, R28 is going to die in half an hour. E14 then told E6 that she had given her 30 mg of Morphine. When E14 noticed the shocked expression on her (E6) face, E14 later said that she gave her 20 mg..." E6 further states in the report, "E7 (RN) took over the care of R28 that night. E6 professed that E7 did not dispense any Morphine to R28 because she was unconscious....E6 stated she determined that one Morphine bottle belonging to R28 had 160 mg of Morphine missing....E6 stated she knew that E14 was overheard bragging about over-medicating R28 in the smoking area in the back of the facility on that Saturday and Sunday. E6 explained E12 (LPN) and other CNA's overheard E14 state, "I can't believe she's still alive with all the Morphine I've given her."

On 2/21/08 at 10:00 AM, E7 (RN) confirmed that she did not need to give R28 Morphine during the night 9/9/06 because she was not restless or short of breath.

On 2/26/08 at 11:30 AM, an interview with E6 confirmed that the events of 9/9/06 and 9/10/06 as documented on the Illinois State Police Investigative Report dated 10/30/06 were accurate.

R28's undated Controlled Substance Sign-Out Sheet documents that R28 was to receive Morphine 10 mg sublingual every 2 hours as needed.

Nurse's Notes dated 9/9/06 at 11:30 PM, state, "Resident (R28) unresponsive to verbal or tactile stimuli. Skin very cold and clammy, respirations mouth breathing associated with 10 seconds of apnea..."

Nurse's Notes dated 9/10/06 at 8:00 AM, document that E14 gave R28 Morphine while having agonal (associated with death) respirations with 30 to 40 sec periods of apnea. At 10:00 AM E14 documents that there was no change in R28's condition and another dose of Morphine was administered. At 12:28 PM the resident is found to have no pulse or respirations.

During the night shift (11-7 am) between 9-9-06 to 9-10-06 documentation shows no Morphine was given to R28. On 2-21-08, E7 said that at the end of her shift she had

CONT.

given report to E14 regarding R28. She stated that E14 was very upset that R28 was not given Morphine and that E14 was going to report her to the DON for not giving Morphine. She stated that she had told her that R28 did not need Morphine as she was unresponsive and not in pain. An ISP interview dated 1-18-07 reflects, "E7 recalled E14 told her that she should have given the Morphine anyway." E7 repeated that she had assessed the resident even before leaving to see how she (R28) was, as she knew E14 was going to report her. E7 indicated that her assessment before she left showed R28 was stable but unresponsive and not in pain.

3. R29, a 52 year old male, had diagnoses of Liver Cirrhosis, Liver Cancer, Hepatitis C, and Ascites per Physician's Orders for September 2006. The Physician Orders dated 9/17/06 documents that R29 may receive Morphine Sulfate 10 - 20 mg sublingual every 4 hours prn (as needed) and Ativan 1 - 2 mg sublingual every 4 hours prn.

The Illinois State Police Investigative Report dated 10/30/06 documents an interview with E6 (LPN). E6 stated, "R29 a resident suffering from liver failure had just been put on Hospice. E6 indicated that R29 had been sitting upright in his wheel chair, was alert, and was even smoking. E6 stated E14 (LPN) gave him (R29) his first dose of Morphine on Saturday or Sunday. E6 reported that R29 became unconscious immediately after E14 administered the Morphine. E6 indicated that she later discovered that 40 mg of Morphine was missing...."

On 2/26/08 at 11:30 AM, an interview with E6 confirmed that the events of 9/17/06 and 9/18/06 as documented on the Illinois State Police Investigative Report dated 10/30/06 were accurate.

R29 was admitted to the facility on 9/15/06 with diagnoses of Alcohol Abuse, Liver Cancer and Cirrhosis and was on palliative care on admission. The discharge chart from the previous facility included a copy of the Physician's Order Sheet that showed R29 was not on any type of pain medication and he was not complaining of any pain. R29's initial admission orders did not include any pain medication.

Nursing Notes shows R29 was not complaining of any pain or discomfort until he came back from lunch on 9/17/06. R29 then went back to bed. E14, the nurse taking care of R29, charted on 9/17/06, "Complaining of extreme pain so returned to bed. Orders rec'd from Registered Nurse Practitioner (RNP) for comfort pack of 10 milligrams (mg) Morphine Sulfate (MSO4) given with relief obtained. Resting comfortably."

The Illinois State Police (ISP) report dated 11/15/06, on page 00036, documented the interview of Z5, R29's sister who was visiting at the time of the incident. In the interview Z5 stated that she went to the nurse's station and told a nurse that R29 needed pain medication. The nurse replied that there was no physician order for Morphine. Z5 said

CONT.

that a different nurse came into the room and gave R29 Tylenol. Z5 went to the nurse's station to ask for another type of medication three times. On the third time, E14 said she did not need a physicians order to give him Morphine. Z5 then witnessed E14 dispense morphine orally to R29. Z5 said that R29 became unconscious.

E4, the medical director and MD for R29, was interviewed on 2/21/08. He said that as the Director, he would expect a pain assessment to be made before calling MD. There was no pain assessment protocol in the facility and no pain assessment was documented. E4 was informed of R29 being given Morphine Sulfate (on 9/17/06) and was not responsive after thirty minutes. E4 stated that he did not order any schedule II medication for that resident, as R29 is on another hospice agency and would be covered by their hospice doctor. E4 was informed that the Morphine order for R29 was signed as a telephone order from Z3, the nurse practitioner, with E4's name on it. He said that the facility would call him or Z3 if they could not reach the regular hospice doctor. He would only order minor pain medications for a resident he has not seen and give a one time order only. E4 stated he did not see R29 and would not order pain medication such as Morphine for him. E4 explained that R29's non responsiveness was either an adverse reaction to medication or a medication error such as higher dose was given than what was ordered. E4 denied being called about R29's change of condition. E4 indicated that he would have ordered the facility to send R29 to the hospital for evaluation. E4 also said that with a change of condition after initial dosing, Morphine should not have been given it was neglect. E4 was asked if the facility continued to give the doses of Morphine with R29's condition, how long it would take before a person would expire. E4 replied that with the continued use every two hours or so, one would see an adverse effect such as a resident's demise in about 8 hours.

4. R32 has a diagnosis of Olivopontocerebellar Degeneration. The Nurse's note on 9-29-06 at 7:15 PM stated "Resident observed lying on the floor in Garden room. Fell face forward lying on right side, wheelchair did not tip over. Able to move all extremities per usual. Laceration of the forehead and left side of the face, reddened area on nose and next to left eye. 108/59- 74 - 18. Pupils fixed won't dilate. Res will respond by squeezing my hand. Z3 notified." R32 was sent to the hospital for evaluation.

On 2/20/08, E9 confirmed that R32 did fall down and his neuro checks were irregular particularly his eyes. She stated that she remembered E14 during the 7-3 pm end of the shift report stating that she (E14) had given R32 a cocktail and that R32 would not be bothering her (E9) during her shift. She called E14 at home to find out what medication she gave R32 during the day shift that made R32 this way. E14 admitted to giving R32 Ativan (amount not provided) and Seroquel 25 tablet scheduled for 9:00 PM. E9 then reported this to Z3, the nurse practitioner for E4. E9 stated that Z3 got very upset that she was not called about any problem for R32 and that she never gave order for Ativan and an extra dose of Seroquel. R32 was sent to the hospital due to his unstable vital signs.

CONT.

Two other residents died in the facility after receiving liquid Morphine Sulfate (R30 and R31) per the Illinois State Police Investigative Summary (Synopsis) dated 12/12/06.

5. R30 received an order dated 8/14/06 for Roxinal liquid (Morphine) 10 to 20 mg sublingual every 2 hours as needed. An order for Morphine was received at 1:51 PM from R30's physician. At 6:50 PM, R30 was found to have no pulse or respirations. The Illinois State Police Investigative report dated 7/10/07 documents that E14 approached E2 (Director of Nursing) and stated that R30 was just prescribed Morphine but it had not been delivered from the pharmacy yet. E2 instructed E14 to use Morphine from a deceased resident R31 who expired on 4/8/06. There was no documentation in R30's chart showing R30 received Morphine. The bottle of Morphine that was given to E14 could not be found the day after R30 expired.

6. R31 died on 4/8/06. The Illinois State Police Investigative Report dated 10/31/06 documents an interview with E13 (LPN). "E13 related that E14 told her that she gave R31 Morphine. E13 explained that R31 was already unconscious, and could not be in any pain. E13 put forth that E14 then told her, 'She won't make it through the day. I made sure of that.' E13 indicated R31 died at noon that day."

The ISP (Illinois State Police) investigative reports from 10/26/06 to 1/10/07 had interviews of E6, E7, E8, E9, E12 and E13. These staff consistently stated that during the period of April 2006 until end of September 2006, extra bottles of Morphine Sulfate prescribed for residents who had expired were available and stored in the Narcotic box of the 200 wing. E6, E9, E12 and E13 all said that there were extra bottles of Morphine that belonged to residents who had died and were kept either in the locked narcotic box in the medication carts or were kept in a drawer in E2's office. All four stated that the narcotic medication should have been disposed of with two nurses witnessing. The bottles were kept per the instruction of E2, DON, in case another resident would need it. E8 stated that if a resident with a narcotic order died on the weekend, they would keep it in the locked boxes in the med cart. Then the narcotic would be brought to the DON's office where they were locked or left at her desk. E8 was not sure what happened when they were left in the DON's office.

ISP interview of E3, ADON, on 11/02/06 reflects: "E3 was asked if E2 had been storing extra Morphine at the facility. E3 replied 'yes' and stated E2 wanted the Morphine kept, 'Just in case somebody needs it.' E3 went on to say, the Morphine was not in the narcotics book...." E3 explained that on 10-30-06, two bottles of Morphine, one bottle of Ativan, an unknown amount of Risperdal and an unknown amount of Vicodin were destroyed. E3 indicated that one of Morphine bottles belonged to R28 who expired on 9-28-06. The destruction of the medication only came about when E3 stated that the facility knew the State Police were coming.

WOODSTOCK RESIDENCE | 0038653
Facility Name | I.D. Number

CONT.

During interview, E6, E9, E12 and E13 validated that before the state police started investigating, Controlled Substances, particularly the Morphine, were not destroyed as their standard of practice indicated but were saved according to the instructions of the DON. All indicated that the practices of destroying controlled substances were implemented after the state police started investigating the residents using Morphine.

ISP interview of E3 also reflects that E6 had brought to her (E3) attention a bottle of Morphine that had a different color and that E6 felt that there was a cover up. E3 recalled that it was after the death of R28. E3 then dumped the questionable Morphine in the toilet but did not investigate the allegation.

ISP documentation of investigation reflects that on 11-02-06 the facility continued to have extra bottles of Morphine kept in the medication cart of the 200 wing.

During initial tour on 2-19-08, the medication cabinet of the 200 wing still had a bingo card containing Lorazepam 0.5 mg tablets belonging to a resident that has been discharged more than a month and the 400 wing contained a Lorazepam liquid being stored in the medication room since 6-6-06.

Review of the Change of Shift Controlled Substance and Narcotic count reflect that Aug and Sept 2006 narcotic counts were not consistently done on every end of each shift and in many shift, only one nurse charted. Review of the last three months of narcotic counts, Dec 2007 to Feb 2008 still showed the counts are not done at the end of each shift and/or by the oncoming and outgoing nurses.

The facility was unable to provide any documentation showing that the local police were ever informed of E14's alleged misuse of Morphine Sulfate for residents receiving end of life care. On 2/21/08 at 12:10 PM E1 (Administrator) confirmed that the police were never notified about any allegation concerning E14 (LPN). The facility was unable to provide a policy and procedure on when local law enforcement is to be notified.

The facility's undated Policy and Procedure entitled Reporting Abuse to Facility Management states, "The administrator and director of nursing services must be promptly notified of suspected abuse or incidents of abuse. If such incidents occur or are discovered after hours, the administrator and director of nursing services must be called at home or must be paged and informed of such incident. When an alleged or suspected case of mistreatment, neglect, injuries of unknown source, or abuse is reported, the facility administrator, or his/her designee, will notify the following persons or agencies of such incident: The State licensing/certification agency responsible for surveying/licensing the facility; The local/State Ombudsman; The resident's representative (Sponsor) of record; Adult Protective Services; Law Enforcement Officials; The resident's attending physician; and the facility's Medical Director."

WOODSTOCK RESIDENCE | 0038653
Facility Name | I.D. Number

CONT.

The facility's undated Policy and Procedure on Abuse Investigation and Reporting states, "Neglect is defined as failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness....When an incident or suspected incident occurs, the Administrator will appoint a management member to investigate the allegation. The individual conducting the investigation will, at a minimum: Review the completed resident abuse report; Review the resident's medical record to determine events leading up to the incident; Interview the person(s) reporting the incident; Interview any witness to the incident; Interview the resident if appropriate; Interview the resident's attending physician to determine the current mental status of the resident; Interview the resident's roommate, family members, and visitors; Interview other residents to whom the accused employee provides care and services; Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; and Review all events leading up to the alleged incident....While the investigation is being conducted, accused individuals not employed by the facility will be denied unsupervised access to residents. Employees who have been accused may be reassigned to nonresident care duties or suspended from duty until the results of the investigation have been reviewed."

(A)

STATE OF ILLINOIS
DEPARTMENT OF PUBLIC HEALTH
STATEMENT OF VIOLATIONS AND PLAN OF CORRECTION

WOODSTOCK RESIDENCE	0038653
Facility Name	I.D. Number
309 MCHENRY AVENUE, WOODSTOCK,ILLINOIS 60098	
Address, City, State, Zip	
02648	APRIL 7, 2008
Reviewed By	Date of Survey
COMPLAINT 0674232, 0870179	02486, 02490, 02493, 02534, 02579, 02631, 11270, 13240, 14208, 15477
Type of Survey	Surveyed By

As a result of a survey conducted by representative(s) of the department, it has been determined the following violations occurred.

IMPORTANT NOTICE: THE STATE AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED UNDER PUBLIC ACT 83-1530. DISCLOSURE OF THIS INFORMATION IS MANDATORY. THE FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

"A" VIOLATION(S):

300.1610a)1)
300.1620a)
300.1620e)
300.1630c)
300.1650c)
300.1650d)1)

Section 300.1610 Medication Policies and Procedures

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 300.1620 Compliance with Licensed Prescriber's Orders

a) All medications shall be given only upon the written, facsimile or electronic order of a licensed prescriber. The facsimile or electronic order of a licensed prescriber shall be authenticated by the licensed prescriber within 10 calendar days, in accordance with Section 300.1810. All such orders shall have the handwritten signature (or unique identifier) of the licensed prescriber. (Rubber stamp signatures are not acceptable.) These medications shall be administered as ordered by the licensed prescriber and at the designated time.

c) Review of medication orders: The staff pharmacist or consultant pharmacist shall review the medical record, including licensed prescribers' orders and laboratory test results, at least monthly and, based on their clinical experience and judgment,

CONT.

and Section 300.Appendix F, determine if there are irregularities that may cause potential adverse reactions, allergies, contraindications, medication errors, or ineffectiveness. This review shall be done at the facility and shall be documented in the clinical record. Any irregularities noted shall be reported to the attending physician, the advisory physician, the director of nursing and the administrator, and shall be acted upon.

Section 300.1630 Administration of Medication

c) Medications prescribed for one resident shall not be administered to another resident.

Section 300.1650 Control of Medications

c) All medications having an expiration date that has passed, and all medications of residents who have been discharged or who have died shall be disposed of in accordance with the written policies and procedures established by the facility in accordance with Section 300.1610. Medications shall be transferred with a resident, upon the order of the resident's physician, when a resident transfers to another facility. All discontinued medications, with the exception of those products regulated and defined as controlled substances under Section 802 of the federal Controlled Substances Act (21 USC 802), shall be returned to the dispensing pharmacy. Medications for any resident who has been temporarily transferred to a hospital shall be kept in the facility. Medications may be given to a discharged resident only upon the order of the licensed prescriber.

d) Inventory Controls

1) For all Schedule II controlled substances, a controlled substances record shall be maintained that lists on separate sheets, for each type and strength of Schedule II controlled substance, the following information: date, time administered, name of resident, dose, licensed prescriber's name, signature of person administering dose, and number of doses remaining.

These regulations are not met, as evidenced by the following:
Based on record review, observation of storage areas, and interview of staff, the facility failed to assure safe and secure storage, accurate labeling, and safe administration of drugs. Also the facility failed to properly enforce disposition of controlled medication, properly monitor controlled substances through an acceptable medical system that reconciled and accounted for all the controlled medication, and provide a consistent and accurate narcotic count that identified missing medications, named medications that

CONT.

should have been disposed of, and provide these medications to the resident accurately as ordered.

These combined system failures resulted in an inaccurate provision of controlled medications in excessive amount without check and balance, observed excess provisions of schedule II medications without orders, and obtaining other residents' schedule II medication to provide a medication dose in excess of the ordered medication. This resulted in residents being harmed and contributing to their death.(R29, R32, R28, R27)

Findings include:

The facility has a Controlled Substance Discontinuation and Destruction policy showing the following procedure:

1. When controlled substance is discontinued, the remaining medication should be sent to a designated area within the facility. They must be stored in a double locked container until destruction can be completed.
2. Do not return controlled substance to pharmacy. The narcotic sign out sheet must accompany to the designated area for all schedules III, IV, or V if determined by the facility policy.
3. The narcotic sign out sheet must accompany to the designated area for all schedule II if determined by the facility policy.
4. Any discrepancy between medication count and count on sign out sheet should be reported to the Director of Nursing.
5. Regulation requires documentation of the disposition of by remaining controlled substances in nurse's note or on MAR.
6. Two licensed personnel need to count and list schedule II medications to be destroyed on the DEA drug destruction form
7. The number of pills remaining in the bubble card or unit box should correspond with the balance shown in the narcotic count sheet. Date of disposition and signature of two licensed staff should be placed in the disposition box at the bottom of the narcotic sign out sheet. This form becomes a part of the resident's permanent record.
8. Medication should be destroyed and disposed of in an irretrievable manner by two licensed staff.
9. The DEA form should be signed by the two licensed staff.

These policies were not followed. Based on interview and review of ISP (Illinois State Police) investigative report of individual staff interview, E6, E7, E8, E9, E12 and E13 all indicated consistently that during the period of April 2006 until end of September 2006, extra bottles of Morphine Sulfate from residents prescribed for residents that have expired were available and stored particularly in the Narcotic box of the 200 wing. E6,

WOODSTOCK RESIDENCE | 0038653
Facility Name | I.D. Number

CONT.

E9, E12 and E13 all indicated on their interview that there were extra bottles of Morphine which had belonged to residents who have died kept either in the narcotic box of the medication carts or on kept in a drawer on E2's office. All four stated that the narcotic medication should have been disposed of with two nurses witnessing but the bottles were kept per instruction of E2, DON, in case another person would need it. E8 stated that if a resident died with narcotic on the weekend, they were kept in the boxes. Then the narcotic is brought to the DON's office where they were locked or left at her desk. E8 was not sure what happens when they are left at the DON's office.

ISP interview of E3, ADON, on 11/02/06 reflects: "E3 was asked if E2 had been storing extra Morphine at the facility. E3 replied 'yes' and stated E2 wanted the Morphine kept, 'Just in case somebody needs it.' E3 went on to say, the Morphine was not in the narcotics book... E3 explained that on 10-30-06, two bottles of Morphine, one bottle of Ativan, an unknown amount of Risperdal and an unknown amount of Vicodin were destroyed." E3 indicated that one of Morphine bottles belonged to R28, who expired on 9-28-06. The destruction of the medication only came about when E3 stated that the facility knew the State Police were coming.

During interview, E6, E9, E12 and E13 validated that before the state police started investigating, Controlled Substances, particularly the Morphine, were not destroyed as their standard of practice indicates, but were saved as were the instruction by the DON. All indicated that the practices of destroying controlled substances were implemented after the state police started investigating the residents using Morphine.

ISP interview of E3 also reflects that E6 had brought to her (E3) attention a bottle of Morphine that had a different E6 felt that there was a cover up. E3 recalled that it was after the death of R28. E3 then dumped the questionable Morphine in the toilet but did not investigate the allegation.

ISP documentation of investigation reflects that on 11-02-06 the facility continued to have extra bottles of Morphine kept in the medication cart of the 200 wing.

During initial tour on 2-19-08, the medication cabinet of the 200 wing still had a bingo card containing Lorazepam 0.5 mg tablets belonging to a resident that has been discharged more than a month and the 400 wing contained an extra bottle that was unaccounted for of Lorazepam liquid being stored in the medication room since 6-6-06.

Review of the Change of Shift Controlled Substance and Narcotic count reflects that Aug and Sept 2006 narcotic count were not consistently done on every end of each shift and on many shifts only one nurse signed. Review of the last three months of narcotic count, Dec 2007 to Feb 2008 still showed the counts are not done every end of the shift and/or by oncoming and outgoing nurse.

CONT.

The facility's poor controlled substance/medication monitoring and control led to the following concerns:

1. Per interview of E4, MD and Z5, it was established that they did not order the comfort pack including the Morphine that E14 wrote as a telephone order: "9/17/06 MSO4 liquid 10-20 mg s/l q4 hours prn. Ativan Lotensol 1-2 mg S/L q 4 hour PRN. TO(Telephone order) Z3/E4" Signed by E14.

Z4, family member, in ISP interview stated that E1 stated that she can give Morphine without medical order.

During interview, E10 indicated that on 9-17-06 she was approached by E14 if she had any extra bottles of Morphine. E10 indicated that she initially denied that she had any in her Narcotic box, but E2, the DON told her to give E14 the bottle that belonged to R31 who had expired 4-8-06. E10 indicated the bottle still had R31's name on it. E10 indicated that she handed the unopened bottle of Morphine to E14. E10 stated that the next day she went to look for the bottle to check how much was given or how much was left. E10 indicated that she went to all the narcotic boxes and medication rooms but there was no trace of the bottle or the record of the Narcotic sign off sheet for the Morphine.

E14 gave R29 Morphine at 2:30 pm. E14 also sent the falsified order to Pharmacy. Pharmacy received the falsified order and sent the medications to the facility. The facility has no record of where the Morphine medication came from as the pharmacy delivered the Morphine after 8:00 pm.

The next documentation on the Nurse's Note was written by E9 on 9/17/06 at 3:00 PM states "Mother in to visit. Resident was not responding at this time. Resident appears to be resting comfortably."

Nurse's note at the next charting at 7:00 PM by E9 states, "Resident remains non responsive. Eyes fluttered briefly. BP 154/81, 98 (pulse) Respiration 14 irregular t 97.8 Non responsive to painful or verbal stimuli. Pulse Ox remained at 85-88 %. At 9 PM BP 165/91, (pulse) 98 Respiration unable to ascertain. Not breathing for 10 seconds then letting out a long sigh." Hospice was called of the condition but not the MD.

On ISP record review, E6 was interviewed on 10-26-06 reflecting the following: "E6 related E14 gave him (R29) his first dose of morphine on Saturday or Sunday. E6 reported that R29 became unconscious immediately after E14 administered him the morphine. E6 indicated she later discovered that 40 mg of morphine was missing. E6 put forth that R29's liver disease would have affected how the drug metabolized in his system, and 40 mg could be a lethal dose."

CONT.

R29 continued to receive Morphine from falsified APN/MD order with 10 mg at 2:30 am 9-18-06, 20 mg at 8 am, 12 PM, 2 PM, 4 PM and 6 PM. The facility did not notify MD but continued to give Morphine which was not ordered for R29 with documented irregular respirations. The facility did not evaluate the effects of Morphine especially with R29 already non responsive to painful stimuli and having liver problems, but continued giving it.

E4 in interview indicated that when a resident is given Morphine this frequently, staff nurse or Hospice nurse should be at bedside all the time to monitor the effects of Morphine. R29 expired at 6:30 PM.

2. R32 has a diagnosis of Olivopontocerebellar Degeneration. Nurse's note on 9-29-06 at 7:15 PM stated, "Resident observed lying on the floor in Garden room. Fell face forward lying on right side, wheelchair did not tip over. Resident was able to move all extremities per usual. Laceration of the forehead and left side of the face, reddened area on nose and next to left eye. 108/59- 74 - 18. Pupils fixed won't dilate. Res. will respond by squeezing my hand. Z3 notified." R32 was sent to the hospital for evaluation.

During interview 2/20/08, E9 indicated that R32 did fall down and his neuro checks were irregular particularly his eyes. She had remembered E14 stating that she (E14) had given R32 a cocktail and that he would not be bothering her during her shift. She called E14 at home to find out what medication did she give R32 during the day shift that made R32 this way. E14 admitted to giving R32 Ativan (amount not provided) Risperdal and Seroquel 25 mg tablet scheduled for 9:00 PM. E9 then reported this to Z5, the nurse practitioner for E4. E9 stated that Z5 got very upset indicating that she was not called about any problem regarding R32 and that she never gave order for Ativan, Risperdal and an extra dose of Seroquel.

The facility had Ativan belonging to expired residents being stored in Medication rooms during 2006 and still at present. The facility had not obtained R32's medication from the Pharmacy but E14 admitted to giving medication without order. The facility did not investigate where controlled medication were obtained. Record of signed out level of Ativan were not kept and facility did not follow its procedure to prevent controlled drug/medication abuse or overuse.

3. R31 was a hospice resident with a diagnosis that included COPD, Alcohol Abuse, MI, Muscle Atrophy, Depression and Alzheimer's Disease. Review of chart shows regularly seen by MD reflecting progress note on 2/3/06 where E4 wrote, "No problem per staff. Denies abdominal pain, nausea or vomiting. Lung has no crackles no, wheezes." On 3/3/06, E4 wrote the same progress note with no pain noted. On 4-6-06, E4 wrote the same progress note adding, "Patient is comfortable, continue with current management and watch closely."

CONT.

During interview on 2/28/08, E10, the nurse in charge of R31 on the day she expired stated she saw R31 during the initial part of her shift. E13 indicated that she saw R31 briefly and did not see anything wrong. E13 indicated R31 did not look like she was in pain nor having problem breathing. E13 then indicated that E14 came to help her give R31 her medication. E13 noted that after E14 gave the medication E14 stated, "R31 would not be bothering you for the rest of the day as I (E14) took care of it." E14 documented she gave Roxanol 1 cc (20 mg) at 7:30 am on R31's (Medication Administration Record) but took out 2 cc (40 mg) and distributed the amount by signing 1 cc at 7:30 am and 1 cc at 9:30 am. The amount taken was verified by E2 by indicating the amount left when the bottle was discarded 4/8/06. R31 expired at 10:30 am.

Per interview of E2 on 2-20-08, she indicated that the nurses came to her about irregularities on R31's care particularly the use of Morphine. E2 stated she reviewed R31's whole chart and found E14's charting to be wonderful and accurate. There were no investigations on the provision of 2 doses of Morphine given at the same time.

4. R28 has diagnoses of Cardiac dysrhythmia, Atrial Fibrillation, Hypertension, Hypotension and Dementia per MAR dated Sept. 2006.

Nurse's note on 9/9/06 at 11:30 PM, states, "Resident unresponsive to verbal or tactile stimuli. Skin very cold and clammy, respirations mouth breathing associated with 10 seconds of apnea."

During the night shift (11-7 am) 9-9-06 to 9-10-06 documentation shows no Morphine was given. On 2-21-08, E7 indicated in interview that at the end of her shift she had given report to E14 regarding R28. She had indicated that E14 was very upset that R14 was not given Morphine and that E14 was going to report her to the DON for not giving Morphine. She indicated that she had told her that R28 did not need Morphine as she was unresponsive and not in pain. ISP interview dated 1-18-07 reflects, "E7 recalled E14 told her that she should have given the Morphine anyway." E7 repeated that she had assessed resident even before leaving to see how she (R28) was as she knew E14 was going to report her. E7 indicated that her assessment before she left showed R28 was stable, no respiratory distress but unresponsive and not in pain.

Nurse's note dated 9/10/06 at 8:00 am, documented that E14 gave R28 Morphine despite having agonal respirations with 20 to 30 second periods of apnea (no breathing.) At 10:00 am, E14 documents that there is no change in condition and another dose of Morphine is administered. In addition, E14 also gave Benadryl 50 mg and Ativan. At 12:28 PM, resident is found to have no pulse or respirations. Review of ISP interview of E6 on 10-26-06 reflects: "R28 died that Sunday morning. E6 stated she came to the facility that Sunday night, and examined the narcotic book. E6 said she compared the narcotic book with the morphine bottles on the medication cart. E6 advised she and E12 had previously

CONT.

marked the morphine bottles in order to detect any morphine that was missing. E6 determined that one bottle belonging to R28 had 160 mg missing. E6 advised she found an extra bottle of morphine that had been full and unopened the previous day. E6 maintained that the bottle now contained a bright yellow liquid. E6 advised Morphine is clear or pink in color. E6 related she smelled the bottle and it smelled sweet like juice. E6 stated she came back to the facility at 7:00 am and went to the Assistant Director of Nursing, E3 's office. E6 added that the administrator E1 and the Social Service Director E19 were present. E6 told them of the missing morphine and the bottle containing a yellow liquid. E6 advised E3 looked at the bottle containing the yellow liquid and commented, "she can't be doing this." E3 said maybe they should try to scare E14 by telling her that autopsies could be conducted on the dead residents. E6 advised that E3 then dumped the morphine bottle containing the yellow liquid and any extra bottles of morphine in the facility." E6 confirmed statements as accurate during interview on 2-26-08.

5. R27 had a diagnosis that included Down's Syndrome, Dysphagia, Parkinson's Disease, Depression and Shy Drager Syndrome per facility Face Sheet dated 3/28/06.

R27's Doctor's telephone orders dated 3/28/06 state "Admit to Hospice, Add Roxanol 5-10 mg PO (by mouth) PRN (as needed)."

E6 interviewed on 2/26/08 confirmed her interview with ISP was accurate and restated that at 6:30 a.m. she had given R27 10 mg of Morphine. She had indicated that she told E14 this on report during the shift change and that she specified the time given to E14. After the report, she went to the other unit and came back after 30 minutes and saw E14 coming out of R27's room with a bottle of Morphine in her hand. E6 indicated in her interview that before she left, R27 was breathing normally without difficulty with respiration.

Nurse's note on 4-2-06 at 7:00 a.m. by E14, states, "Resident observed with rapid resp. abd. (abdominal) Very congested. PO2 86 on 4 liter O2. per mask. Morphine given."

With identified congestion and low PO2 while on Oxygen, E14 gave the Morphine. The Morphine is ordered to be given every two hours for pain or Dyspnea and E14 gave another dose 30 minutes after a dose was given. E14 was fully aware of this as E6 indicated that she emphasized this in her report.

Again at 10:30 am, E14 charted "Continues to have labored respiration 28-30 min c congested gurgling. MSO4 given." At 11:50 a.m. resident expired. There was no assessment to show if Morphine was appropriate for R27 with the congested gurgling with labored respiration. E6 indicated that E14 made a remark during report "Those

CONT.

people aren't meant to live that long. They are meant to die in their teens and I'm going to help him along."

E14 despite being observed, and documenting that she gave the Morphine at 7:00 am, adjusted the time she signed off on the Narcotic sign out sheet to reflect what was ordered, one at 8:30 am and one at 10:30 am.

ISP interview of E6 done on 10-26-06 reflects the following statement: "E6 stated the narcotic book revealed that E14 had allegedly dispensed morphine to R27 every two hours. E6 said the last entry made by E14 was crossed out as R27 was already dead. E6 stated that she compared the narcotics book with R27's bottle. E6 explained that the amount remaining in a morphine bottle could be determined by the lines along the side of the bottle. E6 put forth that she discovered that 160 mg of morphine was missing." This statement was confirmed with interview of E6.

6. The medical records of R30 and R33 were reviewed. Both reflect orders for Morphine which was given regularly until they expired. R30 and R33's record did not reflect initial pain assessment or base lining prior to the use of Morphine and the Morphine was used regularly with no documentation of the type and amount of pain the staff were trying to control nor assessment to show effects and side effect of the Morphine for each resident.

7. The pharmacy review records reflect no problem with the Morphine and other drug regimen of the residents above even though there was no consistent documentation of any monitoring for side effects, the presence of side effects or the effectiveness of the pain medication. The pharmacy also did not see the irregularities in signing of on Morphine count such as R31's when two doses were signed out but only one dose was documented as given. The pharmacy came in to review all residents' charts for any irregularities in their drug regimens but did not identify any problems such as the change of condition on R29 resulting from Morphine being given on an initial dose. The pharmacy filled the falsified telephone order Morphine for R29 when the document reflected it was ordered by MD's Advance Practitioner Nurse who was not authorized to order Level II controlled medication such as Morphine. Pharmacy visit failed to report the presence of extra morphine in the narcotic boxes on the medication cart which the nurses indicated in their interviews was always present. E13 indicated that R31's extra bottle of Morphine was kept in the 200 wing medication cart from April when she expired till it was used on another resident on 8/14/06. Pharmacy visit failed to monitor the continued unlawful storage of controlled medication such as the Ativan found on the 400 wing medication room 2/19/08 being stored in the facility since 6/6/06.

(A)

STATE OF ILLINOIS
DEPARTMENT OF PUBLIC HEALTH
STATEMENT OF VIOLATIONS AND PLAN OF CORRECTION

WOODSTOCK RESIDENCE	0038653
Facility Name	I.D. Number
309 MCHENRY AVENUE, WOODSTOCK,ILLINOIS 60098	
Address, City, State, Zip	
02648	APRIL 7, 2008
Reviewed By	Date of Survey
ANNUAL LICENSURE	02486, 02490, 02493, 02534, 02579, 02631, 11270, 13240, 14208, 15477
Type of Survey	Surveyed By

As a result of a survey conducted by representative(s) of the department, it has been determined the following violations occurred.

IMPORTANT NOTICE: THE STATE AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED UNDER PUBLIC ACT 83-1530. DISCLOSURE OF THIS INFORMATION IS MANDATORY. THE FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

"A" VIOLATION(S):

300.1010h)
300.1210a)
300.1210b)3)
300.3240a)

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

a) The facility must 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 assessment and plan of care. 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.

b) 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,

CONT.

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.

Section 300.3240 Abuse and Neglect

a) *An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.* (Section 2-107 of the Act)

These regulations are not met, as evidenced by the following:

Based on record review, interview and observation the facility systemically failed to monitor their diabetic residents safely.

The facility, in the area of diabetic care, failed to:

1) Notify the physician of alert value and severely low and high blood glucose results,
2) Monitor the clinical condition of residents surrounding the time of low or high blood glucose results,
3) Re-check and treat low blood glucose levels,
4) Have a written policy regarding the treatment and rechecking of abnormal blood glucose levels,
5) Ensure that staff is knowledgeable of the facility's policy for hypoglycemia and hyperglycemia,
6) Give the correct dose of insulin per the physician's sliding scale order, and
7) Follow the physician's order for administering daily insulin and performing blood glucose checks .

These failures are likely to result in serious hypoglycemic or hyperglycemic reactions and have the potential to affect all 17 residents with Diabetes who reside at the facility. The examples include 6 (R9, R16, R10, R11, R18, R12) of the 17 residents with Diabetes who reside at the facility and 1 resident (R14) who was discharged.

Findings include:

1. R16 is a 62 year old resident who was admitted to the facility on 4/27/04 with diagnoses including Insulin Dependent Diabetes Mellitus according to the facility's face sheet. R16's current Physician Order Sheet (POS) documents

CONT.

a physician's order dated 8/16/06 to monitor blood glucose twice daily (6:00 am, 4:00 pm) and notify the physician if blood glucose is less than 70 milligram per deciliter (mg/dL). R16's current POS also documents to administer Novolog 3 units before breakfast (8:00 am), Novolog 5 units before lunch (12 noon), Novolog 8 units daily before supper (5:00 pm) and Lantus 16 units daily at bedtime (9:00 pm).

R16's clinical records from 12/1/07 till 2/20/08 were reviewed. R16's Medication Administration Record (MAR) documents on 1/12/08 at 6:00 am R16's blood glucose was 41 mg/dL. There was no nursing documentation of R16's hypoglycemic symptoms or clinical condition and no documentation of how R16's low blood glucose level was treated or when it was re-tested. This was confirmed by E15 (Nurse) on 2/21/08 at around 12:20 pm.

A review of the facility's Nursing Summary Sheet documents that on 12/10/07 during the 11 to 7 shift R16's blood glucose was 38 mg/dL and "orange and glutose" was given. On 2/21/08 at around 2:15 pm E15 confirmed that it was R16's 6:00 am blood glucose level. There was no nursing documentation of R16's hypoglycemic symptoms or clinical condition. There was no documentation of the amount of orange juice and glucose given and no documentation when R16's blood glucose was re-tested. There was no nursing documentation that R16's physician was notified about this low blood glucose reading. All these were confirmed by E4-A on 2/21/08 at around 2:15 pm.

A further review of R16's clinical record also indicated that 6 times between 12/3/07 and 2/20/08 R16's blood glucose level ranged from 53 mg/dL to 57 mg/dL There was no nursing documentation of R16's hypoglycemic symptoms or clinical condition and no documentation of how R16's low blood glucose level was treated or when it was re-tested. There was no nursing documentation that R16's physician was notified about these low blood glucose readings. All these were confirmed by E15 on 2/21/08 at around 12:20 pm. On 2/10/08 at 6:00 am R16's blood glucose was 52 mg/dL according to R16's MAR. there was "OJ" written next to "52." There was no nursing documentation regarding the amount of orange juice that was given. There was no nursing documentation of R16's hypoglycemic symptoms or clinical condition and no documentation when R16's blood glucose was re-tested. There was no nursing documentation that R16's physician was notified about this low blood glucose reading.

The review of R16's clinical record also indicated that there were 12 times between 12/2/07 and 2/20/08 when R16's blood glucose level was below 70 mg/dL. Z2's (Endocrinologist) progress note dated 12/4/07 documents to notify the physician if R16's blood glucose level is less than 70 mg/dL. There was no nursing documentation that R16's physician was notified about this low blood glucose level.

CONT.

E4-A was interviewed regarding the treatment for low blood glucose level on 2/21/08 at around 12:35 pm. E4-A stated if the blood glucose level was below 90 mg/dL then she would give 4 ounces of milk and 2 graham crackers with peanut butter. E4-A further stated that she would check resident's blood glucose level every 15 minutes until it was greater than 90 mg/dL.

E15 (Nurse) was interviewed regarding the treatment for low blood glucose level on 2/21/08 at around 12:40 pm. E15 stated if the blood glucose level was below 40 mg/dL then she would give 3/4 ounce of peanut butter, two saltine/graham crackers and 5.5 ounce of orange juice and she would check resident's blood glucose level every 15 minutes till it was greater than 80 mg/dL.

There were 11 times between 12/1/07 and 2/20/08 when R16's blood glucose level was greater than 350 mg/dL (ranged from 358 to 499 mg/dL). There was no nursing documentation that R16's physician was notified about this high blood glucose level. The facility's policy and procedure titled "Hyperglycemia" documents to notify the physician for blood glucose above 350 mg/dL. E9 (Nurse) was interviewed on 2/20/08 at around 3:00 pm regarding notifying the physician about R16's high blood glucose level. E9 stated that "(R16) is better running higher level."

A further review of R16's MAR from 12/1/07 till 2/20/08 indicated that the scheduled dose of insulin (Novolog 8 units) at 5:00 pm was not administered on 12/20/07, 1/25/08, and 1/27/08. E9 was interviewed on 2/20/08 at around 3:00 pm. E9 stated that if R16's blood sugar is below 100 mg/dL she holds the scheduled dose of insulin. E9 confirmed that she held the 5:00 pm dose of Insulin on 12/20/07, 1/25/08, and 1/27/08. A review of R16's clinical records showed no physician's order to hold the scheduled dose of insulin. There was no nursing documentation to indicate that R16's physician was notified about the Insulin being held.

Z2 (Physician) was interviewed on 2/26/08 at around 1:50 pm. Z2 stated that he does not recall giving orders to hold Insulin for R16. Z2 further stated that if he was managing a resident with Diabetes Mellitus he would prefer to be notified if the resident's blood glucose level was below 70 mg/dL and above 400 mg/dL.

2. R9 is a 78 year old resident with multiple diagnoses including Diabetes and Dementia according to the facility's face sheet. R9 has physician orders for Glipizide 5 mg at 9:00 AM, Lantus 15 units subcutaneous at 9:00 PM and Accucheck twice daily at 6:00 AM and 4:00 PM according to the physician's order sheet (POS) for December 2007, January 2008 and February 2008. R9's cognitive skills for daily decision-making are moderately impaired - decisions poor according to the facility's most current Minimum Data Sets (MDS) dated 12/31/07. R9 was observed on 2/19/08, 2/20/08 and 2/21/08 in her wheelchair.

WOODSTOCK RESIDENCE 0038653
Facility Name I.D. Number

CONT.

On 12/12/07 R9 had alert level blood glucose of 46 mg/dL at 4:44 AM according to the lab report in the medical record. The lab report documents that E16 (Nurse) was notified at 3:52 PM on 12/12/07 with the alert value. There is no documentation that E16 notified R9's physician regarding this alert level or that any additional blood glucose monitoring was done. There is no nursing note documentation of R9's clinical condition on that day. R9 had 13 (6:00 AM) blood glucose levels below 70 between 12/6/07 and 2/20/08 (6 of these levels were below 60). R9 had 3 (4:00 PM) blood glucose levels below 70 between 1/21/08 and 2/10/08 (1 of these levels was below 50) according to documentation in the Medication Administration Record (MAR). There is no documentation in the nursing notes regarding the medical treatment, physician notification or rechecks of these low blood glucose levels. There is no nursing note documentation of R9's clinical condition at the time of these low blood glucose levels. R9's 12/20/07 dietary assessment does not address these low morning blood sugars, nor is it identified in the care plan titled Diabetic Management.

E16 was interviewed on 2/21/08 at 3:40 PM. E16 stated that she has no specific recollection of R9’s alert low blood glucose level that was phoned to her on 12/12/07. E16 stated that in general when she receives an alert value level she calls the doctor and waits for a response depending on the lab result and if it was accurate for that time. E16 said that in the case of R9's result she would not have tried again to reach the physician because blood glucose levels had already been checked on R9 since the time of the alert value draw. E16 stated that she would not feel it necessary to document in the nursing notes regarding this issue. E16 reviewed the medical record and stated that she could not find documentation that R9's physician was notified. E16 stated that she does not know what the facility's policy and procedure is regarding low blood glucose levels.

E17 (Nurse) was interviewed on 2/20/08 at 11:20 AM. E17 stated that it was conveyed to her in shift change report that R9 had a blood sugar of 59 at 6:00 AM and that orange juice was given. E17 stated that R9's blood sugar level was not rechecked. E17 said that a blood sugar under 60 should be rechecked on some people. E17 stated that she was a new employee and did not know what the facility's policy and procedure was regarding low blood sugar levels.

R9 was interviewed on 2/20/08 regarding her 6:00 AM low blood sugar result of 59 mg/dL. R9 stated that she did not know what her blood sugar was that morning but stated that she did not feel well.

E2 (Director of Nursing) was interviewed on 2/20/08 at 12:20 PM. E2 stated that alert value results should be "red stamped" and faxed to the physician immediately. E2 and E17 confirmed that R9's lab report was not "red stamped." Regarding the facility's policy on hypoglycemia E2 stated that if the blood sugar level was less than 70 with no

CONT.

symptoms the nurse is to treat the low blood sugar with peanut butter and crackers and recheck the level in 15 minutes.

Z6 (R9's daughter) is listed as the responsible person to notify according to the face sheet. Z6 was interviewed by phone on 2/21/08. Z6 stated that she has never been notified about R9's alert level blood glucose or about any other low blood glucose results.

Z2 (R9's physician) was interviewed by telephone on 1/26/08 at 12:15PM. Z2 stated that he does not specifically remember if the glucose alert of 12/12/07 was called to him. Z2 said that he would expect staff to call him for any blood glucose levels below 70 mg/dL.

The facility's policy titled, "Hypoglycemia Policy and Procedure" dated 5/1/06 does not provide any guidelines for treating and rechecking low blood sugar levels. The policy states, "notify physician if blood sugar is fewer than 50...."

The American Diabetes Association 2007 Position Statement defines hypoglycemia as glucose less than 70 mg/dL. The paper states that 15-20 gm of Glucose is the preferred treatment for hypoglycemia and that blood glucose levels should be re-tested in approximately 15 minutes because additional treatment may be necessary. The paper further states that adding fat (i.e., peanut butter) may retard and then prolong the acute glycemic response. The American Dietetic Association also concurs with these guidelines according to the Manual of Clinical Dietetics 5th Edition 1996.

During the group interview on 2/20/08 eight out of eight residents stated that they are not offered bedtime snacks. Four of the residents in group (R11, R12, R24, R25) have a diagnosis of Diabetes and confirmed that they do not regularly receive a bedtime snack.

3. 14 is a 73 year old resident with diagnoses that include IDDM (insulin dependent diabetes mellitus), renal failure, diabetic neuropathy, cellulitis, and S/P BKA (below the knee amputation). Review of the medical record indicated that R14 had orders for Lantus insulin 10 units SQ every morning. R14 also had orders for accuchecks before meals and at bedtime (6am, 11am, 4pm, and 9pm.) Sliding scale insulin was to be given based on the results of the checks as follows: Novolin R 100 units/ml SS: 151-200 = 4U, 201-250 = 6U, 251-300 = 8U, > 350 = 10U then recheck BS and cover with SS, if BS > 350 = call MD.

Review of the MAR (medication administration record) indicates that on multiple occasions in December, 2007 and January, 2008, R14 was given the incorrect dose of insulin, or there is no documentation that the MD was called as the parameters call for, or that the BS was rechecked as ordered. Examples include: The 4:00 pm accucheck results were: 12/15/07 BS result: 167--no coverage given--should have rec'd 4 units; 12/25/07

CONT.

BS result: 342--no coverage given--should have rec'd 10 units; 12/13/07 BS result: 300--8 units given--should have rec'd 10 units.

On 12/20/07, 12/22/07, 12/13/07, 12/24/07, and 1/1/08 the BS results were greater than 350, but there is no documentation of the MD being notified or of a recheck being done. Also on these days and several others, when the resident had blood glucose levels over 300, the resident experienced falls. This occurred on 12/13/07, 12/14/07-two falls, 12/20/07, on 12/24/07, and on 12/28/07-two falls and 1/1/08. The BS ranged between 300 and 500 on these days and there is no notification to the MD documented. There is also no assessment or correlation made between the BS and the falls and the care plans was not reevaluated or updated.

4. R11 is a 57 year old resident with diagnoses that include paraplegia, back pain, IDDM, T7 compression fracture. R11 is ordered to receive Glucophage 250 mg every 12 hours, PH insulin 10 units SQ twice a day and have accuchecks done twice a day with sliding scale insulin based on the results of the checks as follows: Novolog 100 units/ml SS: 151-200 = 2U, 201-250 =4U, 251-300 =6U, 301-350 = 8U, 351-450 = 15 U, 451 - over call MD.

During December there were several times when the insulin was not given according to the sliding scale or notification made to the MD as ordered. On 1/8/08 the BS was 596. The MAR does not document this result for this date, but the nurse's note dated 1/8/08 1600 documents that the "maximum dose of insulin was given." There is no mention of notifying the MD.

On 12/22/07 the 4:00pm BS was 281--4U were given, 6U are ordered; on 12/25/07 the 4:00pm BS was 351--8U were given, at that time the MD was to be called, this is not evident; again on 12/27/07 4:00pm BS was 353 --8 U were given, MD was to be called, no evidence he was; 12/11/07 6:00am BS result was 162--3 U given, 2 U ordered; 12/18/07 the BS was 282--the MAR documentation appears to read 9U given--6U were ordered.

The 2007 8th Edition Drug Information Handbook for Nursing by Turkoski, Lance and Bonfiglio states the following regarding Insulin: "The Institute for Safe Medication Practices includes this medication among its list of drugs which have a heightened risk of causing significant patient harm when used in error."

5. R10 is a 72 years old resident admitted to the facility on July 2002 with a diagnosis which includes Renal failure, Insulin Dependent Diabetes Mellitus,Congestive Heart Failure and AKA (above the knee amputation) of both lower extremities. R10 is also on dialysis and goes 3 x a week (Mon., Wed., and Fri.), for dialysis treatment.

CONT.

Review of R10's physician (MD)order sheet (POS) showed an order which says "Accucheck twice daily," with Novolin R sliding scale coverage, which says, " <150 = 0; 151-200 = 3U (units); 201- 250 = 6U; 251- 300 = 9U; 301-350 = 12U; 351-400 = 15U; 401-450 = 18U. Medication Administration Record (MAR) reviewed showed that accucheck was done at 6am and 4pm.

Review of the December 2007 and January 2008 MAR showed the following;

Dec. 6, 2007, 4:00pm accucheck result was 538. There was no documentation that insulin was not given nor was the physician notified of the result.
Dec. 8, 2007, 4:00pm accucheck result was 500. R10 was given 18 units of Novolin R insulin.
Dec.11, 2007, 4:00pm accucheck result was 474. R10 was given 18 units of Novolin R insulin.
Dec.12, 2007, MAR showed no 6am accucheck was done
Dec.13 & 15, 2007, 4:00pm accucheck result was 451. R10 was given 18 units of Novolin R insulin.
Jan. 7, 2008, 4:00pm accucheck result was 297. No documentation that Insulin was given. R10 also has MD orders for Novolin N 22 units' sub-Q every morning (6am) and evening (4pm). That same day (1/7/08), as documented in the MAR, at 6am, R10 was given 7 units of insulin instead of 22 units ordered by MD, and was not given the 4pm dose.
Jan. 14, 2008, 6:00am accucheck result was 185. No insulin was given as ordered.
Jan. 21, 2008, 4:00pm accucheck result was 218. R10 was given 3 units instead of 6 units Novolin R ordered by physician.
Jan. 29, 2008, 4:00pm accucheck result was 456. R10 was given 18 units of Novolin R insulin.

On these four (4) instances (12/8, 12/11, 12/13, and 1/29/08), review of the nurses notes and the daily summary sheet presented by the facility, showed that the Novolin R was given without MD order, and there was no evidence or documentation that the attending MD was notified about these high blood glucose level results.

Facility policy reviewed states, "Notify MD if blood sugar is fewer than 50 or above 350, unless otherwise ordered." R10's sliding scale physician order states "401-450 give 18 units of Novolin R insulin."

6. R18 is a 64 years old resident admitted to the facility on 5/1/06, with a diagnosis which includes Insulin Dependent Diabetes Mellitus (IDDM), Congestive Heart Failure (CHF), End Stage Renal Disease and Cerebro-Vascular Disease (CVA) with Left sided weakness. R18 is also a dialysis patient and goes for dialysis treatment 3 x a week (Tuesday, Thursday and Saturday).

WOODSTOCK RESIDENCE 0038653
Facility Name I.D. Number

CONT.

Review of R18's quarterly MDS, signed as completed on 1/30/08, documents his cognitive decision making skills as independent with no memory problem. As observed on 2/19 and 2/20/08, and verified by staff, R18 is capable of doing his activities of daily living independently except his bath were he needs a one person assist.

Review of R18's physician order sheet (POS), showed an order which says "Accucheck before meals and at bedtime," with a sliding scale insulin coverage of Novolin which says, “151 - 200 = 2 U (units); 201 - 250 = 4 U; 251 - 300 = 6 U; 301 - 350 = 8 U; 351 - 400 = 10 U. Review of the MAR showed that the accucheck was done at 6am, 11am, 4pm and 9pm.

Review of the December, 2007 MAR showed the following;

Dec.1, 2007, Dec.17, Dec 26, 2007, 11am accucheck was not done as ordered.
Dec.6, Dec.24, 2007, 4:00pm accucheck was not done as ordered.
Dec. 16, 2007, 4pm. accucheck result was 251. R18 was not given the 6 units insulin coverage ordered.
Dec. 22, 2007, 6:00am accucheck result was 161. R18 was not given the 2 units insulin coverage ordered.
Dec. 24, 2007, 6:00am accucheck result was 196, R18 was not given the 2 units insulin coverage ordered.
Dec. 25, 2007, 6:00am accucheck result was 151. R18 was not given the 2 units insulin coverage ordered.
On Jan. 16 and Jan.21, 2008, the physician's orders were not followed for checking the 11:00am accuchecks for R18.

7. R12 is an insulin dependent diabetic (IDDM) who has physician's orders for his blood to be checked twice a day at 6:00 a.m. and 4:00 p.m. with insulin coverage on a sliding scale. This order includes the physician to be notified when R12's blood sugar (accucheck) is over 351. At 4:00 p.m. on 1/1/08 R12's accucheck is documented on his Medication Administration Record (MAR) as being 353, on 1/4/08 it was 359, on 1/7/08 it was 479, on 1/8/08 it was 354 and on 1/11/08 it was 428. There is no documentation in R12's Nurses Notes that the physician was called. E2 (DON) told surveyors that it should be documented in the Nurses Notes. Also, the physician's orders are to give 9 units of insulin when R12's accucheck is between 251 and 300. On 1/3/08, at 4:00 p.m. R2's MAR documents that his accucheck was 253 and 3 units were given instead of 9 units.

(A)