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 03/13/2024

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 Survey: 2421503/IL170120	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)1 300.1210d)3 300.3240)a 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	S9999		

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S9999	Continued From page 1 resident to meet the total nursing and personal care needs of the resident. 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. 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical 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. (Section 2-107 of the Act) These Requirements were NOT MET as evidenced by: Based on observation, interview, and record review the facility failed to administer prescribed opioid medications to keep residents' pain controlled, failed to perform a pain assessment while the residents were not receiving their prescribed opioid medications, and failed to develop a pain plan of care for two of three residents (R1 and R2) reviewed for pain in the sample of three. These findings resulted in R1, who suffers from bone cancer, experiencing uncontrolled lower back pain and resulted in R2,	S9999		

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S9999	Continued From page 2 who suffers from Osteomyelitis from a flesh-eating wound caused by a spider bite, experiencing uncontrolled severe continuous and unbearable pain to his right lower leg wound. Findings include: The facility's Pain Management policy dated 07/2019 documents, "Policy: It is the policy of the facility to facilitate resident safety, independence, promote resident comfort, preserve and enhance resident dignity and facilitate life involvement. The purpose of this policy is to accomplish the goals through an effective pain management program. The resident's descriptive words regarding the quality, duration, and location of pain will be used to evaluate the pain and to identify changes in pain. Pain assessment protocol may be initiated under any of the following situations: Resident received routine pain medication and/or pain is not controlled and a change in pain identification related to behavior, cognition, or mood. An immediate care plan will be initiated at the time of admission for any resident with physician orders for pain management, when the resident expresses pain, or exhibits behaviors indicative of having pain. An interdisciplinary process and care plan will be developed and implemented based on the assessed findings, pain rating scale, and pain-relieving strategies (interventions). A provision of pain treatment that includes pharmacological and non-pharmacological interventions will be included in the care plan. Responsible use of opioid's medications will include the monitoring of the use of opioids." The United States Food and Drug Administration Safety Communication Website article dated 4-9-19 documents, "Opioid's are a class of	S9999		

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S9999	Continued From page 3 powerful prescription medicines that are used to manage pain when other treatments and medicines cannot be taken or are not able to provide enough pain relief. Rapid discontinuation can result in uncontrolled pain." R1's History and Physical dated 8-10-23 documents, "Chief complaint is intractable back pain. Multiple Myeloma. (R1) has known Multiple Myeloma has been under therapy by Oncology. (R1's) pain has become severe. (R1) cannot ambulate. Pains all up and down (R1's) spine. (R1) apparently has lesions at various levels of the spine with her myeloma." R1's Face Sheet documents R1 is an 87-year-old admitted to the facility on 8-24-23 with the diagnoses of Multiple Myeloma not having achieved remission and low back pain. R1's Admission Orders dated 8-23-24 document R1 was admitted to the facility on Fentanyl (Opioid) 75 mcg (microgram)/hour transdermal extended release one all up patch every 72 hours. Morning time is a hard time of day regarding pain. (R1) is able to sleep at night. Location (of pain) is mid-back today. Planning to increase fentanyl patch (dose)." R1's Care Plan dated 8-23-23 (Admission) through 3-7-24 does not include a plan of care to address R1's chronic pain due to Multiple Myeloma. R1's Progress Notes dated 10-4-24 and signed by V4 (R1's Palliative Physician) document, "(R1) is being seen in the geriatric clinic today for palliative care follow-up regarding pain management associated with Multiple Myeloma."	S9999		

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R1's Progress Notes dated 10-5-24 and signed by V6 (RN/Registered Nurse) document, "(R1) seen by (V4/R1's Palliative Care Physician) with Fentanyl patch increased to 100 mcg per hour for diagnosis of cancer pain. Follow-up with (V4) in four months. Will continue to monitor."

R1's Physician's Orders dated 10-5-24 through 3-8-24 document, "Fentanyl 100 mcg per hour one patch transdermal once a day every three days at 9:00 PM for the diagnoses of Multiple Myeloma not having achieved remission."

R1's Medication Flow Sheets dated 1-1-24 through 2-31-24 document R1's Fentanyl Patch 100 mcg/hour transdermal placed at 9:00 PM was not administered as scheduled on 1-25-24, 1-28-24, 1-31-24, or 2-3-24. These same Medication Flow Sheets document R1 did not have a Fentanyl 100 mcg/hour patch applied until 2-6-24.

The facility's email dated 2-5-24 and sent to the facility's pharmacy from V2 (Director of Nursing) states, "I am not sure how things need to be fixed, but (R1) has been without her Fentanyl patch going on two weeks which is completely unacceptable. This is becoming a huge problem of people going days without their narcotics and is causing residents to being in a great deal of pain or even worse going into withdrawals."

R1's Progress Notes dated 2-21-24 and signed by V4 (R1's Physician) document, "A few weeks ago (R1) was having significant issues with delirium at night and there was a night where an ambulance had to be called. On further investigation from family, turns out (R1) had not been getting her fentanyl patches. I am unsure about what efforts (if any) the facility pursued to

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get (R1) her pain medications. Not only was my office unavailable during this time, the patient's primary care provider's office was available and our nurse practitioner who rounds at the facility would have also been available to help troubleshoot. This appears to be inadequate care and my duty as a mandatory reporter required me to report this. Assessment and recommendations: 1. Encounter for palliative care. 2. Multiple Myeloma not having achieved remission. 3. Bone Metastasis. 4. Cancer related pain."

R1's Medical Record does not include a completion of a pain assessment after R1 did not receive her scheduled Fentanyl patch from 1-25-24 through 2-6-24.

On 3-8-24 at 9:30 AM R1 was lying in bed in her room. R1 stated, "I did not know I wasn't getting my pain medication. I know my lower back was on fire. Most all of my pain is in my lower back."

On 3-8-24 at 9:45 AM V2 (Director of Nursing/DON) stated R1 went without her scheduled Fentanyl Patch for from 1-25-24 through 2-6-24. V2 also stated R1's Fentanyl Patch was given for R1's pain related to bone cancer. V2 confirmed R1 did not have a pain assessment conducted after missing her Fentanyl Patch dose.

On 3-8-24 at 11:00 AM V4 (R1's Palliative Care Physician) stated, "I am responsible for (R1's) palliative care. I saw (R1) in my office on 2-21-24. I was told on 2-21-24 that (R1) did not receive her Fentanyl patch for two weeks. I was not informed by the nursing home of (R1's) Fentanyl patch not being available or administered. (R1) should not have gone two

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weeks without Fentanyl. Fentanyl is the only medication that keeps (R1's) pain control. (R1) has excruciating pain from bone cancer and I have had to increase (R1's) Fentanyl dose to keep the pain under control. No other pain medication has been effective."

On 3-8-24 at 11:40 AM V7 (Nurse Practitioner) stated, "I did not know (R1) had went without Fentanyl for two weeks. (R1) should not have never been without her Fentanyl, especially for two weeks. I was only notified one day (1-19-24) of the need for a signed prescription. (R1) has bone cancer to her spine and her pain is very detrimental to her."

On 3-8-24 at 12:25 PM V8 (R1's Power of Attorney) stated, "On 2-1-24 I called the nurse (V9/RN), and she told me (R1) had been out of her Fentanyl patch for two weeks and that was causing her night terrors. (R1) was going crazy and was in such pain while being out of her Fentanyl. It was just awful. (R1) has terrible bone pain and cancer."

On 3-8-24 at 4:25 PM V10 (MDS/Minimum Data Set Coordinator) stated, "(R1) did not have a pain plan of care developed prior to today. I am responsible for developing pain care plans. I do not have a reason as to why (R1) did not have a pain care plan."

2. R2's Face Sheet documents R2 is a 46-year-old admitted to the facility on 8-16-23 with the diagnoses of Type II Diabetes Mellitus and a non-pressure chronic ulcer of unspecified part of right lower leg.

R2's MDS Assessment dated 1-25-24 documents R2 is cognitively intact and has frequent pain at a

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S9999	Continued From page 7 pain intensity of "7" on a 0-10 pain scale (zero being no pain and ten as the worst pain you can imagine). R2's Pain Observation Assessment dated 1-25-24 documents R2 had almost constant moderate pain at a "7" and received scheduled and as needed pain medications for pain control. R2's Progress Notes dated 1-8-24 and signed by V7 (Nurse Practitioner) document, "(R2) requested to see me due to pain not currently controlled with Oxycodone 10 mg every four hours PRN (as needed). New orders: Schedule Oxycodone 10 mg tablets three times daily and continue with current Oxycodone 10 mg one tablet every four hours as needed." R2's Care Plan dated 8-16-23 (Admission) through 3-7-24 does not include a plan of care to address R2's chronic pain due to Osteomyelitis and wound to the right lower leg. R2's Physician's Order Report date 3-1-24 through 3-8-24 documents, "Order date 1-8-24 to current: Oxycodone 10 mg (milligram) tablet two tablets three times daily. Order date 11-30-23 to current: Oxycodone 10 mg one tablet every four hours as needed (PRN)."` R2's Medication Flow Sheets dated 1-1-24 through 1-31-24 document R2's Oxycodone 10 mg two tablets was not administered as ordered on 1-26-24 at 8:00 PM, 1-27-24 at 8:00 AM, 2:00 PM, or 8:00 PM, 1-27-24 at 8:00 AM, 2:00 PM, or 8:00 PM, and 1-28-24 at 8:00 AM. These same Medication Flow Sheets dated 1-1-24 through 1-31-24 document R2 did not receive a PRN dose of Oxycodone 10 mg on 1-26-24 through 1-31-24.	S9999		

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R2's Progress Notes dated 1-28-24 at 3:11 PM and signed by V9 (RN) documents R2 was complaining of increased pain and withdrawals due to his scheduled pain medication not being available from pharmacy due to insurance. This same not documents R2 remained in bed and was not eating meals.

R2's Progress Notes dated 1-29-24 at 1:47 PM and signed by V11 (RN) documents, "(R2) has remained in bed thus far today. (R2) went all weekend and today without pain medication."

R2's Medical Record does not include a completion of a pain assessment after R2 did not receive his scheduled Oxycodone on 1-26-24 through 1-28-24.

On 3-8-24 at 11:10 AM R2 was lying in bed. R2's right lower leg was wrapped in gauze. R2 stated, "I was out of the Oxycodone for three days. I was bit by a recluse spider and that is why I am here for treatment. When I was out of the Oxycodone, I was having withdrawals of nausea, vomiting, and dry heaving and I was having pain at an "11" on a 1-10 pain scale. The pain was continuous and unbearable. It felt like my wound was split open and burning."

On 3-8-24 at 11:40 AM V7 (Nurse Practitioner) stated, "I oversee (R2's) care at the facility. (R2) ran out of Oxycodone on 1-26-24. I was not notified of the need for a prior authorization until (R2) already ran out. (R2) did not get his medication for three days. (R2) got bitten by a Brown Recluse spider that caused a wound with bone exposure. (R2) has Osteomyelitis (bone infection) and has had several debridements done and has a lot of pain with this wound. I am

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S9999	Continued From page 9 sure his pain was excruciating when he had to go without his Oxycodone." On 3-8-24 at 9:45 AM V2 (DON) confirmed that R2 did not have a pain assessment completed after missing his scheduled doses of Oxycodone on 1-26-24 through 1-29-24. On 3-8-24 at 4:25 PM V10 (MDS Coordinator) stated, (R2) did not have a pain plan of care developed prior to today. I am responsible for developing pain care plans. I do not have a reason as to why (R2) did not have a pain plan of care." (A)	S9999		