STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010250	A. BUILDING _____ B. WING _____	C 08/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEMINARY MANOR	2345 NORTH SEMINARY STREET GALESBURG, IL 61401

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S 000	Initial Comments Original Complaint Investigation 1925679/IL114534 Statement of Licensure violations	S 000		
S9999	Final Observations 300.610a) 300.1210b) 300.1210d)1) 300.3240a) 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 care needs of the resident. Restorative	S9999	Attachment A Statement of Licensure Violations	

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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.
Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident

These requirements were not met as evidenced by:

Based on interview and record review the facility failed to remove old transdermal patches prior to applying a new patch for one (R1) of four residents reviewed for medication errors in a sample of four. This failure resulted in R1 requiring hospitalization for seizures.

Findings include:

Facility Admission of A Resident Policy, revised 1/04, documents that: the objective is to facilitate the transition from prior living arrangements to long-term care in a caring, professionally comprehensive manner; to review the resident's personal data with resident and family, to be sure all information on the Admission Notice is correct and current; complete the Nursing Body Assessment in its entirety; and to assess the resident's condition specific to the admitting diagnoses, in addition to the general nursing assessments, and document findings.

Facility Medication Administration Policy, revised 2/04, documents the objective to provide the resident with those medications deemed

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necessary by the physician to improve and/or stabilize specified diagnosis of the resident; and that all medications must be administered to the resident in the manner and method prescribed by the physician.

Facility Medication Errors and Drug Reaction Policy, revised 2/04, documents the objective is to safeguard the resident and that the nurse administering medication should be familiar with the drug reaction, effects and contraindications.

The rivastigmine package insert that accompanied the transdermal patches, copyright 2019, documents: to always remove the old patch before applying a new patch and that medication errors resulting in overdose have involved the use of multiple patches at one time.

R1's Hospital Discharge Summary Report, dated 8/1/19, documents an order for rivastigmine (Exelon) transdermal 4.6 milligram (mg)/24 hours, once a day, last dose given was 7/31/19, at 8:23 am.

R1's Physician Order Sheet, dated 8/1/19, documents an order for rivastigmine transdermal patch 24 hour/4.6 mg, once a day, to be applied at 5:00 am. Physician Order Sheet, dated 8/3/19, documents an order to remove the rivastigmine transdermal patch at 5:00 am, prior to applying the new patch.

R1's Nursing Progress Note, dated 8/1/19 at 2:10 pm, documents that R1 was admitted to the facility from a local hospital with diagnosis of dementia and no transdermal patches were noted.

R1's Admission Skin Assessment, dated 8/1/19 at

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6:46 pm, does not document any transdermal patches.

R1's Nursing Progress Note, dated 8/3/19, at 4:05 am, documents that R1 was bleeding from the mouth, unresponsive and pupils were unreactive.

R1's Nursing Progress Note, dated 8/3/19, at 10:29 am, documents that R1 was admitted to the local hospital.

R1's Hospital Progress Note, dated 8/3/19, at 9:46 am, documents that: R1's seizure was probable from the "postictal" phase and that no further bleeding was from the mouth; and that the Poison Center was concerned about the elevated rivastigmine level.

R1's Hospital Progress Note, dated 8/5/19, at 6:27 am, and electronically signed by V3 (R1's Physician), documents that R1 presented with a "new onset of seizures, in the ER visit they found the patient had three to four Exelon patches on, so the nursing home was applying them without taking off the previous one. Poison Control thought that this could be an etiology. After being admitted to the hospital she had another seizure. At that point, we treated her with intra-venous Keppra (anti-seizure medication)."

Facility Notification to the Public Health Agency, dated 8/5/19, documents on the Serious Injury Incident Report (dated 8/2/19 at 1:00 pm), that R1 was admitted to the local hospital on 8/2/19, at 4:05 am with a diagnosis of Overdose from a Rivastigmine (Exelon) transdermal patch. It also documents that R1 was noted in bed with seizure like activity with blood around mouth from biting R1's tongue. R1 had three transdermal patches

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on with only one dated 8/1/19. R1's Facility Admissions Body Assessment did not reveal any patches in place, however, the facility had only applied the one documented patch on 8/2/19.

Facility Medication Error Report, dated 8/3/19, documents the rivastigmine transdermal patch error was related to an admission assessment that did not identify two patches in place upon admission and that the nurse applying the patch did not check or remove the outdated patches.

On 8/6/19, at 9:40 am, V1 (Administrator) stated, "We sent (R1) out to the Emergency Room for seizures and blood coming from her mouth from biting her tongue. She was admitted for overdose from having 3 dementia patches on." V1 confirmed that the nurses involved did not follow the protocol for ensuring there is no old patch prior to applying the new one and that the admission nurse did not perform the admission skin assessment.

On 8/6/19, at 12:45 pm, V4 (Licensed Practical Nurse/LPN) stated, "I admitted her to the facility on 8/1/19 and did her Admission Body Assessment. I rolled her from side to side and pulled her shirt up, but did not fully remove her shirt to check her skin. I must have overlooked the patches."

On 8/6/19, at 1:06 pm, V5 (Licensed Practical Nurse/LPN) stated, "She admitted on Thursday, 8/1/19, and her new medicine came in from Pharmacy that night. I worked that night (Thursday 8/1/19 through 8/2/19) and the next morning, on 8/2/19 at 5:00 am, I applied the new rivastigmine patch that had come in the night before. I did not even think to look for an old patch because I thought it was a brand new

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S9999	Continued From page 5 order. " On 8/6/19, at 12:29 pm, V3 (R1's Physician) stated, "I have been following her in the hospital and her seizure activity is exactly related to an overdose of the rivastigmine. Seizures are an overdose side effect. The facility is directly responsible for her medical harm due to the three patches being on." (A)	S9999		