STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005474	A. BUILDING: _____ B. WING _____	C 01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIA OF BELLEVILLE	150 NORTH 27TH STREET BELLEVILLE, IL 62226

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S 000	Initial Comments Complaint Investigation: 2540560/IL185012 2540654/IL185227	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)1) 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	S9999		

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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.

These requirements are not met as evidenced by:

Based on interview and record review the facility failed to administer a seizure medication for 1 of 8 residents (R7) reviewed for significant medication errors in the sample of 9. This failure resulted in R7 having multiple seizures, requiring hospitalization.

Findings include:

On 1/28/25 at 1:20 PM, R7 stated she didn't get her seizure medication for two days, had four seizures and was admitted to the hospital. R7 stated this happens often but she has and is getting her medication now.

R7's Face Sheet, undated, documents R1 has a diagnosis of Epilepsy.

R7's MDS (Minimum Data Set), dated 12/2/24, documents R1 has a BIMS (Brief Interview for Mental Status) score of 15, indicating R1 is cognitively intact.

R7's Care Plan, dated 9/23/19, documents R7 requires healthcare monitoring related to a

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diagnosis of a seizure disorder. She is at risk for injury due to uncontrolled seizure activity. She is at risk for aspiration of respiratory secretions or vomiting during seizure and suffocation. She receives antispasmodic medication per physician orders. Intervention is to administer medications as ordered.

R7's POS (Physicians Order Sheet) documents the following orders: 6/8/23 - Vimpat Oral Tablet 50 MG (Milligrams), Give 1 tablet by mouth two times a day for Epilepsy, Give with 200 mg to equal 250 mg two times a day.
7/19/22 - Vimpat Tablet 200 MG, Give 1 tablet by mouth two times a day related to Epilepsy.

R7's Progress Notes, document the following:
-11/18/2024 at 11:26 AM - "This writer made aware that res stated she just had small seizure in room while sitting in wheelchair. Stated it only lasted a few seconds, no falls or injuries. Vitals 105/58, 69, 97.6, 98%. NP (Nurse Practitioner), admin (Administrator), and DON made aware. Resident also stated that she had a fall last night, assessed that left middle finger is swollen. Pain level 6 PRN (as needed) Norco given. Will continue to monitor."
-1/1/2025 at 3:45 PM - "Patient was noted to have seizure activity for 30 seconds, in her wheelchair, patient came out of the seizure. Patient v/s (vital signs) was taken 122/80, 81, 98.2, 18, 98%. Patient took all her meds after the episode, resident family, DON made aware, MD was made aware of the incident. Res Keppra (seizure medication) level reordered for tomorrow. Resident in a pleasant mood and cooperative to cares."
-1/20/2025 10:45 PM - Medication Administration Note - Vimpat Oral Tablet 50 MG, Give 1 tablet by mouth two times a day for Epilepsy Give with 200

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mg to equal 250 mg two times a day, Need a script."
-1/20/2025 at 6:16 PM - "Resident noted to have a seizure lasting approximately 1 minute NP made aware new order for labs resident and family aware."
-1/21/2025 7:36 PM - "This resident had a 2 minute witnessed seizure, resident was seizing in her chair and was sliding downward this nurse caught her in time and let her seizure take its course before assisting her correctly in her seat. This resident was a bit lethargic and confused once coming out of seizure after a few minutes this nurse asked her name, birthday, and place and she answered correctly. BP 142/69, P 63, R 18, T 97.9. This res was out of Vimpat, there wasn't any in the Cubic to pull from. Script was sent over around noon and when this nurse called for an update the pharmacy stated they never received it. This nurse resent the script and they stated it would be sent out tonight and that they are unable to send it to our backup pharmacy because they would want a separate script. (On-call MD) notified, POA (Power of Attorney) called n/a (not available) at this time, & DON notified. The doctor on call was also made aware that pharmacy was called and stated that meds will be sent out tonight she stated to monitor this resident until her medications arrive. Resident is now in her bed watching TV (television) at this time. Call light is in place."
-1/21/2025 8:20 PM - "This nurse called and spoke with (on call MD) about sending a stat script for this resident's Vimpat, she stated it has been sent over to our backup pharmacy and it should cover tonight's and tomorrow morning med pass. DON and Admin notified."
-1/21/2025 at 10:46 PM - "Medication Administration Note, Vimpat Tablet 200 MG, Give 1 tablet by mouth two times a day related to

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Epilepsy, Medication not available."
-1/22/2025 6:03 PM - "This resident had a seizure that lasted 59 seconds while lying down in her bed. Resident stating, she didn't feel well and said she felt like she was going to seize, this nurse stated to her that it is best she lie down instead of sitting in chair, so she does not fall, and she agreed, moments later resident started seizing and this nurse was a witness and turned her to her side and counted it to 59 seconds. Res VS are: b/p 120/64, P 63, T 97.3, O2 97, R 20, PAIN 0. Pupils are equal and reactive, POA has been notified and stated to this nurse Thanks and that she appreciates the call. DON & ADMIN notified, & (on call MD) notified to just keep an eye out on res throughout the night. There are NNO (No new orders) at this time."
-1/22/2025 9:10 PM - "This resident started having seizures back to back, M.D. stated to send this resident out. Resident has been sent to the hospital for observation. POA, Admin and DON notified."
-1/23/2025 6:29 AM - "Resident admitted to the hospital, room 140 with a Dx (diagnosis) of Seizures."
-1/24/2025 at 2:35 PM - "Resident arrived back at facility in wheelchair, assisted by 2 (facility) employees with NNO."

R7's Medication Administration Record (MAR), dated 1/20/25, documents R7's Vimpat was not given as ordered on 1/19/25, 1/20/25, and 1/21/25.

R7's Hospital Records, dated 1/22/25, R7 was admitted to the hospital with a diagnosis of Seizures.

On 1/28/25 at 11:05 AM, V11, Family Nurse Practitioner, stated R7 not being given the Vimpat

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on 1/19/25, 1/20/25, 1/21/25, and 1/22/25, did contribute to R7 having seizures and subsequently being admitted to the hospital. V11 stated that medications are a "big issue at this facility, there is no initiative from the nurses to make sure residents have prescriptions for their medications." V11 stated it is left on the DON (Director of Nurses) and ADON (Assistant Director of Nurses) to ensure this is happening. V11 stated he will check with the DON/ADON to see if any prescriptions are needed, if so, he will take care of it, give it to the DON/ADON to send to the pharmacy. V11 stated it's also a pharmacy issue because once they have sent a copy of the prescription to them and have confirmation that it was received, the facility still has to call them to get confirmation that they received it and find out when the medication is going to be arriving at the facility. V11 stated a lot of times, pharmacy will say that they didn't receive the prescription even though the facility has fax confirmation that it was sent.

On 1/28/25 at 1:23 PM, V16, LPN (Licensed Practical Nurse), stated she sent R7 to the hospital for seizures. V16 stated R7 went for a couple of days without her Vimpat (seizure medication), and she can't go without it for one day and she has seizures. V16 stated normally they could get the medication from the emergency kit, but the Vimpat was not available. V16 stated pharmacy wouldn't send it and told the facility that they didn't receive the prescription for it, so they sent it again and finally received it.

On 1/29/25 at 6:45 AM, V1, Administrator, stated they were unable to get R7's Vimpat due to the insurance not paying for the medication until 1/24/25, so when the DON was notified, unsure of the date, that R7 was out of the medication and

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S9999	Continued From page 6 pharmacy would not send it until 1/24/25, the medication order was sent to the local pharmacy and the facility paid for it and picked it up on 1/22/25. The Medication Administration Policy, dated 6/2015, documents if a medication is not given as ordered, document the reason on the MAR and notify the Health Care Provider if required. If a medication is ordered but not present, check to see if it was misplaced and then call the pharmacy to obtain the medication. If available, obtain from the contingency or convenience box. If the Physician's order cannot be followed for any reason, the physician should be notified in a timely manner (depending on the situation), and a note should reflect the situation in the resident's medical record. (A)	S9999		