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
	IL6006837	A. BUILDING: ______ B. WING ______	C 12/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENERATIONS OAKTON PAVILLION	1660 OAKTON PLACE DES PLAINES, IL 60018

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S 000	Initial Comments Complaint Investigation: 2299661/IL154016 Investigation of Facility Reported Incident of October 17, 2022/IL152746	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210d)1)2) 300.1630d) 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 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.	S9999	**Attachment A** Statement of Licensure Violations	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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2) All treatments and procedures shall be administered as ordered by the physician.

Section 300.1630 Administration of Medication
d) If, for any reason, a licensed prescriber's medication order cannot be followed, the licensed prescriber shall be notified as soon as is reasonable, depending upon the situation, and a notation made in the resident's record.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, and record review facility failed to provide emergency diagnostic services and failed to follow up and relay emergency diagnostic services' results to medical practitioner. The facility also failed to administer three out of four seizure medications for two (R3, R4) out of two residents reviewed for quality of care in the sample of 11. These deficiencies resulted in R3's delayed treatment of right hip fracture with subsequent right hip surgery and R4's hospitalization due to multiple seizures.

Findings include:

1. R4 admitted to facility 12/02/2022 and has past medical history not limited to: Epilepsy, Metabolic Encephalopathy, Other specified postprocedural s/p craniotomy, Cerebral Ischemia, Other cervical disc degeneration (unspecified cervical region), Presence of cerebrospinal fluid drainage device s/p shunt, and Spinal stenosis (cervical region). Reviewed R4's "facility transfer/discharge summary" that showed on 12/04/2022, R4 was transferred to the emergency room as a result of having "multiple

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seizures" while at facility. No care plan found in R4's electronic medical record.

Progress Note dated 12/04/2022 04:32 PM showed facility called hospital for follow up. Nurse stated that resident has been admitted with diagnosis of seizure.
Progress Note dated 12/04/2022 04:30 AM showed, "Pt began seizing @0345, lasted for 1.5 minutes. After seizure pt (patient) eyes open to stimulus but was not responding as usual. VS BP 129/84 P 134 RR 20 O2 93% BS 150. Pt began seizing again 2 minutes apart for 2.5 minutes. Called primary physician regarding findings and was advised to send pt to local emergency per nurse practitioner order. Pt was sent via fire department @0400. DON (Director of Nurses) notified. Nurse Practitioner aware. Emergency contact notified; SMS VM left with call back number and extension. Gave report to [nurse] in ER".

Reviewed R4's active physician orders from 12/02/2022-12/04/2022 (upon discharge) that showed orders for the following anti-seizure medications: clobazam (Schedule IV) 10 mg tablet via gastric tube twice a day 09:00 AM, 04:30 PM; levetiracetam solution 100 mg/mL amt:20mL via gastric tube every 12 hours 09:00 AM, 09:00 PM; phenytoin suspension 125 mg/5 mL amt:10mL via gastric tube twice a day 06:00 AM, 06:00 PM; Vimpat (lacosamide) (Schedule V) 200 mg tablet via gastric tube every 12 hours 09:00 AM, 09:00 PM.

Reviewed R4's medication administration record from 12/01/2022-12/20/2022 that showed R4 was not administered 3 of 4 scheduled seizure medications while at the facility as follows:
R4 was not administered clobazam (Schedule IV)

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S9999	Continued From page 3 10 mg tablet at 04:30 PM on 12/02/2022 and at 09:00 AM and 04:30 PM on 12/03/2022. Total of 3 missed medication administrations. R4 was not administered phenytoin suspension 125 mg/5 mL (10mL) at 04:30 PM on 12/02/2022. Total of 1 missed medication administration. R4 was not administered Vimpat (lacosamide Schedule V) 200 mg tablet at 09:00 PM on 12/02/2022, at 09:00 AM and 09:00 PM on 12/03/2022. Total of 3 missed medication administrations. R4's medication administration record from 12/01/2022-12/20/2022 also showed that R4 was not administered warfarin 6mg (anticoagulant) at 04:00 PM on 12/02/2022. Documented reasons all showed "not administered: drug/item not available". On 12/20/2022 at 2:44 PM, V2 (Director of Nursing) said her expectations regarding medication administration is for nurses to administer medications as prescribed within the 1-hour window before and after its scheduled time. V2 then said if a medication is unavailable, nurses should check in the facility's automated medication dispensing system first to see if medication is available for administration, then call the pharmacy to inquire why medication is not available and can do a stat (emergency) order. When asked if a resident's physician should be contacted, V2 said she was unsure of their policy on how many missed doses warrant contacting the physician. V2 also said nurses should document the missed medication and any correspondence with pharmacy and the resident's physician within their medical record. At 2:48 PM, V2 said the facility has several consistent agency staff who are coming in to help fill staffing holes. When asked what the process is when an agency nurse comes into facility, V2 said they receive a	S9999		

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brief one-time orientation.

Requested facility policy for contract staff, none provided during course of investigation. Requested facility policy for missed medication administration, none provided during course of investigation. Requested list of medications stored within the facility's automated medication dispensing system. None provided during course of investigation.

Reviewed facility's medication administration policy last reviewed 05/17 that showed:
Objective: To document the administration and ordering of those medications deemed necessary by the physician to improve and/or stabilize specified diagnosis of the resident.
Procedure: All Medications must be administered to the resident in the manner and method prescribed by the physician. In the event that a medication cannot be given, the reason must be documented in the Nurses Medication Notes on the MAR or Progress Notes. Documentation of meds given will be done in a consistent manner by the nurse placing their initials in the appropriate space on the MAR.

2. R3 was admitted to the facility on 08/12/2022 with diagnosis including but not limited to bipolar disorder, History of Falls, Scoliosis, Personal history of transient ischemic attack (TIA) and cerebral infarction without residual deficits, Age-related osteoporosis without current pathological fracture, Unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety.

According to MDS (Minimum Data Set) dated

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09/30/2022 under Section C, R3 has a BIMS (Brief Interview of Mental Status) score of 6 indicating severely impaired cognitive functioning.

On 12/19/2022 at 11:23 AM the surveyor observed R3 sitting in the wheelchair in the common area, participating in the activities at this time.

On 12/19/2022 at 11:23 AM the surveyor asked R3 about her fall incident on 10/17/2022, R3 stated, "Where did it happen?" Surveyor clarified that R3 suffered a fall at the facility where she currently resides. R3 stated, "Oh yes, I think I fell and hurt my hip but it's all better now. Not sure how it happened. I don't remember what happened after that". Surveyor unable to interview R3 due to R3's severe confusion.

Per record review, incident report with occurrence date of 10/17/2022, reads in part, "At approximately 5:00 PM on October 17th, 2022, nurse (V10 Licensed Practical Nurse) was notified by Certified Nursing Assistant that R3 had fallen in her room. R3 complained of mild pain to the right hip. Medical doctor notified with order for stat x-ray of right hip and pelvis. At approximately 11:40 AM on October 18th, 2022, x-ray results of right hip and pelvis received and revealed a fracture of the right femoral neck. V14 (Nurse Practitioner) made aware with order to send to hospital's emergency department for further evaluation and treatment".

Per record review, progress note dated 10/17/2022 at 9:58 PM written by V10 (Licensed Practical Nurse) reads in part, "[V10 (LPN)] was informed by the duty Certified Nursing Assistant that R3 is sitting on the floor near the edge of the bed. [V10] Conducted physical assessment, R3

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S9999	Continued From page 6 [displayed] little discomfort to her right hip. Primary doctor was informed and ordered right hip x-ray; order was carried out". Per record review, radiology order dated 10/17/2022 at 9:13 AM reads in part, "Order description: Rt Hip, STAT - Immediately". Per record review, outpatient medical diagnostic service company radiologic order dated 10/17/2022, reads in part, "Study description: R-hip with Pelvis; reported date and time: 10/18/2022 12:06 AM; Impression right hip: impacted transcervical fracture of the right femoral neck with varus deformity". Per record review, ambulance report dated 10/18/2022 reads in part, "Ambulance at scene 10/18/2022 at 1:37 PM. Emergency medical crew assessed vital signs at this time which revealed several emergent findings". Per record review, surveyor noted ambulance arrived approximately 20 hours after R3 suffered fracture to the right hip. Per record review, hospital record dated 10/19/2022 at 7:50 AM, reads in part, "R3 presented to emergency department after fall. Diagnosed with right hip fracture and urosepsis. Patient has right hip pain". Per record review, operative note dated 10/20/2022 reads in part, "R3's pre-op diagnosis: right hip fracture; Procedure: Hemiarthroplasty Right Hip; Findings: Displaced comminuted femoral neck fracture". Per record review, surveyor noted that R3's right femoral fracture went from an impacted fracture	S9999		

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to a displaced fracture between 10/17/2022 and 10/20/2022.

On 12/19/2022 at 2:23 PM the surveyor interviewed V2 (DON). V2 (DON) stated, "Stat order should be carried out within 4-6 hours from the time when it was received. Outpatient diagnostic services company provides all of our x-ray needs, including regular and stat. When a nurse becomes aware that stat x-ray is needed, he or she should put the order into electronic health record system and call the outpatient diagnostic services company to make sure they received the order. Outpatient diagnostic services company should come withing 2 hours from the time when they receive our stat order".

On 12/19/2022 at 3:33 PM the surveyor interviewed V10 (Licensed Practical Nurse/LPN). V10 (LPN) was a nurse on duty upon R3's fall. V10 (LPN) stated, "R3 suffered a fall on 10/17/2022 around 5:00 PM. Once the fall was reported to me, I performed an assessment and R3 expressed that she has some pain in the right hip area. I called the doctor and suggested that we should do a stat x-ray. I proceeded to put the order into electronic health record system for stat right hip x-ray and called outpatient diagnostic services company to ensure that they received the order. I didn't see them before end of my shift at 11:00 PM".

Per record review, progress note dated 10/18/2022 at 12:02 AM written by V10 (LPN) reads in part, "R3 was x-ray on her right hip, waiting for results".

Discrepancy in V10's (LPN) interview and progress note noted.

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S9999	Continued From page 8 On 12/20/2022 at 10:00 AM the surveyor interviewed V11 (LPN). V11 stated, "I worked night shift from 10/17/2022 to 10/18/2022 from 11:00 PM to 7:00 AM. I don't remember seeing outpatient diagnostic services company come out on my shift. I knew that the resident suffered a fall in the afternoon of 10/17/2022 and was waiting for an x-ray. I called around 4:00 AM on 10/18/2022 to follow up with outpatient diagnostic service company and they said that they will send somebody out; however, I didn't see anyone before the end of my shift at 7:00 AM. I did not chart that I made a follow up call". Per record review, progress note dated 10/18/2022 at 11:40 AM written by V16 (LPN) reads in part, "[R3's right lower extremity] shortened and externally rotated". Per V2 (DON), V16 (LPN) did not answer the phone and V2 feels that she should not provide contact number to surveyor without V16's approval. Unable to interview V16 (LPN). On 12/20/2022 at 12:11 PM the surveyor interviewed V14 (Nurse Practitioner). V14 (NP) stated, "I found out about R3's fall on 10/18/2022 around 9:30 AM during team's morning meeting. I went up and checked on R3. R3 didn't complain of any major discomfort, only mild pain to her right hip that was treated with in-house pain medication. There were no x-ray results available at that time. I spoke to V16 (Licensed Practical Nurse) around 11:00 AM, and we called outpatient medical services company; we received results over the phone, and they also faxed them to the facility around that time". The surveyor asked if delay in receiving x-ray results of R3's hip could have a negative outcome on her injury. V14 (NP) stated, "R3 needed an	S9999		

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S9999	Continued From page 9 orthopedic evaluation to determine appropriate treatment. Supposedly, R3 was at a higher risk for blood clot formation due to fracture". On 12/20 2022 at 12:42 AM the surveyor interviewed V2 (DON). V2 stated, "I just spoke to outpatient medical services company that performed R'3 x-ray on the night of 10/17/2022-10/18/2022. They informed me that they faxed results on 10/18/2022 at 1:11 AM to a number that doesn't belong to our facility". Surveyor asked how did V2 (DON) find out about R3's missing hip x-ray results. V2 (DON) stated, "On 10/18/2022 at 9:30 AM, during team meeting, we realized that there was no follow up of R3's fall and that's when V14 (NP) and V16 (LPN) called outpatient medical services company to follow up on R3's hip x-ray results". Surveyor clarified what could V11 (LPN) have done to prevent delay in receiving R3's stat x-ray results. V2 (DON) stated, "V11 could have reached out to me to notify me that R3's x-ray was done but no results were reported. I could have tried to get R3's results myself. Our nurses are aware of urgency of stat results; however, I can't speak for the agency nurses". No stat order facility policy available upon request per V2 (DON). "A"	S9999		