Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007330	A. BUILDING: ______ B. WING ______	C 03/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERCREEK REHAB & HEALTHCARE CENT	**2220 STATE STREET PEKIN, IL 61554**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Final Observations STATEMENT OF LICENSURE VIOLATIONS 300.1210a) 300.1210b) 300.1210c) 300.1210d)1 300.1210d)2) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) b) The facility shall 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 resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each	S9999		

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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S9999	Continued From page 1	S9999		

resident to meet the total nursing and personal care needs of the resident.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

d) Pursuant to subsection (a), 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.

2) All treatments and procedures shall be administered as ordered by the physician.

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 REQUIREMENTS ARE NOT MET AS EVIDENCED BY:

Based on interview and record review the facility failed to administer insulin as ordered by a physician for one of nine residents (R4) reviewed for insulin administration in a sample of 13. This

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S9999	Continued From page 2 failure resulted in a three day hospitalization in intensive care for R4. FINDINGS INCLUDE: R4's Nurse's Notes document on 1/31/14 at 7:45 p.m. "medication discrepancy discovered (R4) given inappropriate amount of insulin, Novolog (insulin). Z1 (Physician) notified....send to ER (Emergency Room) for evaluation." R4's MAR (Medication Administration Record) documents R4 gets a sliding scale of Novolog insulin. On 1/31/14 at 7:00 p.m. R4's MAR documents R4's blood sugar level was 338. R4's MAR documents for a blood sugar reading of 338 R4 would receive 8 units of insulin. The same MAR also documents R4 received Lantus (insulin) 30 units at 8:00 p.m. R4's hospital report dated 1/31/14 documents "sent to ED (Emergency Department) because he (R4) received too much insulin....patient was supposed to get Novolog 8 units and Lantus 30 Units but instead received 84 units of Novolog insulin and 30 units of Lantus insulin." R4's History and Physical dated 2/1/14 documents: "........yesterday he (R4) got a wrong dose of 84 units of Novolog insulin instead of 8 at 7:20 P.M. ... . his sugar (blood sugar) was 266 however, began to drop and had to be put on a D10 (Dextrose/sugar) IV (intravenous) drip and sent to the ICU (Intensive Care Unit) with q (every) 1 hour vitals and accu checks (blood sugar monitoring)." The same history and physical documents R4 was on the D5 IV drip for 8-10 hours. On 3/13/14 at 1:30 p.m. E4 LPN (Licensed Practical Nurse) reported that E4 completed R4's	S9999		

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S9999	Continued From page 3 blood sugar reading on 1/31/14 around 7:20 p.m. E4 stated "I can't remember what the reading was." E4 stated E4 misread the MAR and thought it said R4 was to get 84 units of insulin based on R4's sliding scale. E4 stated needing to use 2 syringes to administer the insulin. E4 stated after administering the insulin to R4, E4 went back to R4's medication cart and realized the wrong amount of insulin was administered to R4. E4 reported calling the physician right away and R4 was sent to the hospital. On 3/13/14 at 10:05 a.m. R4 stated on 1/31/14 a nurse gave him insulin about 7:30 P.M. R4 stated the nurse then came back a short time later and told R4 he was given too much insulin and "could die." R4 reported coming back to the facility on a Sunday and on the following Monday R4 spoke to E2 DON (Director of Nursing) because R4 was afraid a nurse would give the wrong medicine or the wrong dose of Insulin and "they would kill me." (A)	S9999		