STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012678	A. BUILDING: _____ B. WING _____	C 05/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESENCE VILLA FRANCISCAN	210 NORTH SPRINGFIELD AVENUE JOLIET, IL 60435

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S 000	Initial Comments Statement of Licensure Violations	S 000		
S9999	Final Observations 300.610a) 300.1210b) 300.1620a) 300.3220f) 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 resident to meet the total nursing and personal care needs of the resident. 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 are not acceptable.) These medications shall be administered as ordered-by the licensed prescriber and at the designated time. Section 300.3220 Medical Care f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. (Section 2-104(b) of the Act) 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 Regulations were not met as evidenced	S9999		

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S9999	Continued From page 2	S9999		

by:

Based on interviews and record review the facility failed to ensure that an anticonvulsant medication was administered as ordered by the physician. This applies to one of three residents (R1) reviewed for significant medication error. This failure resulted in R1 having a seizure episode on April 30, 2016 that required hospitalization. R1 missed 9 doses of the anticonvulsant medication ordered twice daily from April 25 through April 30, 2016.

The findings include:

R1 was originally admitted to the facility on January 11, 2016 with multiple diagnoses which included dementia without behavior, early onset Alzheimer's disease, metabolic encephalopathy and paroxysmal atrial fibrillation based on the face sheet and diagnosis history.

R1's quarterly MDS (minimum data set) dated April 7, 2016 showed a BIMS (Brief Interview for Mental Status) score of "03," indicating that the resident is severely impaired with cognition. The same MDS showed that R1 would require extensive assistance from the staff with most of her ADL's (activities of daily living).

R1's incident report dated April 30, 2016 showed, "Resident was admitted to the facility on 4/25/16. Medication review noted that she missed 9 doses of Keppra."

The facility's final report to the State agency regarding potential medication variance dated, May 6, 2016 showed that on April 30, 2016, R1 was sent to the hospital as a result of a witnessed seizure. The hospital phoned with questions regarding R1's medication list. It was discovered at that time that there was a potential medication error. The same report showed, "It was determined that there was an order given for Keppra that had not been processed. The family

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and physician of R1 were notified by the facility.
R1's departmental notes dated March 15, 2016 showed that at 5:10 AM, the resident was observed having seizure episode and became unresponsive. The facility called 911 and R1 was transported to the hospital emergency room.
R1's hospital records for admission date of March 15, 2016 showed that the resident was admitted to the hospital for seizure. R1 returned to the facility on March 25, 2016, with multiple medication orders which included an anticonvulsant medication, "Levetiracetam liquid (Keppra) 500 milligram per gastrostomy tube twice daily." R1's POS (physician order sheet) and MAR (medication administration record) showed that the resident received the anticonvulsant medication, until R1 was sent out to the hospital emergency room on April 18, 2016 for abnormal WBC (white blood count) result.
R1 was readmitted to the facility on April 25, 2016 with multiple hospital discharge orders which included the anticonvulsant medication, "Levetiracetam liquid (Keppra) 500 milligram per gastrostomy tube twice daily." R1's physician order sheet on readmission and the medication administration record from April 25, 2016 through April 30, 2016 showed no order to indicate that the hospital discharge orders for the anticonvulsant medication was verified and carried out.
R1's departmental notes dated April 30, 2016 showed that at 5:35 AM, the head of R1's bed was lowered after the resident received a bolus gastrostomy tube feeding, "As the head of bed was lowered resident screamed out and then her body began shaking, resident became unresponsive," " white foam is noted from resident's mouth." The facility called 911 and R1 was transferred to the hospital emergency room.
R1's hospital records (History and Physical) dated

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April 30, 2016 showed, "Per my discussion with the daughter this morning, she had witnesses seizure at the nursing home, and she had frothing in the mouth and generalized body jerking; it was 1 episode." R1's hospital neurology consultation report dated May 1, 2016 showed under the history of present illness that the resident was not given her anti-seizure therapy medication for 9 doses. The same consultation report showed under impression, "The patient has dementia and seizure disorder. There has been recurrence of seizure due to patient not getting the medication. In an interview held on May 12, 2016 at 12:12 PM, E3 (nurse) stated that on April 25, 2016 she was working as a unit manager and was helping E4 (nurse) readmit R1 to the unit. Per E3, Z1 (physician) was in the facility on April 25, 2016 and gave the order to her and to E4 to continue all orders from the hospital. According to E3, she told E4 that she will transcribe Z1's orders for R1 by placing the orders in the electronic system. E3 stated that she reviewed the hospital discharge orders, placed a check mark on the discharge orders to indicate that it was transcribed in the facility's electronic physician orders and medication administration record system. However, E3 does not know why the anticonvulsant medication "Levetiracetam" was not transcribed. Per E3, during the time when she was transcribing R1's orders in the computer, she (E3) was called away from the computer at least three times to attend to other matters, since she was the unit manager. According to E3, she probably transcribed the orders on the electronic physician order sheet and electronic medication administration record but forgot to save the data when she was interrupted and when she came back to continue transcribing the orders, she did not check to make sure that the orders were in the electronic system.

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In an interview held on May 12, 2016 at 12:50 PM, E4 stated that she was the assigned nurse to R1 when the resident was readmitted to the facility on April 25, 2016. E4 stated that during R1's readmission, she was extremely busy so, E3 volunteered to verify and transcribed the orders for R1. Per E4, she did not review or check R1's admission orders against the hospital discharge orders and she did not verify the medication listed in the electronic medication administration record.
The facility's policy and procedure regarding medication reconciliation showed that, "Upon admission to the facility, the admitting nurse will review the discharge orders including the medications from the sending organization." "The nurse will compare the medication information the Hospital/ Home Health/ resident/ family provides with the medication order to identify and resolve discrepancies." "Within three (3) hours of admission, the nurse assigned to the care of the patient will review admission orders against hospital discharge orders and reconcile and verify the medication list placed in the EMAR (electronic medication administration record)." "Throughout care all medication orders for the resident are reviewed, compared and documented."
R1's care plan initiated on April 25, 2016 shows that the resident has a potential for injury related to seizure activity. The goal and part of the approaches showed that the medication will be administered as ordered.
In an interview held on May 16, 2016 at 11:30 AM, E2 (Director of Nursing) stated that after review of R1's medications it was noted that the resident missed 9 doses of her anticonvulsant medication from the day R1 was readmitted (April 25, 2016) to the facility until the day of discharge (April 30, 2016) to the hospital due to seizure activity.

(B)

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