STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004592	A. BUILDING: _____ B. WING _____	04/27/2022

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HERITAGE HEALTH-HOOPESTON	423 NORTH DIXIE HIGHWAY HOOPESTON, IL 60942

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S 000	Initial Comments Annual Health Certification Survey	S 000		
S9999	Final Observations 1 of 2 Statement of Licensure Violations 300.1210b) 300.1210c) 300.1210d)6 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 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: 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 that each resident receives adequate supervision and assistance to prevent accidents. These Requirements were NOT MET as evidenced by: Based on observation, interview, and record review the facility failed to thoroughly investigate falls to identify the root cause and develop appropriate interventions, and failed to implement post fall interventions for six (R2, R9, R29, R41, R52, R56) of seven residents reviewed for accidents in the sample list of 35. The facility failed to implement safety interventions following seizures resulting in falls, this failure resulted in R56 falling and sustaining a left elbow laceration that required sutures. Findings include: 1.) On 4/25/22 at 12:00PM R56 was sitting in a wheelchair in the hallway, dropped R56's drink on the floor, and fell forward. Staff was called for assistance. R56 was unresponsive and having a seizure: R56's arms and legs were spastic and shaking, R56 was drooling and made a gurgling sounds, and R56's eyes were rolled back. Staff transported R56 into R56's room. On 4/25/22 at 2:50 PM R56 stated R56 has a history of falling out of R56's wheelchair due to seizures, resulting in R56 being treated at the hospital. R56 was asked what the facility has done to keep R56 safe from injury during the seizures. R56 stated "I'm just on heavy medications." R56's Minimum Data Set (MDS) dated 3/29/22 documents R56 is cognitively intact. R56's Care Plan dated 9/1/20 documents R56 has a seizure disorder and includes an	S9999		

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S9999	Continued From page 2 intervention dated 2/15/22 to "continue to try and provide a safe environment and prevent injuries during seizure activity." R56's Care Plan dated 4/5/22 documents R56 is at risk for falls due to R56's seizure disorder, and includes an intervention dated 3/7/21 to encourage R56 to notify staff when R56 feels a seizure coming on so that staff can potentially be with R56 and provide a safe area. R56's Nursing Notes document the following: On 4/26/2021 at 8:00 AM R56 had a seizure, fell forward out of R56's wheelchair, and hit R56's face on the floor. R56 had a 1 cm (centimeter) laceration to the left eyebrow, and a 3 cm soft tissue injury to the right forearm. R56's nose was swollen, bleeding, and bruising. R56 was sent to the emergency room for evaluation. On 4/28/2021 at 1:03 PM the IDT (Interdisciplinary Team) discussed R56's fall. R56's fall was discussed with R56. R56 said R56 felt the seizure coming on, but couldn't reach the call light in time to call for staff assistance. R56 was told it is ok to yell for help in an emergency situation. The root cause of R56's fall was the seizure, interventions continue per R56's plan of care, and provide safety during seizures. On 8/10/21 at 6:20 AM R56 was in R56's wheelchair, fell to the floor, and began to seize. R56 seized for 45 seconds to 1 minute. R56 had blood noted to both nostrils, an abrasion to the knee, and a 1 inch skin tear to the left elbow. R56 was sent to the emergency room and received two sutures to the left elbow. On 8/12/21 the IDT reviewed R56's fall and post fall interventions were to try and keep R56 safe and prevent injuries during seizures. On 2/14/22 at 7:05 AM R56 was found on the floor of R56's room, hallway under R56's bed. R56 had a seizure and fell out of R56's wheelchair. On 2/15/22 the IDT reviewed R56's fall. The root	S9999		

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cause of the fall was that R56 had a seizure while in the wheelchair. The interventions were to obtain Keppra level and Basic Metabolic Profile, and continue to try and provide a safe environment and prevent injury during seizures. There is no documentation that safety interventions were developed and implemented following R56's falls on 4/28/21, 8/10/21, and 2/14/22.

R56's Hospital Summary dated 8/10/21 documents R56's Encounter Diagnoses were seizure and left elbow laceration, and to remove R56's left elbow sutures in 10 days.

On 4/25/22 at 1:26 PM V4 Registered Nurse (RN) stated: R56 has a history of seizures. We monitor R56's Keppra levels and adjust R56's seizure medications. We count on the medication to keep R56 safe. V4 confirmed no other safety interventions or seizure precautions are used. On 4/27/22 at 11:50 AM V4 stated: V4 was working when R56 fell in August 2021. R56 had a seizure and fell forward out of R56's wheelchair onto the floor. R56 was bleeding from the nose and had "skinned up" R56's elbow. R56 was sent to the hospital and received two stitches to the left elbow.

On 4/27/22 at 10:31 AM V2 Director of Nursing (DON) stated R56's seizure and fall interventions are that R56 takes Keppra for seizures, and R56's Keppra level is monitored. V2 stated R56 has been instructed to alert staff if R56 feels a seizure coming on, and we try to have a safe area when R56 is seizing. V2 confirmed no safety interventions were developed/implemented after R56's seizures and falls.

2.) R9's MDS dated 1/24/22 documents: R9 has a

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Brief Interview for Mental Status score of 12, indicating R9 is at the higher range for moderate cognitive impairment. R9 requires extensive assistance of one staff person for transfers and toileting, and R9 is frequently incontinent of bowel and bladder.

R9's Fall Investigation dated 3/21/22 documents: R9 was found on the bathroom floor at 2:50 PM. R9 was last observed at 2:20 PM sleeping, and "N/A" (Not Applicable) is listed as the last time R9 was toileted. "Residents (R9) is alert with confusion. (R9) does not recognize (R9's) limitations. (R9) needs one assist for transfers and ambulation. Root Cause: Resident (R9) took self to the bathroom and lost balance and fell. Intervention: Alarm placed on bathroom door to alert staff to attempts at self transferring/toileting."

R9's Care Plan dated 1/19/22 documents R9 is at risk for falls, and includes an intervention dated 3/22/22 for an alarm on the bathroom door to alert staff that R9 is attempting to self toilet. R9's Care Plan dated 1/26/22 documents R9 is incontinent of bowel and bladder, R9 wears incontinence briefs, and includes an intervention dated 1/26/22 to change R9's brief every shift and as needed. There is no documentation to assist R9 with toileting regularly.

On 4/25/22 at 3:01 PM R9 stated staff had disconnected R9's bathroom alarm this morning when R9 was given a shower, and the staff must have forgot to turn the alarm back on. At this time R9's bathroom door was opened. There was an alarming device at the top of the door with a switch in the off position, and the alarm did not sound. R9's bathroom contained a shower. On 4/25/22 at 4:49 PM R9's bathroom door alarm was not turned on, and the alarm did not sound

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when the door was opened. On 4/26/22 at 8:10 AM R9 stated the staff never turned the bathroom alarm back on last night. R9's bathroom alarm switch was in the off position, and the alarm did not sound when the door was opened.

On 4/26/22 at 10:50 AM V7 MDS Coordinator was in R9's room. V7 confirmed R9's bathroom door alarm was not turned on.

On 4/27/22 at 1:15 PM V2 DON confirmed R9's fall investigation for the 3/21/22 fall does not document the last time R9 was toileted prior to the fall. V2 stated: R9 does require assistance with transfers and toileting, but R9 tries to self toilet and transfer at times. R9's post fall intervention was to use the bathroom door alarm.

3.) R41's MDS dated 3/9/22 documents R41 is cognitively intact, and requires extensive assistance of two staff for transfers and walking in R41's room.

R41's Care Plan documents R41 is at risk for falls and has impaired balance. R41's Care Plan includes interventions to encourage R41 to have R41's feet elevated in the recliner, staff to check on R41 hourly and offer toileting, and to place the wheelchair in front of R41 when sitting in the recliner.

R41's Fall Investigations document the following: On 3/2/22 at 9:30 PM R41 was found on the floor near R41's recliner. R41 said R41 was sleeping prior to the fall and did not know how R41 ended up on the floor. R41 had a bump to the ride side of the head with a gash 1.5 cm in length. R41 had a 5.5 cm by 2.5 cm skin tear. The intervention was to place the wheelchair directly in front of R41 when sitting in the recliner. On 3/4/22 at 8:15

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AM R41 was found on the floor in between two recliners in R41's room. R41's right forearm skin tear reopened. R42 told staff that R41 was sleeping in the recliner and fell onto the floor. The intervention was to encourage R41 to elevate R41's feet when sitting in the recliner. There is no documentation that R41's wheelchair was in front of R41's recliner prior to the fall. On 3/4/22 at 2:15 PM R4 fell and had a laceration to the right ear. R41 was sleeping in the recliner and fell. There is no documentation that R41's wheelchair was positioned in front of R41 at the time of the fall. On 4/12/22 at 1:00 AM staff responded to R41's call light and found R41 sitting on the floor in front of R41's recliner. R41 often refuses to elevate R41's legs in the recliner. The fall intervention was staff were educated if R41 refuses to have R41's feet elevated when in the recliner, place the wheelchair directly in front of R41. The root cause of R41's falls is that R41 was sleeping and fell from the recliner.

On 4/25/22 at 10:12 AM R41 was asleep in the recliner and R41's feet were not elevated. R41's wheeled walker was positioned in front of the recliner. On 4/26/22 at 1:42 PM R41 was asleep in the recliner and leaning to the left. R41's left arm was draped over the arm rest, and R41's feet were not elevated. R41's wheelchair was in the hall way, and R41's wheeled walker was not positioned in front of the recliner. On 4/27/22 at 8:21 AM R41 was asleep in recliner, and R41's feet were not elevated. R41's wheelchair was in the hallway, and R41's wheeled walker was near the bathroom door. R42 (R41's Spouse) stated: R41 prefers to sleep in the recliner. R41 has slid to the floor and fell forward out of the recliner.

4/26/22 at 1:44 PM V13 Certified Nursing Assistant (CNA) stated R41 refuses to elevate

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S9999	Continued From page 7 R41's legs while sitting in the recliner. V13 was asked what is done if R41 refuses to elevate R41's legs, and V13 replied "nothing." On 4/27/22 at 1:15 PM V2 DON reviewed R41's fall investigations and confirmed R41's fall intervention for fall on 3/2/22 was to place the wheelchair in front of R41's recliner. V2 confirmed the wheelchair was not positioned in front of R41's recliner during R41's falls on 3/4/22 and 4/12/22. V2 stated: Staff were educated to position the wheelchair in front of R41's recliner after the fall on 4/12/22. R41's falls usually occur while R41 is sleeping in the recliner, and R41 refuses to elevate R41's legs. 4.) R52's Physician Orders dated 4/27/22 documents diagnoses including Dementia without Behavioral Disturbance, Urinary Incontinence, Chronic Obstructive Pulmonary Disease, Osteoporosis and Malnutrition. R52's Minimum Data Set (MDS) dated 1/4/22 documents R52 has moderately impaired cognition and requires extensive assistance of two staff for transfers and toileting and R52 does not walk. This MDS documents R52's balance during transitions is not steady and only able to stabilize with staff assistance with moving from a seated to a standing position, getting on and off the toilet and surface to surface transfers. R52's Care Plan dated 8/18/21 documents, "Place alarm on bathroom door and make sure it is on when door is closed so that if I (R52) attempt to take myself (R52) to the bathroom the alarm will sound." R52's Fall Investigation dated 2/23/22 documents R52 was observed on R52's bottom in the bathroom next to the locked wheelchair. R52	S9999		

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received scratches on R52's back. No bleeding, bruising or swelling. The root cause documented for this fall is documented as, "(R52) transferred self to toilet and lost balance while wiping." The intervention documented for this fall is, "alarm on bathroom door changed out for louder alarm, education provided to staff to ensure it is activated at all times."

On 4/27/22 at 11:40 AM, V2 Director of Nursing confirmed R52's bathroom alarm is suppose to be on, and confirmed that for R52's fall on 2/23/22 the bathroom alarm was not on and did not sound. V2 stated that staff should have been checking to make sure the bathroom alarm was on during rounds.

5.) R2's Physician Orders dated 4/27/22 documents diagnoses including Anemia, Hypertension, Rheumatoid Arthritis, Unspecified Dizziness and Giddiness, Atrial Fibrillation and Dementia with Behavioral Disturbance.

R2's MDS dated 1/11/22 documents R2 has moderately impaired cognition and requires one person assistance to transfer and use the toilet. R2's balance during transitions documents R2 is unsteady and only able to stabilize with staff assistance with walking and turning around.

R2's Care Plan dated 6/7/21 documents R2 is at risk for falls due to weakness and lack of safety awareness due to Dementia. This Care Plan documents an intervention dated 6/7/21 and revised on 12/2/21 for an alarm placed on the bathroom door to alert staff of resident trying to take self to the bathroom.

On 4/26/22 at 11:10 AM, R2 was lying in bed and the bathroom alarm is turned off and the

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S9999	Continued From page 9 bathroom door is closed. On 4/27/22 at 7:49 AM, R2 was lying in R2's bed and the bathroom alarm is missing the cover to it exposing the batteries and the alarm is turned off. On 4/27/22 at 10:53 AM, V12 Certified Nursing Assistant confirmed R2's bathroom alarm was off and stated that V12 must have forgotten to turn it back on after R2's shower. On 4/27/22 at 11:40 AM, V2 confirmed R2's bathroom alarm is suppose to be turned on. 6. R29's Progress Notes dated 4/27/22 includes the following diagnoses: Dementia, Muscle Wasting and Atrophy, Difficulty Walking, Right Wrist Fracture, and Osteoporosis. R29's Minimum Data Set (MDS) dated 2/22/22 document R29 is independent with Activities of Daily Living. R29's Care Plan includes the following: "(R29) is at risk for falls related to weakness and confusion. (R29) had a recent fall that resulted in a bruise on right side of forehead, scalp laceration, right wrist Skin Tear, and Right wrist fracture. Date Initiated: 08/06/2021 Revision on: 03/31/2022. (R29) will resume usual activities without incident through the next review date Date Initiated: 08/06/2021 Revision on: 02/23/2022 Target Date: 05/30/2022 Assist (R29) to keep non-skid footwear on at all times while up Date Initiated: 08/06/2021 Education provided to allow staff to care for other Residents instead of attempting to provide assistance/care for her friends. Date Initiated: 03/18/2022 (R29) was educated that if she drops something to ask staff to pick it up Date Initiated: 02/21/2022 Make sure call light is always within reach Date Initiated:	S9999		

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S9999	Continued From page 10 08/06/2021. Please do not place bed all the way to the floor, as resident is independent it needs to be at proper height so that she can get to a standing position easily. Date Initiated: 02/15/2022 educate to use call light and ask for assistance. Staff is able to assist with adjusting bed to residents liking and safety. Date Initiated: 02/22/2022." R29's Progress Note dated 2/15/22 at 1:05AM documents "(R29) found on the floor in the middle of the hallway in front of her room. Resident stated she was doing her hair and fell out of bed onto her head. During neurological assessment resident stated she was seeing double and was lightheaded. 911 was called. They departed facility at 12:43AM. Resident is documented as returning to facility without injury later 2/15/22. Facility's Full Occurrence Report dated 2/15/22 does not identify a root cause for R29's fall. R29's Progress Note dated 2/16/22 at 3:10PM documents "(R29) in dining room for activities with Power of Attorney (POA). Reported that resident dropped tissue box under the table and bent over to pick it back up. Upon rising, resident lost balance and landed on buttocks. Resident's POA helped resident backup and into dining chair. Facility's Full Occurrence Report dated 2/16/22 at 3:10PM documents root cause as "Bending over caused (R29's) balance to be off." Underlying causes for loss of balance were not assessed. R29's Progress Note dated 3/16/22 at 5:35PM documents "(R29) observed on floor of (other resident's room). States she tripped on wheelchair leg and lost balance and fell. States she landed on her right buttocks. Denies injury or pain. Laying on back with head on pillow. Full	S9999		

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S9999	Continued From page 11 Range of Motion to all extremities without difficulty. No redness or bruising to right buttock. Stood up with assist x 2 (staff members). Able to bear weight without difficulty. Taken back to room and resting in chair. Alert,oriented as before with occasional confusion. POA and physician notified. No new orders received. VS:98.1 91 16 144/72 with O2 sat 98%." Facility's Full Occurrence Report dated 2/16/22 does not identify a root cause for R29's fall. R29's Progress Note dated 3/30/22 at 1:35PM documents "resident heard yelling for help in hallway. Resident found in hallway lying on right side on floor. Upon observation, laceration noted on right side of forehead, skin tear noted on right wrist". R29's Progress Note dated 3/30/22 at 4:40PM documents "(R29) returned to the facility from Emergency Room at 4:20PM. Right wrist is fractured." Facility's Full Occurrence Report dated 3/30/22 at 1:40PM documents root cause as (R29) "did not pick her foot up causing a stumble." Underlying causes for loss of balance or unsteady gait were not assessed. On 3/27/22 at 3:00PM V2, Director of Nursing stated that "the root cause analysis needs to include underlying causes of falls not just circumstances surrounding falls" and that a complete fall investigation requires a complete root cause analysis. The facility's policy Fall Assessment and Management revised April 2019 states "Interventions will be based on the fall risk assessment,and the circumstances surrounding the risk for injury or actual injury or fall. Some examples may be: Fall related to gait or balance deficit, Falls related to confusion, Falls related to positioning problems, Falls related to toileting	S9999		

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(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
S9999	Continued From page 12 needs, Falls related to syncopal episodes, Falls related to environmental hazards, Falls related to sensory/perceptual problems, Falls related to poor judgement or knowledge deficit." (B) 2 of 2 Licensure Findings 300.610a) 300.1210b) 300.1210d)1)2 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 resident to meet the total nursing and personal	S9999		

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	IL6004592	A. BUILDING: _____ B. WING _____	04/27/2022

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S9999	Continued From page 13 care needs of the resident. 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. These Requirements were NOT MET as evidenced by: Based on observation, interview, and record review the facility failed to administer seizure medications as ordered for one (R56) of seven residents reviewed for accidents in the sample list of 35. This failure resulted in R56 having a seizure that resulted in a fall with an elbow laceration that required sutures. Findings include: 1.) On 4/25/22 at 12:00 PM R56 was sitting in a wheelchair in the hallway, dropped R56's drink on the floor, and fell forward. Staff was called for assistance. R56 was unresponsive and was having a seizure: R56's arms and legs were spastic and shaking, R56 was drooling and made a gurgling sounds, R56's eyes were rolled back. Staff transported R56 into R56's room. On 4/25/22 at 2:50 PM R56 stated R56 has a history of falling out of R56's wheelchair due to seizures, resulting in R56 being treated at the hospital. R56 was asked what the facility has done to keep R56 safe from injury during the seizures. R56 stated	S9999		

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S9999	Continued From page 14 "I'm just on heavy medications." R56's Care Plan dated 9/1/20 documents R56 has a seizure disorder and includes an intervention to administer seizure medications as ordered. R56's August 2021 Order Summary Report documents an order initiated on 1/20/21 to administer Keppra (seizure medication) 750 mg (milligrams) one tablet twice daily for a diagnosis of epileptic seizures. R56's August 2021 Medication Administration Record (MAR) does not document that R56's Keppra was administered on 8/8 and 8/9/22, and documents to refer to the progress notes. R56's Progress Notes document the following: On 8/8/21 at 8:17 AM R56's Keppra was "on order." On 8/8/21 at 7:09 PM R56's Keppra entry documents "Medication ordered; awaiting pharmacy." On 8/9/21 at 8:33 AM R56's Keppra was unavailable. On 8/9/21 at 9:20 PM R56's Keppra entry documents "awaiting pharmacy." There is no documentation of any follow up with the pharmacy or that V15 Physician was notified of R56's missed doses of Keppra. R56's nurses notes document: On 8/10/21 at 6:20 AM R56 was in R56's wheelchair, fell to the floor, and had a seizure. R56 seized for 45 seconds to 1 minute. R56 had blood noted to both nostrils, an abrasion to the knee, and a 1 inch skin tear to the left elbow. R56 was sent to the emergency room and received two sutures to the left elbow. On 8/12/21 the IDT reviewed R56's fall and post fall interventions were to try and keep R56 safe and prevent injuries during seizures. R56's Hospital Summary dated 8/10/21	S9999		

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S9999	Continued From page 15 documents R56's Encounter Diagnoses were seizure and left elbow laceration, and to remove R56's left elbow sutures in 10 days. On 4/25/22 at 1:26 PM V4 Registered Nurse (RN) stated: R56 has a history of seizures. We monitor R56's Keppra levels and adjust R56's seizure medications. We count on the medication to keep R56 safe. On 4/27/22 at 11:50 AM V4 stated: V4 was working when R56 fell in August 2021. R56 had a seizure and fell forward out of R56's wheelchair onto the floor. R56 was bleeding from the nose and had "skinned up" R56's elbow. R56 was sent to the hospital and received two stitches to the left elbow. We were out of R56's Keppra. 8/9/22 was a Sunday, and we don't receive pharmacy deliveries on Sunday. We were waiting for pharmacy to deliver the medication. If a medication is unavailable we should notify the physician and document in the progress notes. On 4/27/22 at 12:00 PM V2 Director of Nursing stated V2 was not aware that R56 missed doses of Keppra in August 2021, and there was no medication error report completed. V2 stated we are to notify pharmacy and have the backup pharmacy deliver medications when they are unavailable. V2 stated the physician should be notified if the medication is not obtained and doses are missed. V2 stated Keppra is not in our convenience box of medications. V2 confirmed R56's nursing notes document Keppra was not available and was awaiting pharmacy deliver on 8/8 and 8/9/21, and there is no documentation that V15 Physician was notified of the missed doses. On 4/27/22 at 12:23 PM V16 Pharmacist stated: The half life of Keppra is 6-8 hours for instant release. R56 is on instant release Keppra. If	S9999		

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S9999	Continued From page 16 Keppra doses are missed for 48 hours, V16 would be concerned about the patient having seizures and putting the patient at risk. The facility notified the pharmacy on 8/5/21 to request a refill of the Keppra. We told the facility that we still had R56 discharged to the hospital in our system and would need updated orders in order to refill the medication. We did not receive R56's orders until 8/9/21. The last fill of the Keppra was on 6/30/22, so that would have put R56 out of the medication roughly around 7/30/21. Usually the facility would let us know when they are out of a medication so that we can notify the backup pharmacy to have the medication delivered. V16 did not see any other documentation of communication from the facility regarding R56's Keppra during 8/5-8/9/21. On 4/27/22 at 1:51 PM V15 Physician stated: V15 was unsure if the facility had notified V15 of R56's missed doses of Keppra in August 2021. The facility should have had the backup pharmacy send the medication. The missed doses would be contributory to R56's seizure. Seizures can result in a fall, and depending on the type of seizure and if it affects the brain stem could result in death. V15 was unsure of the type of seizures that R56 has. The facility's Medication Administration policy dated 1/11/2010 documents: "It is the policy of this facility to accurately administer medication following physician's orders." Missed doses of medications may occur, and the facility will contact the back up pharmacy or resident family for provision to the facility. Medication errors should be reported to the physician. (B)	S9999		

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