

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146114	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/27/2024
NAME OF PROVIDER OR SUPPLIER Lena Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1010 South Logan Street Lena, IL 61048	

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 - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36186</p> <p>Based on interview and record review the facility failed to administer a Physician prescribed medication as ordered. This applies to one of three residents (R1) reviewed for medication administration in the sample of six.</p> <p>The findings include:</p> <p>The facility face sheet shows R1 was admitted to the facility with diagnoses to include Type 2 Diabetes Mellitus, congestive heart failure and hypertension. The facility assessment dated [DATE] shows R1 to be cognitively intact and requires moderate assistance with his activities of daily living.</p> <p>On 8/27/24 at 9:30 AM, V2 (Director of Nursing) said she was the nurse working the floor on 8/18/24. V2 said she was having a very busy night with another resident having a change in condition. V2 said she was running behind in her bedtime medication pass and was also trying to give a shift to shift report to the oncoming nurse. V2 said she looked at the Medication Administration Record (MAR) and saw the order for R1's scheduled insulin and she prepared that and then drew up 40 units of R1's regular sliding scale insulin and gave the injections to R1. V2 said she quickly realized she had given R1 his regular sliding scale insulin when it wasn't needed and had also given 40 units. V2 said the scheduled insulin was for 40 units as well and she must have had the 40 units in her head. V2 said R1's blood glucose level was 103 and R1 did not need any sliding scale insulin. V2 said she never should have been trying to give a report to the oncoming nurse while passing medications to the residents. V2 said when passing medications to a resident, the nurses focus should be on the medications.</p> <p>On 8/27/24 at 9:45 AM, V5 (Certified Nursing Assistant/CNA) said she worked the day shift on 8/19/24 and saw R1 in bed most of the day but did eat lunch and supper. V5 said R1 acted tired.</p> <p>On 8/27/24 at 9:50 AM, V4 (Registered Nurse/RN) said she was working the day shift on 8/19/24, the day after R1 received too much insulin. V4 said R1 was tired that day but was up for his meals. V4 said R1 had one emesis in the hall as he was walking but denied feeling sick and only apologized for making a mess.</p> <p>On 8/27/24 at 9:55 AM, V6 (CNA) said she was working the day shift on 8/19/24 and said R1 never complained of anything but did vomit one time. R1's gait was steady and he felt bad for vomiting on the floor.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146114	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/27/2024
NAME OF PROVIDER OR SUPPLIER Lena Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1010 South Logan Street Lena, IL 61048	
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 - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/27/24 at 10:06 AM, V3 (RN) said she was the nurse receiving report from V2 on the night of 8/18/24. V3 said V2 had had a bad shift and was very busy and running late with the bed time medication pass. V2 was telling me about the change in another's resident's condition as she was drawing up the insulins. V3 said V2 told her right away what she had done by giving R1 regular sliding scale insulin when it wasn't necessary and that 40 units had been given. V3 said V2 called the Physician right away and also called the POA (Power of Attorney).</p> <p>On 8/27/24 at 12:20 PM, V1 (Administrator) said he expects the nursing staff to have their full attention on the medication pass and never try to do anything else at the same time. V1 said he heard V2 was talking to another nurse while preparing R1's medications.</p> <p>The Physician Order Sheet (POS) dated August 2024 for R1 shows an order for Insulin Glargine-Lixisenatide inject 40 units subcutaneously at bedtime. The same POS also shows an order for blood glucose monitoring two times a day. The POS shows an order for Insulin Lispro injection to be given per sliding scale. If blood sugar is 151-200 give 4 units, if blood sugar 201-250 give 6 units insulin, if blood sugar is 251-300 give 8 units insulin, if blood sugar is 310-350 give 10 units insulin, if blood sugar is 351-400 give 12 units insulin and call the Physician if the blood sugar is over 401.</p> <p>The Medication Administration Record (MAR) dated August 2024 shows R1's blood sugar was 103 at the time of his insulin administration. (According to the sliding scale insulin instructions, R1 did not need any sliding scale insulin.) The MAR shows the insulin was administered and to see R1's nursing progress note.</p> <p>The nursing progress note dated 8/18/24 at 10:07 PM shows accidental lantus (insulin) administration given to the resident</p> <p>The facility policy for Insulin Administration dated 3/4/2020 shows it is the policy of this center to assure that residents with diabetes mellitus, who are ordered to have insulin to control their blood glucose levels, will receive the medications correctly. The procedure shows to 3. check the blood glucose per Physician orders or facility protocol 8. check and re-check that the type of insulin on the vial matches the type of insulin ordered. 9. check the order for the amount of insulin.</p>		