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	IL6005227	A. BUILDING: _____ B. WING _____	C 08/24/2022

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S 000	Initial Comments Facility Reported Incident of July 17, 2022/IL149443- F684G cited.	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 300.1210d)1)2)6) 300.1620a) 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. 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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. 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. 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.	S9999		

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These requirements were not met as evidenced by:

Based on observation, interview, and record review, the facility failed to follow their policy to administer anti-seizure medications according to physician order for 2 (R1, R2) out of 2 residents reviewed for medication administration and appropriately supervise resident (R1). This failure resulted in R1 having a seizure and a fall with a serious head injury.

Findings include:

R1's Facility Investigation Report (7/17/2022) documents in part: A full investigation was completed including a review of the resident's medical record, care plan and interviews with staff. Plausible cause determined as resident was observed in the room shaking and unresponsive during an unwitnessed fall with a laceration to the back of the head. R1 was transferred to hospital and later returned with 6 staples to the back of his (R1) head. Approximately two hours after the return, R1 experienced an additional episode of shaking and unresponsiveness and transferred back to the hospital.

V7's (Certified Nursing Assistant) statement form for the Facility Reported Investigation (7/17/2022) documents in part: I (V7) was making my rounds when I heard a loud sound and I observed R1 on the floor and I called the nurse.

On 08/23/2022 at 11:00 AM, surveyor observed R1 laying on his bed low position, call light within reach and floor mats on the floor. There were no padded side rails. R1 stated that the floor mats

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were not there when he (R1) fell. He (R1) stated that he (R1) is not able to walk on his (R1) own. They put him (R1) on the side of the bed where they give him (R1) time to pivot to the chair. R1 stated that sometimes they are late giving him (R1) medications. They have missed giving him (R1) medications one time as he (R1) can remember.

On 08/23/2022 at 11:05 AM, R2 stated that, some nurses have missed medications. Sometimes I don't receive my medications at night. I have complained to the state about nurses missing my medications. At one time, I had to go to the hospital because my blood pressure was so high because nurses didn't give me my blood pressure medications.

On 08/23/2022 at 12:05 PM, V2 (Interim Director of Nursing) stated he (V2) had sent in a reportable for the fall of R1. V2 stated has was an Interim DON at Lakeview Rehab for a couple of weeks. V2 was not present at the time of the incident. The report was that the nurse noted an open area to the back of his (R1) head after he (R1) had fallen, and the nurse had to send him to the hospital via 911. R1 then returned with staples to the back of his head. The expectation is for nurses to administer medications by following the physician orders by administering the correct medications, correct dose, correct route, correct time, and correct patient. In an occasion a medication is ordered to prevent certain symptoms, if the medications is not appropriately administered then adverse reactions can occur.

On 08/23/2022 at 12:55 PM, V3 (R1's Primary Care Physician) stated that depending on seizure medication we don't do medication blood levels. V3 stated, "I (V3) don't usually test Keppra levels

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because it is not a level related medication. We adjust the dose based on if he (R1) has a seizure based on the current dose and then increase it if he has a seizure. Usually if Keppra is continued 5-6 days, it is less likely of him (R1) to have a seizure. If medications are missed, then adverse reactions can take place. Fall can cause seizure to precipitate. Once you have injury your risk of risk of seizure becomes higher. The fall is definitely a factor to the seizure."

On 08/23/2022 at 1:11 PM V4 (Registered Nurse) is familiar with R1 on the night that he (R1) fell. When she (V4) came on shift, she (V4) received report that he (R1) was sent out to the hospital after he (R1) fell. Then he (R1) came back that night and we received him (R1) with staples on the back of his (R1) head due to fresh wound. He (R1) was able to communicate and oriented. V4 stated (V4) did the neuro check on him (R1) with vital signs, then placed call lights within reach and he (R1) was not in any distress. R1 is weak and unsteady on his (R1) feet. He (R1) is not allowed to ambulate by himself (R1). We heard a noise and saw him (R1) on the floor having seizures. We stayed with him (R1), monitored him (R1), and then placed him (R1) on the bed using the Hoyer lift and made him (R1) comfortable. Immediately after that he (R1) had another seizure. If the seizure comes back to back then that was a concern to me (V4) to send him to the hospital. The CNA had to monitor him 1:1 closely because he (R1) keeps getting up. V4 stated the facility is expected to give him the anti-seizure medication every day. If the seizure medications are not administered every day, the level would be low in his (R1) and that would trigger a seizure.

On 08/23/2022 at 1:36 PM, V5 (Registered

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S9999	Continued From page 5 Nurse) stated she is expected to administer every scheduled seizure medication. She (V5) stated that she does do lab draws to monitor the effectiveness of the of the medications. She (V5) stated she does do lab draws on Keppra medications. If Keppra medications are not administered regularly the resident's Keppra levels will drop and they can have multiple seizures. On 08/23/2022 at 1:40 PM, V6 (Director of Nursing) stated that the ordered medications are administered at the proper time and sign off on the medications within a prescribed time frame. The prescribed time frame is an hour before and an hour after. If a medication administration record is not signed it means the medication was not given. As ordered by the physician, we do lab draws to monitor the effectiveness of the medication. To prevent a fall, we remind him (R1) to stay in bed, with bed in low position. If he (R1) was someone who was a high risk for fall and someone who was constantly getting up, I would have brought him (R1) out to the nurse's station and watched him (R1) over there. When he (R1) came back from the hospital, he (R1) was placed on 1:1 supervision. Seizures could be from head trauma and/or it could be from missed medications. On 08/23/2022 at 2:00 PM, V1 (Administrator) stated no one was supervising R1 before he (R1) fell. He (V1) stated according to his (V1) knowledge no one brought R1 out to the nurse's station to watch him (R1). R1's progress note (7/17/2022) documents in part: "Resident was in room with bed in lowest position call light and urinal in reach. Writer heard a thump while at the nurses station. Proceeded to	S9999		

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S9999	Continued From page 6 see what happened. Resident was observed on the floor near door. Residents head was bleeding no other injury noted. Open area to back of head cleansed with normal saline solution and pressure dressing applied. Resident was able to stand and was assisted by writer and CNA back to bed. Head to toe assessment and neuro checks completed. site was cleaned and dressing was applied. MD/NP, ADON made aware." Reviewed R1's Medication Administration Record for June 2022: Levetiracetam (Keppra) ordered to be given twice a day every day. Keppra not administered on 6/16/2022 and 6/26/2022. Reviewed R1's Medication Administration Record for July 2022: Levetiracetam (Keppra) ordered to be given twice a day every day. Keppra not administered on 7/03/2022, 7/04/2022, 7/6/2022, 7/7/2022, and 7/11/2022. R1's hospital record after fall (7/18/2022) documents in part: In the floor R1 evaluated with EEG and Keppra levels were found to be therapeutic. R2's July Medication Administration Record documents in part: Keppra not administered on 7/4/2022, 7/7/2022, 7/11/2022, 7/17/2022, 7/18/2022. Nifedipine ER tablet not administered on 7/4/2022, 7/7/2022, 7/11/2022, 7/17/2022, 7/18/2022. R1's care plan documents in part: Medication levels as ordered by MD. Administer medications as directed and follow pharmaceutical recommendations. Ambulatory: I'm non-ambulatory. I require extensive assistance and 1 person support for Locomotion on unit with wheelchair.	S9999		

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S9999	Continued From page 7 Facility's Medication Administration Policy documents in part: Purpose: to ensure that resident medications are administered in a timely manner and documentation is completed to substantiate administration. Licensed professional nurses administer medications according to times documented on Medication Administration Record. Medication administration pass may begin sixty minutes before the scheduled times of administration but may not exceed sixty minutes after the scheduled time of administration. Medication Administration Record will be signed for each medication administered to the resident. The reason for not administering the medication will be documented on the back of the Medication Administration Record. (A)	S9999		