

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  146080	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/14/2024
NAME OF PROVIDER OR SUPPLIER  Countryview Care Center-Macomb		STREET ADDRESS, CITY, STATE, ZIP CODE  400 West Grant Street Macomb, IL 61455	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>38396</p> <p>Based on observation, interview and record review, the facility failed to accurately administer physician ordered GlucaGen (injectable medication to increase blood sugar) according to the physician order for a resident with Type II Diabetes Mellitus and already elevated blood glucose (sugar) levels, for one of three residents (R1) reviewed for Medications in the sample of three. This failure resulted in R1's hyperglycemia worsening and requiring R1 to be transferred to the emergency room for treatment to lower her blood glucose.</p> <p>Findings Include:</p> <p>The facility's Adverse Drug Reactions and Medication Discrepancy policy, dated 10/2006, documents A medication discrepancy/error has been made when one of the following occurs: Wrong medication administered, Wrong dose administered, Medication administered by wrong route, Medications administered to wrong resident, Medication administered at wrong time, Medication not administered.</p> <p>R1's current Care Plan, dated 4/15/24, documents The resident has Diabetes Mellitus Type II. Monitor/document/report as needed any signs or symptoms of hyperglycemia: increased thirst and appetite, frequent urination, weight loss, fatigue, dry skin, poor wound healing, muscle cramps, abdominal pain, kussmaul (rapid, deep breaths) breathing, acetone breath (smells fruity), stupor, coma.</p> <p>R1's Current Physician Order sheet, dated 5/7/24 documents R1 has orders for Blood glucose monitoring four times a day. Novolog Regular (insulin) 100 units/ milliliter, inject seven units as needed four times daily if blood sugar greater than 350 (milligrams per deciliter, mg/dl). This same order sheet documents R1 has an order for GlucaGen one milligram (mg) injection, inject one mg intramuscularly one time as needed for low blood glucose.</p> <p>On 5/13/24 at 10:30 AM, R1 was laying in her bed in her room. R1 confirmed she was taken to the hospital recently. R1 recalled before she went to the hospital, she remembered feeling dizzy. R1 could not recall any other events that occurred that day before being sent to the hospital.</p> <p>(continued on next page)</p>		

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>R1's Nursing progress note, dated 5/5/24 at 6:40 PM and signed by V4 (Licensed Practical Nurse, LPN) document At 6:05 PM (R1) was acting off in the dining room, dropping liquids and seeming not quite right. Blood sugar assessed at 432 (mg/dl). Writer asked nurse on days (V8, Registered Nurse) and she stated she checked her sugar and gave sliding scale insulin per the doctor's order. 6:10 PM, resident non-responsive in the dining room. Blood glucose reading High. Intramuscular GlucaGen administered by writer and (emergency medical services) called. LPN (V4) administering medication realized the error and notified Medical Doctor (V9, R1's Physician).</p> <p>R1's Medication Discrepancy Report, dated 5/5/24 and signed by V4 documents GlucaGen injection was given to R1 and realized after injecting that it was an error. This report documents Possible effects to the resident: Elevating already high blood glucose.</p> <p>On 5/13/24 at 10:15 AM, V5 (Ambulance Paramedic) confirmed he responded to the facility for R1's transfer to the hospital. V5 stated The ambulance was called due to (R1) having increased blood sugar levels and being unresponsive. Our glucose meter reads up to 600 (mg/dl) and then it will just say high. Our reading of her blood sugar in the ambulance was high. The facility called us and initially said she was in the 500 (mg/dl) reading and then they got a high reading and they said they gave GlucaGen. I told them that GlucaGen raises the blood sugar and the nurse walked away and stated I messed up, I messed up several times. I did not catch the nurse's name. She (R1) became responsive to pain in the ambulance, but it was a moan and then back to unresponsive. She never woke up fully before arriving at the hospital.</p> <p>On 5/13/24 at 1:54 PM, V8 (Registered Nurse) stated I was working that day (5/5/24) and getting ready to leave. It was supper time. (R1) was having high blood sugar. She was tired and so I checked her blood sugar. I had to go back to see her again, she was almost asleep at the table. (R1) said she was dizzy. I checked her blood sugar and it said High. (V4) was already working and I didn't think (R1) was hypoglycemic (low blood sugar). I was trying to get staff to get her back to bed. (V4) checked her and said, Oh she is not feeling well and I said I know, and she is not low, she is showing signs of being septic. (V4) got GlucaGen and said, Sometimes you can show signs of high (blood sugar) when you're low. I think almost immediately she realized it was wrong because she came back to the nurse's station and said, I just made a rookie mistake. We didn't give any more insulin again. Initially (V4) was talking about giving orange juice and such, I said (R1) can't be low. I had just checked her blood sugar. After the GlucaGen was given, we then called the ambulance. (V4) realized it pretty quick. At that point we knew she would need to be sent to the hospital for care.</p> <p>R1's Emergency Department notes, dated 5/5/24, documents R1 was evaluated in the emergency room and later admitted to a tertiary hospital (higher level of care) for associated diagnoses of Septic shock, Urinary tract infection, Acute Kidney injury and Hyperglycemia. This note also documents on 5/5/24 at 6:49 PM in the emergency room , R1's laboratory value of blood glucose was 713 mg/dl.</p> <p>On 5/13/24 at 1:10 PM, V9 (R1's Physician) confirmed R1's blood sugar being over 350 mg/dl is high (hyperglycemia) and requires insulin medication to lower the level of glucose in the blood. V9 also confirmed that GlucaGen increases blood sugar and is meant for hypoglycemia (low blood sugar, below 60 mg/dl). V9 stated Once they (facility) gave her the extra injection of glucose (GlucaGen) it would cause the hyperglycemia to become worse and elevate the (R1's) blood sugar levels further. V9 confirmed R1 was sent to the hospital and treated for hyperglycemia as well as other medical conditions on 5/5/24.</p>		