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S 000	Initial Comments Complaint Investigation: 2458004/IL178804	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210b) 300.1210d)1)2) 300.3220f) 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 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's	S9999		

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plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.

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.

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.

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)

These Regulations are not met as evidenced by:

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Based on observation, interview, and record review the facility failed to obtain scheduled medications from the pharmacy and secure emergency medications for 1 (R1) of 5 residents reviewed for medication administration in the sample of 8. This failure resulted in R1 abruptly stopping and missing his scheduled seizure medication resulting in R1 experiencing two seizures lasting approximately four minutes each. Additionally, this failure has the potential to result in prolonged, life-threatening seizures when abruptly stopping anti-seizure medication.

Findings include:

On 10/3/24 at 1:11 PM, V9 (Case Coordinator) stated when R1 was admitted to the facility R1 had two seizures in the first week due to the facility not administering R1's seizure medication. V9 stated she had been R1's case manager for the past year while R1 was residing in a group home. V9 stated in the year prior to this investigation R1 had three seizures. V9 stated R1 had never had two seizures in the same day.

On 10/3/24 at 2:56 PM, V11 (R1's Power of Attorney) stated about two years prior to this investigation, R1 had started having more seizures. V11 stated prior to R1 being admitted to the facility R1 had been in the hospital to have a gastrostomy tube (g-tube) placed. V11 stated R1 had a seizure during the hospitalization. V11 stated R1 had been discharged from the hospital on 9/23/24 around 5:30 PM and the hospital had not sent any medications to the facility for R1. V11 stated "you would think the hospital would have sent one or two doses of the medications with (R1) to the facility."

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R1's Admission Record documented an admission date of 9/23/24 with diagnoses including dysphagia following cerebral infarction, extrapyramidal and movement disorder, and epilepsy. R1's 9/25/24 Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 3, indicating R1 was severely cognitively impaired.

R1's 9/23/24 After Visit Summary from the hospital documented in part " ... Start taking these medications ... lacosamide 10 mg/ ml solution ... Commonly known as: Vimpat ... Administer 10 ml through peg tube 2 (two) times a day ... Levetiracetam 500 mg/ 5 ml solution ... Commonly known as: Keppra ... Administer 10 ml (1,000 mg total) through tube 2 (two) times a day ... oxcarbazepine 300 mg/ 5 ml (60 mg/ ml) suspension ... Commonly known as: Trileptal ... Administer 5 ml (300 mg total) through g-tube 2 (two) times a day ..."

R1's September 2024 Order Summary Report from the facility's Electronic Medical Record documented the orders for Keppra solution 100 mg/ ml, oxcarbazepine oral suspension 300 mg/ 5 ml, and Vimpat oral solution 10 mg/ ml, as ordered on the hospital's Visit Summary, with an order date of 9/23/24.

The facility's pharmacy Packing Slip documented R1's Keppra, Vimpat, and Trileptal were shipped to the facility on 9/24/24. R1's E-Courier Delivery Status documented R1's medications were delivered to the facility on 9/25/24 at 12:18 AM.

R1's September 2024 Medication Administration Record (MAR) documented R1 did not receive the 9/23/24 8:00 PM dose and the 9/24/24 8:00 AM dose of Keppra, Trileptal, or Vimpat. R1's

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September 2024 MAR documented R1 did not receive the 9/24/24 8:00 PM dose of Trileptal. R1's September 2024 MAR documented R1 did receive the 9/24/24 8:00 PM dose of Keppra and Vimpat and were initialed as being administered by V10 (Licensed Practical Nurse/ LPN).

On 10/10/24 at 1:27 PM, V2 (Director of Nursing) stated she did not know why V10 had documented administering R1's 9/24/24 8:00 PM dose of Keppra and Vimpat when the medications were not delivered to the facility until 9/25/24 at 12:18 AM. V2 stated V10 must have documented in error.

On 10/10/24 at 10:07 AM, V10 (Licensed Practical Nurse/ LPN) stated resident medications were delivered to the facility daily from approximately 12:00 AM to 2:00 AM. V10 stated if a resident is admitted after 5:00 PM the facility would not receive the resident's medication in that night's medication delivery but the next night's medication delivery, indicating the resident would be without medication for longer than 24 hours. V10 stated she was the nurse caring for R1 on the night shift of 9/24/24 to 9/25/24. V10 stated she did not know why she documented administering R1's Keppra and Vimpat on 9/24/24 at 8:00 PM. V10 stated she did not notify R1's medical provider on 9/24/24 when the facility did not have R1's seizure medications to administer.

On 10/9/24 at 12:43 PM, V2 stated she was caring for R1 on the dayshift of 9/24/24. V2 stated on 9/24/24 she had notified R1's medical provider's office via fax of the facility not having R1's Vimpat, Trileptal, or Keppra and had contacted the pharmacy. V2 stated she was not sure if R1's medical provider had contacted the

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facility back with a substitution order or a medication hold order. The facility was not able to provide reproducible evidence or documentation that V2 had sent a fax to R1's medical provider's office or of V2 contacting the pharmacy on 9/24/24.

On 10/8/24 at 9:47 AM, V20 (Pharmacist) stated the pharmacy received orders for R1 Vimpat, Trileptal, and Keppra on 9/23/24 at 9:56 PM. V20 stated the pharmacy sent R1's Vimpat, Trileptal, and Keppra on 9/24/24 due to not having an overnight pharmacist. V20 stated there was an overnight pharmacist on call and if a facility needed medications right away that pharmacist could try to get the medications to the facility from a closer pharmacy. V20 stated if the overnight pharmacist could not get the medications to the facility that night from a closer pharmacy they would get the medication from another pharmacy the next morning. V20 stated she was not sure if anyone from the facility had called the pharmacy to let them know.

On 10/8/24 at 9:57 AM, V19 (Pharmacist in Charge) stated she did not see any documentation in her system of the facility contacting the pharmacy on 9/24/24 or ordering R1's Vimpat, Trileptal, or Keppra STAT (stat or immediately) or from a backup pharmacy on 9/24/24. V19 stated if a facility did not have a resident's medications, she would expect the facility to call the resident's medical provider to obtain an order for another medication until the resident's medication could arrive.

On 10/3/24 at 3:27 PM, V3 (Care Plan Coordinator/ Registered Nurse) stated R1's Vimpat, Trileptal, or Keppra had not been ordered STAT or from a backup pharmacy. V3 stated

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when R1 was admitted on the evening of 9/23/24 there were a lot of things going on in the facility so V3 had stayed late to put R1's medication orders into R1's Electronic Medical Record (EMR). V3 stated since it was past 8:00 PM when R1's medication orders were entered R1's September MAR would document R1's 9/23/24 Vimpat, Trileptal, and Keppra were blank.

On 10/10/24 at 10:25 AM, V4 (Physician) stated he was not made aware the facility was not administering R1's Keppra, Trileptal, or Vimpat due to the facility waiting on the medications to be delivered from the pharmacy. V4 stated R1 missing a dose of R1's seizure medication could cause R1 to have a seizure.

The Center for Disease Control (CDC) website Treatment of Epilepsy (https://www.cdc.gov/epilepsy/treatment) documented in part " ... Medicine ... Anti-seizure medicines limit the spread of seizures in the brain. It may take time to find the right medicine. Sometimes you'll need a combination of medicines. It's very important to take your medicine as prescribed ... Do not skip or stop your seizure medicine ... You should not skip or stop taking your seizure medicine without talking to your provider. Suddenly stopping your medicine might cause withdrawal symptoms, including life-threatening seizures. Taking your medicine is the most important thing you can do to prevent seizures ..."

R1's Progress Note dated 9/24/24 at 4:09 AM documented R1 had a seizure lasting approximately four minutes with R1's oxygen saturation dropping to 80%, R1 becoming febrile, and tachycardic with R1 being lethargic, clammy, pale, and short of breath after the seizure.

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R1's Progress Note dated 9/24/24 at 11:31 AM documented R1 had another seizure lasting approximately four minutes.

On 10/10/24 at 10:07 AM, V10 (LPN) stated she was the nurse caring for R1 on 9/24/24 at 4:09 AM when R1 had the first seizure. V10 stated she was completing medication pass when a Certified Nursing Assistant (CNA) alerted V10 that R1 was having a seizure. V10 stated when she entered R1's room, R1 was seizing with his eyes rolled back and his lips blue. V10 said she applied oxygen and recorded the time R1 was seizing. V10 stated R1's seizure stopped after 4 minutes. V10 stated after R1's seizure stopped R1 was slow to "come back," lethargic, and tired. V10 stated she had contacted R1's medical provider and obtained an order to send R1 to the hospital. V10 stated V11 (R1's Power of Attorney) had refused to transfer R1 to the hospital.

On 10/15/24 at 10:00 AM, V2 stated she was the nurse caring for R1 on 9/24/24 at 11:31 AM when R1 had the second seizure. V2 stated R1 had a seizure lasting four minutes. V2 stated V11 had refused to send R1 to the hospital and had instructed V2 if R1 had another seizure to send R1 to the hospital.

On 10/9/24 at 1:32 PM, V5 (LPN) was asked what the facility would have done if R1's 9/24/24 seizures would have lasted longer than five minutes and V5 responded the facility would have called 911 for emergency services but there was nothing else the facility could have done for R1 due to the facility pharmacy not allowing the facility to keep injectable Ativan, injectable Valium, or rectal Valium gel in the emergency medication stock. V5 was asked what the facility

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would have done if R1's 9/24/24 seizures would have lasted longer than five minutes and county's emergency medical services were not able to arrive to the facility in a timely manner and V5 responded she did not know. The facility's medication room was toured and V5 used the pharmacy's emergency stock medication computer to show the facility did not have any injectable Ativan, injectable Valium, or rectal Valium gel available in stock or any other medications that could aide in stopping seizures timely. V5 stated when the facility changed pharmacy companies, about a year prior to this survey, the facility no longer kept any injectable Ativan or injectable Valium in the emergency stock medication.

On 10/9/24 at 3:15 PM, V4 (Physician) stated he should be notified anytime a resident is having a seizure. V4 stated he would order the facility to call 911 for emergency services to transfer the resident to the hospital and if the seizure lasted longer than five minutes to administer intramuscular Ativan or Valium, whichever the facility had in stock in the emergency stock medication. V4 stated the facility should have injectable Ativan or Valium in the emergency stock medications and was not aware the facility did not. V4 stated there were several factors on how long a seizure had to last to cause brain damage, but it was possible brain damage could occur with a seizure lasting longer than five minutes.

On 10/10/24 at 8:53 AM, V17 (Pharmacist) stated there had been a national shortage of Ativan and Valium periodically for the past 2 years. V17 stated due to the national shortage the pharmacy had not been able to stock the facility's emergency medication stock with injectable

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Ativan or Valium. V17 stated if the facility had an order for resident specific injectable Ativan or Valium the pharmacy could obtain the medication and have it sent to the facility or find an equivalent medication to be sent to the facility. V17 was asked why the pharmacy would be able to send injectable Ativan or Valium if it was resident specific but not able to send injectable Ativan or Valium for emergency stock medication and V17 stated she was not sure. V17 stated on 9/24/24 the facility had Ativan and Valium tablets in the emergency stock medication. V17 stated the physician could have ordered the facility to crush an Ativan or Valium tablet and administered it rectally.

On 10/10/24 at 10:25 AM, V4 stated it is possible to administer an Ativan or Valium tablet rectally but V4 had never ordered it for someone having a seizure. V4 stated the onset of a rectally administered Ativan or Valium tablet would be about half an hour or approximately as long as administering the tablet orally. V4 stated the onset of the medication would take too long and emergency services would still have to be called. V4 stated the gold standard would be intravenous valium but V4 was unsure if the facility had that capability.

The facility's undated pharmacy policy titled "What to Do If a Medication is Not Available during a Med Pass" documented in part " ... 1. Review the pharmacy packing slip to verify if the medication has been delivered. You may also check the (pharmacy website portal) to review the delivery status of the medication. 2. Check all medication carts for the missing medication. Did the resident recently transfer from room/ unit? 3. Check the medication room and confirm all pharmacy deliveries have been properly checked

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in. 4. Utilize the (emergency medication stock) for availability of the medication. Remove dose for administration and administer to the resident ... 5. If the medication is not available in the (emergency medication stock), Is there an alternative medication (or dose equivalent) available to administer with a prescriber's order? 6. If the medication cannot be located and is not available in the (emergency medication stock), please notify the pharmacy or request delivery from a backup pharmacy, or request a stat delivery, and finally verify the medication will be sent on the next pharmacy delivery. 7. Notify the provider the medication will not be available for administration at the current scheduled time. Request an order to hold the medication and administer upon delivery from the pharmacy.. By following the steps above, we will avoid the need to document 'Medication not available.' This will ensure the resident receives the medication timely and avoids any further potential delay in treatment ..."

The facility's March 19, 2020 "Administering Medication" policy documented in part " ... Purpose: To ensure safe and effective administration of medication in accordance with physician orders and state/ federal regulations ... Procedure: ... 6. Medications should be administered within one (1) hour of the prescribed times ... 9. Should a drug be withheld, refused, or given other than at the scheduled time, the individual administering the medication shall chart in the Electronic Medical Record (eMAR) and sign off for that particular drug and document a rational ..."

(A)