STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145691	A. BUILDING _____ B. WING _____	C 11/09/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HALLMARK HOUSE NURSING CENTER	**2501 ALLENTOWN ROAD PEKIN, IL 61554**

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F 333	Continued From page 7 nurse receiving the order will highlight the dose, but the person reviewing the new months MAR's will be responsible for highlighting carry over insulin dosages.	F 333		
F9999	FINAL OBSERVATIONS Licensure Violations 300.1210a) 300.1210b)1) 300.1630a)e) 300.3220f) 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: 1) Medications including oral, rectal, hypodermic, intravenous and intramuscular shall be properly administered. Section 300.1630 Administration of Medication a) All medications shall be administered only by personnel who are licensed to administer medications, in accordance with their respective	F9999		

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F9999	Continued From page 8 licensing requirements. Licensed practical nurses shall have successfully completed a course in pharmacology or have at least one year's full-time supervised experience in administering medications in a health care setting if their duties include administering medications to residents. e) Medication errors and drug reactions shall be immediately reported to the resident's physician, licensed prescriber if other than a physician, the consulting pharmacist and the dispensing pharmacist (if the consulting pharmacist and dispensing pharmacist are not associated with the same pharmacy). An entry shall be made in the resident's clinical record, and the error or reaction shall also be described in an incident repor Section 300.3220 Medical and Personal Care Program f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's Director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. (Section 2-104(b) of the Act) These requirements were not met as evidenced by the following: Based on record review and interviews the facility staff failed to administer insulin as ordered to 1 of 3 sampled residents (R1) and to notify the resident's physician of when R1's blood sugar levels dropped and was symptomatic for hypoglycemia. R1 was given 10 times more inulin than the insulin the physician ordered.	F9999		

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F9999	Continued From page 9	F9999		

R1's blood sugar dropped to 32, and R1 became diaphoretic and required emergency Intramuscular glucose treatment and hospitalization. Six additional residents had orders for insulin injections.

Findings include:

R1's Medication Administration Record (MAR) for September 2006 states that R1, an 80 year old female, has Type 2 Diabetes uncontrolled, with insulin dependence, as well as senile dementia, and heart failure. This MAR states that R1 is to receive Novolin Regular Insulin per sliding scale at 7:00 a.m., 11:30 a.m., 4:30 p.m. and 8:30 p.m. according to her blood glucose levels. It also states that she receives Lantus 5 Units of Insulin at bedtime (8:30 p.m.)

According to "A Manual of Laboratory Diagnostic Tests," Third Edition, the non-fasting blood sugar in persons over the age of 50 should be 85-124 mg./dl (milligrams per deciliter). Under the Clinical Alert section #3 it states: "When glucose is <30 (less than 30) mg./dl.....brain damage is possible."

The September 2006 MAR shows the following low blood sugars: 9/8/06, 6:30 a.m. = 70; 9/18/06 at 6:30 a.m. = 57 and 9/21/06 at 6:30 a.m. = 49. September 2006 Nurses Notes did not reflect any interventions for these blood sugars, nor notification of the physician.

September 2006 Nurses Notes showed that on 9/16/06 at 4:00 a.m., R1 was found to be "cold and clammy and disoriented in bed. (Blood glucose) 40. Gave O.J. (Orange juice) and sugar and peanut butter on crackers. Bed was soaking

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wet with sweat. O2 (oxygen) sat. (saturation) 79% on RA (room air) placed on O2 at 2 L (liters). O2 sat up to 85%. (E3). 4:20 a.m. Recheck (blood glucose) increased to 70. Resident now alert and speech clear, no longer garbled."

9/23/06 Nurses Notes state: 12:45 a.m., Res. found cold and clammy when checking her O2 sat. BS (blood sugar) found to be 46. Glucose tube given at this time. 1:20 a.m. BS @ 50, still monitoring. 3:00 a.m. BS 96." On 9/26/06 at 3:15 a.m. Nurses Notes indicate: "Res found cold and clammy to touch. BS 40. Glucose tube given at this time."

E3, LPN (Licensed Practical Nurse), night shift nurse, stated at 2:20 p.m. on 10/30/06 that she had sent a fax to the doctor on 9/26/06 to let him know about the low blood sugars and to see if he wanted to discontinue the 8:30 p.m. sliding scale insulin. E4, LPN, day shift nurse stated on 10/30/06 at 1:15 p.m. that the 6:30 a.m. blood sugars are done by the night shift and that R1 had already "been treated by the night shift nurse with food, juice or a glucose tube," so by the time she checked the blood sugar after taking report, it was in "the normal range." E4 stated that she "did not report them to the doctor" as a result of her tests being normal. A phone order was obtained on 9/26/06 to discontinue the 8:30 p.m. sliding scale insulin.

R1's October 2006 MAR (Medication Administration Record) states that R1 has diagnoses of type 2 Diabetes, uncontrolled, Congestive Heart Failure, and COPD (Chronic Obstructive Pulmonary Disease). The MAR also states that R1 was to receive "Lantus 100

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F9999	Continued From page 11 Units/ml. (milliliter) vial. Inject 10 units at bedtime (8:30 p.m.) and record site. Start Date 7/20/06." The facility Transfer and Referral Record dated 10/15/06, states that R1 was transferred to the local hospital with a blood sugar of 32. This Transfer and Referral Record further states that R1 was given 1 vial of glucagon IM (intramuscular) and 1 tube of glucose prior to the transfer. The Medication Error Report dated 10/15/06 states that R1 was found by CNA's(Certified Nurse Aides) at "2:30 a.m." to be "diaphoretic," and that R1 had been given 100 units of Lantus insulin instead of the 10 units ordered by the doctor. The Medication Error Report further states that the dose "could have endangered the life or welfare of the resident" since "Lantus will continue to drop the blood sugar for 24 hours after administration." The Nurses Notes dated 10/15/06 at 3:00 a.m. states, "Discovered resident during bed check to be diaphoretic. Took her blood sugar to discover it at 32. Called the second shift nurse to see how much Lantus insulin she had given. Discovered from conversation she had given her (R1) 100 units of Lantus instead of 10 units of Lantus. Called the doctor who said to give her 1 mg. (milligram) of Glucagon now and send her to the E.R.(Emergency Room) Called 911 and sent her to E.R. (E3).. An interview was conducted on 10/30/06 at 2:20 p.m. with E3, LPN (Licensed Practical Nurse) who verified that E6, LPN, had given 100 units of Lantus on 10/14/06 at 8:30 p.m., instead of the 10 units of Lantus as ordered. She stated that she was the night shift nurse who found R1 with the blood sugar of 32.	F9999		

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F9999	Continued From page 12 Z1, attending physician stated on 10/30/06 at 3:00 p.m., that he "would have expected to be notified of a resident who had a blood sugar of 60 or less and symptomatic for hypoglycemia". He stated he was unaware of these low readings in September of 2006. An undated facility policy page "128" provided on 10/30/06 states under #11. a." ...Contact physician if two weekly glucose readings are less than 70 or more than 200." E1, Administrator, stated at 10:00 a.m. on 10/30/06 that staff are "not supposed to fax changes in condition information to the doctors, but are supposed to call the doctor when there are changes. I've hit really hard on that one since I've been here." E1, administrator, on 10/30/06 at 9:30 a.m., verified that the incident had occurred. E1 stated that she had fired E6 as a result of the incident. (A)	F9999		