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
	IL6003750	A. BUILDING: ______ B. WING ______	C 06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBER POINT HEALTHCARE CENTER	205 EAST SPRING STREET CAMP POINT, IL 62320

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S 000	Initial Comments Complaint #1723644/IL94834 Statement of Licensure Violations	S 000		
S9999	Final Observations 300.610a) 300.1210b) 300.1630d) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures 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. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting Section 300.1210 General Requirements for Nursing and Personal Care 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 resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:	S9999	**Attachment A** **Statement of Licensure Violations**	

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Section 300.1630 Administration of Medication
d) If, for any reason, a licensed prescriber's medication order cannot be followed, the licensed prescriber shall be notified as soon as is reasonable, depending upon the situation, and a notation made in the resident's 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

These requirements were not met as evidenced by:

Based on record review and interview the facility failed to provide physician ordered scheduled medication for one of three residents (R1) reviewed for medication availability in the sample of six. This failure resulted in R1 having increased negative behaviors, increased nervousness, and an altered mental status, which required treatment at the emergency department for benzodiazepine withdrawal.

Finding include:

The facility's Medication Administration Policy dated 03/2014 documents, "Drugs will be administered in accordance with the orders of licensed medical practitioners. Medical errors, drug side effects, and adverse reactions will be immediately reported to the Director of Nursing and the pharmacist. The error or clinical symptoms will be documented in the clinical record and on the facility designated form."

1. R1's Physician's Order Sheets dated 2-13-17 (Admission) to 6-19-17 documents R1 has an order to receive Ativan 0.5 mg (milligrams) every

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eight hours for the diagnosis of Anxiety, and Ativan 0.5 mg every six as as needed. R1's Medication Administration Record (MAR) dated 5-1-17 to 6-19-17 indicates R1 did not receive any of the ordered scheduled doses of ativan from 6-4-17 through 6-13-17 and 5-1-17 through 5-4-17.

R1's Progress Notes dated 6-8-17 at 10:50 p.m. and signed by E12 (Registered Nurse/RN), document R1 started having increased behaviors of yelling at R6, becoming physically aggressive toward R6 and staff, having increased paranoia, and slamming a walker. These same notes document staff attempted redirection of R1 which was unsuccessful, 911 was called, and R1 was sent to the emergency room for evaluation.

R1's Progress Notes dated 6-10-17 at 6:15 a.m., document R1 was argumentative with staff, interrupting staff report, and was unable to be redirected.

R1's Progress Notes dated 6-11-17 at 4:38 p.m., documents R1 was yelling at certified nursing assistants, cursing, and, threw a shoe.

R1's Progress Notes dated 6-13-17 at 4:30 a.m. and signed by E12 (RN), document R1 spent the entire shift yelling at peers and staff, was physical with the writer (E12/RN) and with R4, was standing over R4 yelling with a clenched fist, "Shut the f*** up God d*** it", and was verbally aggressive to R4 and R5 for using the bathroom. This same Progress Note documents R1 was redirected without success and R1 was sent to the emergency room for evaluation.

R1's ED (Emergency Department) Record dated 6-8-17 documents R1 presented to the ED with

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combativeness towards staff members and agitation. This same note indicates R1 had not been receiving her scheduled ativan and was given ativan at the ED. R1 then calmed down and was sent back to the facility with orders to continue R1's normal medication regimen.

R1's Hospital ED (Emergency Department) Assessment dated 6-13-17 documents R1 had a change in mental status and has not had ativan for several days. R1's ED Discharge instructions dated 6-13-17 and signed by Z7 (R1's ED Attending Physician) document R1 had an Altered Mental Status and Agitation due to a Benzodiazepine (Ativan) withdrawal and an order was given to resume R1's normal dose of ativan.

On 6-20-17 at 8:25 a.m., Z2 (Emergency Department Registered Nurse) stated, "(R1) came to the emergency department with behaviors after not receiving her scheduled ativan for days prior. There is no reason why (R1) has not had her scheduled ativan at the facility and has to come to the emergency department on two different occasions within a week to get the ativan. On arrival to the emergency department on 6-13-17, (R1) was agitated and combative with staff. (R1) was a fall risk and was trying to hit anyone she could. I gave (R1) ativan. (R1) calmed down and the agitation was relieved after giving the ativan. (Z7/Emergency Department Attending Physician) said (R1's) behaviors were due to benzodiazepine withdrawal. After receiving ativan at the emergency room (R1) returned to baseline status and was returned to the facility with orders to ensure (R1) receives ordered ativan."

On 6-19-17 at 9:30 a.m., E5 (Certified Nursing Assistant/CNA) stated, "(R1's) behaviors have

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gotten a lot worse since a few weeks ago. There is no re-directing her anymore."

On 6-19-17 at 9:35 a.m., E4 (RN) stated, "(R1's) behaviors worsened when she was out of ativan. (R1) would get more physical and yell more. (R1) could not be re-directed. (R1) required being sent to the emergency room for treatment several times when she was out of her ativan."

On 6-20-17 at 10:45 a.m., E8 (CNA) stated, "Over the last couple of weeks (R1's) behaviors are worse. (R1) gets agitated more easily and yells more.

On 6-20-17 at 11:00 a.m., E9 (CNA) stated, "(R1's) behaviors have worsened over the last two to three weeks. (R1) is loud and rude. (R1) has been saying 'I am nervous.' (R1) has been very anxious."

On 6-20-17 at 11:15 a.m., Z6 (R1's Power Of Attorney) stated, "(R1) has had increased agitation. The emergency department doctor said (R1) had been out of her medication for several days and it caused (R1) to have behaviors. (R1) had never required emergency room treatment before for behaviors. It is disturbing to me that the facility let (R1's) ativan run out and (R1) had to go to the hospital to get it. (R1) should not have had to suffer withdrawal and behaviors because of running out of ativan."

On 6-20-17 at 12:30 p.m., E2 (Director Of Nursing) stated, "(R1) has been out of scheduled ativan from 6-4-17 through 6-13-17 and 5-1-17 through 5-4-17. We have had multiple issues with the pharmacy sending the ativan, and with the physician signing a prescription refill. That is why (R1) has not had her ativan. I was never

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informed that (R1) did not have her ativan. A Medication Incident form has never been completed from the nursing staff for R1 being out of ativan. According to the facility's medication administration policy a medication incident should have been done. I should have been told within twenty four hours of the first missed dose. No staff have reported to me that (R1's) agitation had gotten worse. If I had known I would have assessed her and got a psychiatrist involved. The cause of (R1's) emergency room visits and increased agitation was due to (R1) not getting her ativan as ordered."

On 6-20-17 at 1:00 p.m., E1 (Administrator) stated, "(R1) should have never went without her ativan. We have had way too many issues with the pharmacy and communication."

On 6-21-17 at 11:30 a.m., E12 (RN) stated, "(R1's) behaviors had worsened since she wasn't getting her ativan. I have never noticed (R1's) behaviors to be this extreme before missing her ativan, and I took care of her at the facility prior to this facility."

(B)