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
	IL6010110	A. BUILDING: _____ B. WING _____	C 04/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKELEY NURSING & REHAB CENTER	6909 WEST NORTH AVENUE OAK PARK, IL 60302

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S 000	Initial Comments Complaint Investigation: 2192500/IL132723 - F684; F686 2192440/IL132632 - No Deficiency	S 000		
S9999	Final Observations Complaint Investigation 2192500/IL132723 STATEMENT OF LICENSURE VIOLATIONS 300.1610a)1) 300.1630a)2) 300.1630e) 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 in compliance with all applicable federal, State and local laws. Section 300.1630 Administration of Medication a) All medications shall be administered only by personnel who are licensed to administer medications, in accordance with their respective licensing requirements. Licensed practical nurses shall have successfully completed a	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 course in pharmacology or have at least one year's full-time supervised experience in administering medications in a health care setting if their duties include administering medications to residents. 2)Each dose administered shall be properly recorded in the clinical record by the person who administered the dose. (See Section 300.1810.) Section 300.1630 Administration of Medication e)Medication errors and drug reactions shall be immediately reported to the resident's physician, licensed prescriber if other than a physician, the consulting pharmacist and the dispensing pharmacist (if the consulting pharmacist and dispensing pharmacist are not associated with the same pharmacy). An entry shall be made in the resident's clinical record, and the error or reaction shall also be described in an incident report. These regulations were not met as evidenced by: Based on interviews and record reviews, the facility failed to administer anti-seizure medications as ordered for one (R1) of three residents reviewed for medication administration. This failure resulted in R1 sustaining multiple episodes of seizure activities and subsequent emergent transfers to the emergency room. Findings include: R1 is a 74 year old, female, originally admitted in the facility on 12/07/2007 with diagnosis of Other Generalized Epilepsy and Epileptic Syndromes, Intractable, With Status Epilepticus, per face	S9999		

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S9999	Continued From page 2 sheet. R1's POS (Physician Order Sheets) and MAR (Medication Administration Record) documented the following: 1. Depakote tablet Delayed Release (Divalproex Sodium) 500 mg (milligrams) give one tablet by mouth two times a day and Levetiracetam tablet 1000mg, give 1000 mg by mouth two times a day. Per MAR, the following dates do not contain nurses' signatures: 09/29/20 at 5PM; 10/27/20 at 5PM; 10/28/20 at 5PM; 10/31/20 at 5PM; 11/05/20 at 9AM and 11/27/20 at 5PM. Vimpat 100 mg (Lacosamide) give one tablet by mouth two times a day. Per MAR, there were no signatures indicated on 11/20/20 at 9AM; and on 11/27/20 at 5PM. Vimpat 50mg (Lacosamide) give 100 mg by mouth every 12 hours. Again, there were missing nurses' signatures on 09/29/20 at 9PM; 10/02/20 at 9PM; 10/22/20 at 9PM; 10/27/20 at 9PM; 10/28/20 at 9PM; 10/31/20 at 9PM; and 11/05/20 at 9AM. According to R1's laboratory test dated 11/10/20, her Valproic (Depakote) level was 41.3, which means low. Progress notes dated 11/28/20 documented that R1 was observed having seizures and was sent to the hospital and was admitted. She was readmitted back in the facility on 11/30/21. Hospital records dated 11/28/20 indicated that R1 was admitted for seizures. 2. Depakote 500mg. 1.5 tablets by mouth two times a day and Levetiracetam 1000mg by mouth two times a day. MAR indicated missing signatures on 12/01/20 at 9AM and 5PM; 12/04/20 at 9AM; 12/08/20 at 9AM; 12/25/20 at 5PM; 12/31/20 at 5PM; 01/05/21 at 5PM; and 02/07/21 at 5PM. Vimpat 100mg. give one tablet by mouth two	S9999		

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times a day. MAR also indicated that there were no signatures indicating that this medication was administered on 12/01/20 at 9AM and 5PM; 12/04/20 at 9AM; 12/08/20 at 9AM; 12/25/20 at 5PM; 12/30/20 at 5PM; 12/31/20 at 5PM; 01/05/21 at 5PM; and 02/07/21 at 5PM. Her (R1) laboratory results dated 12/10/20 documented that her Valproic level was 42.9 meaning low; 02/09/21 of Valproic level of 46.8 which means low and 03/09/21 of Valproic level of 40.2 which also means low. Progress notes dated 03/10/21 showed that she was sent to the hospital due to Status epilepticus. She came back in the facility on 03/18/21. Hospital records dated 03/10/21 recorded a chief complaint of R1 experiencing a witnessed seizure in the facility.

3. Further review of R1's MAR also revealed that Depakote and Levetiracetam was not signed off on the following dates: 03/20/21 at 9AM and 5PM; 03/21/21 at 9AM; 03/22/21 at 9AM; 03/24/21 at 9AM; and 03/25/21 at 5PM. There were also missing signatures on 03/20/21 at 9AM and 5PM; 03/21/21 at 9AM; 03/22/21 at 9AM; 03/24/21 at 9AM; 03/25/21 at 5PM for Vimpat medication. She was again sent to the hospital on 04/01/21 due to seizures and came back in the facility on 04/06/21. Her hospital records dated 04/01/21 indicated her final hospital diagnosis as seizure.

On 04/26/21 at 11:43 AM, V2 (Director of Nursing) was asked regarding R1 and anti seizure medications. V2 stated, "She does have a diagnosis of seizures. In order to control her seizures, she receives Keppra, Depakote and Vimpat. Her Depakote levels and Keppra levels are checked monthly. I have spoken to V4 (Physician) about her having seizures, said he (V4) would not change the dosage because he felt it was adequate. To my knowledge, she (R1)

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was getting her medications on a regular basis. Based on the MAR from September 2020 to April 2021, there were missing signatures. I can't answer why it was blank. But per policy, if it is not signed off, then it was not given. There were no issues with her medication availability, appeared given and nothing was left in the cart."

According to progress notes dated 03/19/21, 03/23/21, 03/27/21 and 03/28/21, R1's Vimpat was not available in the facility.

On 04/26/21 at 1:48PM, V5 (Licensed Practical Nurse, LPN) was interviewed regarding R1's anti seizure medications. V5 stated, "Regarding her anti seizure medications, not that I remember that I miss giving doses. Once I give the medications, I sign it off. If the medication is not available, I will document it. I usually sign off the medications once it is administered. If it is not signed off, then it was not given." V5 was the scheduled licensed staff on 03/20/21 when medications were not signed off.

On 04/26/21 at 1:37PM, V6 (LPN) was also asked regarding R1's medications. V6 stated, "On medication administration, once I administered the medications, I signed it off. If its not signed off, I usually put a code why resident did not take it."

04/26/21 at 3:33PM, V8 (LPN) was also interviewed regarding R1. V8 stated, "I don't have any issues. She always take it when I give it, then I sign the MAR. When I give it, I sign it, if I don't, I chart it in the progress notes and use codes in MAR." V8 was the scheduled licensed staff on 03/24/21.

R1's care plan on seizure disorder dated

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S9999	Continued From page 5 03/13/2019 documented: Intervention - give seizure medication as ordered by doctor. Monitor/document side effects and effectiveness. On 04/26/21 at 2:25PM, V4 (Physician) was interviewed regarding R1 and anti-seizure medications. V4 stated, "In order to prevent recurrence of seizures is making sure the resident is under the care of a neurology specialist who adjust seizure medications. Medications in controlling seizures should be taken regularly as ordered. On R1, she has significant seizures. Medications in controlling seizures is important. If a resident is not getting the medications on a regular basis, she can have seizures. It is the duty of the physician to prescribe medications. It is the duty of the nurses to give it as ordered. Nurses will have to make a follow-up with Pharmacy to make sure medications are available for resident." Facility's policy titled, "Medication Administration", revised date 04/26/21 documented in part but not limited to the following: General: All medications are administered safely and appropriately to aid residents to overcome illness, relieve symptoms and help in diagnosis. Guideline: 18. Document as each medication is prepared on the MAR. 20. Explain procedure to resident and give the medications. 32. Sign MAR after administration. (B)	S9999		