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 10/15/2021

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

(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
S 000	Initial Comments Facility Reported Incident of 10/1/2021-IL139077	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)1) 300.1610a)1) 300.1630c) 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	S9999	Attachment A Statement of Licensure Violations	

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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:

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.

Section 300.1610 Medication Policies and Procedures

a) Development of Medication Policies

1) Every facility shall adopt written policies and procedures for properly and promptly obtaining, dispensing, administering, returning, and disposing of drugs and medications. These policies and procedures shall be consistent with the Act and this Part and shall be followed by the facility. These policies and procedures shall be in compliance with all applicable federal, State and local laws.

Section 300.1630 Administration of Medication

c) Medications prescribed for one resident shall not be administered to another resident.

These requirements were not met as evidenced by:

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Based on interview and record review, the facility failed to ensure a resident (R1) was not administered medications prescribed for another resident which affected one of four residents (R1) reviewed for significant medication errors in the sample of six. This failure resulted in R1 receiving another resident's prescribed medications and becoming ill with vomiting, loss of consciousness, decreased blood pressure, slow respirations and a decrease in blood oxygen saturation level and subsequently being transported to a local emergency room.

Findings include:

The Facility Medication Administration Policy dated March 2014 states, "Drugs will be administered in accordance with orders of licensed medical practitioners of the State in which the facility operates; Setting up doses for more than one (1) scheduled administration is not permitted; Medications or supplies intended for one resident will not be administered to another resident."

The Pharmacy Policy and Procedure Manual dated April 24, 2017 states, "Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication."

R1's Progress notes dated 10/01/2021 at 11:12 a.m., document, "(R1) received another resident's (R2's) medications at 800 a.m. this morning. At 830 a.m., (R1) was eating breakfast in the North Dining Room when staff noted (R1) to have lost

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consciousness and had an emesis (vomiting). (R1) was immediately taken to room and laid down in bed, (vital signs) were taken by a nurse and resident (R1) was noted to have low (blood pressure-86/44) and SpO2 (oxygen levels) <90%. 911 was called. EMS (emergency medical personnel) arrived at 8:50 a.m. Report given to them; All paperwork given along with list of medications (R1) had received. EMS left with resident at 9:00 a.m. (R1's) HCPOA (health care power of attorney) was notified at that time. MD (Physician) updated."

R1's local hospital visit summary dated 10/1/2021 documents that R1 was seen in the emergency room with chief complaint, "Received another resident's medications today at 8:00am, decreased level of consciousness along with vomiting."

A facility incident report form dated 10/1/2021 documents: "(R1) and (V3) RN (Registered Nurse) were involved with a medication error incident and that (R1) at 8:00 a.m., received medications that were not prescribed to R1 and were prescribed for R2. (R1's) Physician was notified immediately after. (R1) was sent to emergency room for evaluation (returned to facility that same day). On 10/1/2021, an investigation was conducted after (R1) received medications that were not prescribed to R1, the nurse (V3) was found to have not followed the facilities medication administration policy."

A facility Medication Error Report dated 10/1/2021 documents: "(V3, RN) gave (R2)'s 8:00 AM medications to (R1)." The following medications were listed on the Medication Error report indicating these medications has been administered to R1: "Quetiapine (antipsychotic)

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50 milligram (mg), Aspirin 81 mg, Benazepril (blood pressure) 20 mg, Calcium 600 mg, Carvedilol (blood pressure) 25 mg, Diltiazem Extended Release (blood pressure) 24 hour 240 mg, Ferrex 150 mg, Fish Oil, Magnesium Gluconate 27 mg, Vitamin D3 4000 Unit, Vitamin C 500 mg, Colace 100 mg, Zoloft (antidepressant) 50 mg, MiraLAX 17 gram, Hydralazine (blood pressure) 25 mg, and Probichew 1 gram. (R1) sent to hospital. (V3 RN) educated and then sent home. In-service provided on 10/1/2021 to all nurses on medication administration. All pre-poured medications discarded."

R1's Physician order report (POS) dated 10/1/2021 documents that R1's medications ordered for 8:00 a.m. on 10/1/2021 were Lisinopril (blood pressure) 40 milligram (mg), Memantine (Alzheimer's Disease) 10 mg, Potassium Chloride 20 mEq (milliequivalent), Multivitamin, Vitamin D2 50,000 Units, Calcium with Vitamin D 600 mg, Hydrochlorothiazide (blood pressure/fluid retention) 25 mg, Sertraline (antidepressant) 25 mg and Sertraline 12.5 mg.

R2's POS dated 10/1/2021 documents that R2's medications ordered for 8:00 a.m. on 10/1/2021 were Quetiapine (antipsychotic) 50 mg, Aspirin 81 mg, Benazepril (blood pressure) 20 mg, Calcium 600 mg, Carvedilol (blood pressure) 25 mg, Diltiazem Extended Release (blood pressure) 24 hour 240 mg, Ferrex 150 mg, Fish Oil, Magnesium Gluconate 27 mg, Vitamin D3 4000 Unit, Vitamin C 500 mg, Colace 100 mg, Zoloft (antidepressant) 50 mg, MiraLAX 17 gram, Hydralazine (blood pressure/fluid retention) 25 mg, and Probichew 1 gram and R2's medication administration record (MAR) documents that the medications were initialed as administered by V3,

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S9999	Continued From page 5 RN. R1's Minimum Data Set (MDS) Assessment, Brief Interview for Mental Status (BIMs) dated 7/15/2021, documents that R1 scored a 9, indicating R1 had moderately impaired cognition. On 10/13/2021 at 9:00 a.m., V3, Registered Nurse, stated that on 10/1/2021 she began the 8:00 a.m. medication pass between 6:00 a.m. and 7:00 a.m. by opening and pre-pouring all of the medications for each resident on V3's hall and then put them in individual pill cups, labeled with resident names, ahead of time . V3 then put the pill cups in the drawer, so she wouldn't be so slow during medication pass. V3 stated that during the medication pass, she must have picked up R2's medications and given them to R1. R1 took the medications because R1 is cognitively impaired. V3 then stated, a dining room staff came and reported that R1 just had an emesis (vomiting) and that R1 wasn't waking up. V3 stated that R1 was unconscious, at first, with decreased awareness. R1 wasn't responding to any stimulation, had decreased respirations, was moaning and was not verbally responsive. A wheelchair was brought in and staff got R1 to room and took vitals. R1's blood pressure was very low (86/44). V3 then stated that another nurse came in and assisted V3. After about 20 or 30 minutes, V3 went back to the medication cart to finish the medication pass. That is when V3 realized she had given R1 someone else's medications. V3, RN then stated that she immediately reported the medication error to V2 (Director of Nursing) and 911 was called. V3 stated that R1 was sent to a local emergency room and R1 returned to the facility that evening and has had no adverse effects as of today, which has been 13 days. V3 also stated that she	S9999		

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S9999	Continued From page 6 was given immediate education by V2 and then V3 left for the day. V3 stated that she knew better and should never have pre-poured medications for all the residents ahead of time. V3 stated, "That (Pre-pouring medications) goes against what our medication policy states, and I should have done one resident at a time." On 10/13/2021 at 9:25 a.m., V5, Nurse Practitioner stated, "Obviously, those medications (given by V3 on 10/1/21) were not ordered for (R1) and initially did some harm as (R1) vomited, had a loss in consciousness, low blood pressure, was not verbally responsive and a few other immediate reactions, but (R1) was returned that same day and has had no adverse effects. (R1) was monitored for several days once returned and the Pharmacist gave us signs and symptoms to watch for after ingesting those medications. (R1) has been stable since that day with no long-lasting effects." (A)	S9999		