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	IL6014682	A. BUILDING _____ B. WING _____	C 04/12/2019

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S9999	Final Observations Statement of Licensure Violation: 1 Of 1 Violation 300.610a) 300.1210b) 300.1210d)1)2) 300.1620a) 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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. 2) All treatments and procedures shall be administered as ordered by the physician. Section 300.1620 Compliance with Licensed Prescriber's Orders a) All medications shall be given only upon the written, facsimile or electronic order of a licensed prescriber. The facsimile or electronic order of a licensed prescriber shall be authenticated by the licensed prescriber within 10 calendar days, in accordance with Section 300.1810. All such orders shall have the handwritten signature (or unique identifier) of the licensed prescriber. (Rubber stamp signatures	S9999		

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S9999	Continued From page 2 are not acceptable.) These medications shall be administered as ordered-by the licensed prescriber and at the designated time. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act) These Requirements are not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a resident's seizure medications were available and scheduled per the physician orders, resulting in several significant medication errors. This failure resulted in R2 experiencing prolonged seizure activity and a hospital admission to the intensive care unit. This applies 1 of 4 residents (R2) reviewed for medication availability in the sample of 6. The findings include: R2's Electronic Medical Record (EMR) showed R2 was admitted to the facility on March 19, 2019 and transferred to the hospital on March 23, 2019. R2 remained hospitalized during the survey.	S9999		

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On April 5, 2019 at 12:05 PM, V11 (R2's Mother and Caregiver) stated R2 has a longstanding history of seizures since he contracted encephalitis in 2001 when he was a child. V11 stated R2 lived at home and she managed his medications. V11 stated R2 is high-functioning, and at home she sets up all of his medications for him and would remind him to take them. V11 stated when R2 was discharged from the hospital to the facility for strengthening, the hospital waited until R2 received all of his seizure medications before he was transferred. R2's March 19, 2019 Nursing Admission Assessment Comprehensive showed R2 was admitted to the facility at 10:30 PM, and he was alert, ambulatory with assistance, and continent of bowel and bladder.

R2's March 2019 Physician Order Sheet (POS) showed he takes a combination of six different seizure medications. In the medication room on the floor where R2's room was located, there was a computerized medication storage unit stocked by the pharmacy where nurses may access medications that are not available in their medication carts. The listing for the unit showed only one of R2's seizure medications (divalproex) was available. R2's March 2019 Physician Order Sheet (POS) showed an order for divalproex 750 mg twice daily (R2's first seizure medication) at 9:00 AM and 9:00 PM. R2's March 2019 Medication Administration Record (MAR) showed R2's 9:00 PM divalproex dose was not signed off as administered, and his 9:00 AM dose was administered at 1:50 PM (over four hours late).

R2's March 19, 2019 hospital discharge orders showed to administer one 97.2 mg tablet of phenobarbital (R2's second seizure medication)

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every morning, and one and a half tablets of 97.2 mg phenobarbital at night. R2's March MAR showed an entry for one tablet of phenobarbital 97.2 mg at 9:00 PM, and a second entry for phenobarbital 97.2 mg one and a half tablets, also scheduled for 9:00 PM. Neither of the doses were signed off as administered on March 20, 2019. R2's March MAR also showed two entries on March 21, 2019, each again timed at 9:00 PM, where neither the single tablet dose nor the one and a half tablet dose were administered. MAR documentation showed "Not Administered (Medication Not Available)" for both entries on March 21, 2019. Another entry from the next day at 9:00 PM for the single tablet dose showed "Not Administered (Medication Not Available)."

R2's hospital discharge orders showed to administer lamotrigine 100 mg (R2's third seizure medication), one tablet in the morning and one and a half tablets in the evening. R2's March MAR showed his lamotrigine was scheduled for one and a half tablets at 5:00 PM, and one tablet at 9:00 PM instead. R2's March MAR showed he received no lamotrigine at all on March 20, 2019, and received the doses scheduled backwards and four hours apart on the evenings of March 21 and March 22, 2019.

R2's hospital discharge orders showed to administer zonisamide nightly (R2's fourth seizure medication). R2's March 2019 MAR showed R2 received no zonisamide on March 20, 2019.

R2's hospital discharge orders showed to administer lacosamide (R2's fifth seizure medication) every 12 hours. R2's March 2019 MAR showed no lacosamide was administered to R2 on March 20, 2019.

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R2's hospital discharge orders showed to administer cannabidiol (R2's sixth seizure medication) 2.2 ml twice daily for one week, then to increase the dosage to 4.4 ml twice daily. R2's March 2019 MAR showed he received 2.2 ml at 9:00 AM only on March 20. For March 21, 2019, R2's MAR showed he received 2.2 ml at 5:00 PM, and 4.4 ml at 10:00 PM. For March 22, R2's MAR showed he received 2.2 ml at 9:00 AM and 5:00 PM, and 4.4 ml at 11:00 AM. For March 23, the MAR showed R2 received 2.2 ml 9:00 AM and 5:00 PM, and 4.4 ML at 11:00 AM.

R2's March 22, 2019 nursing progress note from 6:23 PM showed "notified by [Certified Nursing Assistant] that resident was having seizures ... writer made aware seizure lasted about 5-10 minutes ..." R2's 4:34 PM nursing note from March 23, 2019 showed "Resident noted with altered mental status today after having seizure activity on 3/22 ..." R2's March 23, 2019 note showed "resident had seizure activity noted by his mother, lasting for 5 minutes (5:38 PM), as reported per resident's mom ..." The note showed an ambulance arrived at 5:44 PM on March 23 for transport to the hospital.

On April 5, 2019 at 12:40 PM, V11 (R2's Mother) stated when R2 was stabilized at the hospital after leaving the facility, he was transferred to another hospital and admitted directly into the intensive care unit. V11 stated R2 "couldn't talk and just stared, he couldn't walk, and now he's incontinent ... that's how out of it he is." V11 stated R2 said "Hi Mom" for the first time on April 3, 2019, 11 days after leaving the facility.

On April 5, 2019 at 2:15 PM, V4 RN (Registered Nurse Manager) stated medications should be given as prescribed by the physician because

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they are part of a resident's health process. V4 stated some medications have to stay at specific times, like seizure medications and Parkinson's disease medications. V4 stated if medications are not available, pharmacy should be called and the physician should be notified that the medication is not available to get further guidance.

On April 9, 2019 at 1:30 PM, V2 (RN, Director of Nursing) stated it is very important to give seizure medications as ordered and the way the physician wants it to avoid relapse. V2 added "seizure medication levels need to be maintained."

On April 11, 2019 at 9:15 AM, V12 (R2's Neurologist) stated he has been seeing R2 for many years and described R2's seizure activity as "very brittle" and his medication regimen as "critical." V12 added R2's seizure activity as such that if his medications are taken an hour late, it is ok, but 90 minutes is "pushing it." V12 stated there is no question that R2 not receiving his medications on schedule was a contributing factor with his seizures. V12 stated that without giving medications, lacosamide, lamotrigine, and divalproex levels drop quickly in the body. V12 added there is definitely a high probability R2's seizures could have been prevented if he had received his medications on schedule and the lack of medication played a dominant role in R2 being transferred to the hospital.

On April 9, 2019 at 12:15 PM, V3 (Pharmacist) stated "it is important to take seizure medication as ordered by the physician as it is prescribed."

The facility's "7.0 Medication Shortage/Unavailable Medications" policy

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S9999	Continued From page 7 (revised January 1, 2013) showed "2.2 If the next available delivery causes delay or a missed dose in the resident's medication schedule, facility nurse should obtain the medication from the Emergency Medication Supply to administer the dose." The policy further showed "2.3 If the medication is not available in the Emergency Medication Supply, facility staff should notify pharmacy and arrange for an emergency delivery ..." (A)	S9999		