STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008130	A. BUILDING: _____ B. WING _____	C 10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENERATIONS AT ROCK ISLAND	2545 24TH STREET ROCK ISLAND, IL 61201

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S 000	Initial Comments Complaint: 21273502/IL138894	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 300.13210d)1)2) 300.1220b)2) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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 measures shall include, at a minimum, the following procedures: 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: 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 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.	S9999		

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S9999	Continued From page 2 These requirements were not met as evidenced by: Based on interview and record review, the facility failed to obtain medication orders for one resident (R7) of three residents, reviewed for new admission orders, in a total sample of three. This failure resulted in R7 not receiving needed anti-seizure medications which resulted in R7 experiencing a seizure, requiring R7 to be transferred to a local hospital. Findings include: Facility policy, entitled "Admitting the Resident", dated 4/21, document, "12. F. The nurse is to review admission paperwork from the hospital, along with information obtained through nurse-to-nurse report to ensure that all care needs have been identified and physician/NP [Nurse Practitioner] informed of necessary monitoring, such as diagnostic, laboratory, or point of care monitoring such as BGM [blood glucose monitoring]; g. The nurse is to reconcile the hospital orders for medications and report these to the Physician/Physician extender to verify the continuation of orders." Resident document, used during the admission process/from local healthcare organization, entitled "[R7's name, medical record number and date of birth]", document the following seizure medications, "Levetiracetam 750 MG [milligram] take one tablet by mouth 2 (two) times daily; and Oxcarbazepine 300 MG take one tablet by mouth 2 (two) times daily"; and "Hx [history] of brain surgery after blunt head trauma 12/23/2015; Seizure disorder; and Seizures post brain surgery".	S9999		

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S9999	Continued From page 3 A typed letter, dated 4/12/2021, from V6/Medical Doctor-Neurologist, documents, "[R7] Is a patient in my office at [Blank] Health Group Neurology. Due to [R7's] neurological condition he is unable to care for himself and needs 24-hour supervision." R7's Electronic Medical Record [EMR] documents: "10/3/21 5:04 p.m., Admission Note Date and Time of arrival: 10/02/2021 4:16 PM Admitted from: Home" and "Admitting diagnosis: Dementia, Alcoholic Encephalopathy, CKD [Chronic Kidney Disease], Non-insulin dependent DM (Diabetes mellitus), Seizures". R7's EMR, documents, medication orders were not received until "10/3/21 (1:55 PM) [V5/Medical Doctor/Director] contacted for medication orders and lab requests. Orders received for medications." R7's EMR, under "Orders", dated 10/3/21, at 4:19 p.m., document, " Levetiracetam tablet; 750 mg; amt: 1 tab; oral Twice A Day 08:00 AM, 08:00 PM and Oxcarbazepine tablet; 300 mg; amt: 1 tab; oral Twice A Day 08:00 AM, 08:00 PM". R7's EMR, dated 10/3/21, at 8:58 p.m., document, "Resident (R7) noted sitting on bed talking on phone. CNA (Certified Nurse Assistant) ran over for nurse to respond emergently to (R7's) room around 8:30 p.m.. At that time resident noted laying on bed with head facing footboard, alert but unresponsive. Resident making moaning noises but unable to respond appropriately. Resident's pupils are equal but grossly enlarged. Resident noted to have urinated self when normally continent. Resident's left side of body appears limp. Hematoma noted to R[ight] side of head. Resident vitals 170/93, 84, 95% RA,	S9999		

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(Respirations) 14, (Temperature) 99.1. CNA [Certified Nursing Assistant] noted seeing resident 10 mins [minutes] prior to event sitting on bed with no issue and responsive per norm. When returning on wellness checks, resident noted shaking violently on bed with eyes rolling toward back of head and unresponsive. [V5] made aware and orders resident to be sent out to ER [emergency room]. 911 notified and taking (R7) to [local hospital] for further evaluation. POA [Power of Attorney] made aware. ADON [Assistant Director of Nursing] to f/u [follow/up] with POA regarding concerns d/t [due to] nurse gathering paperwork to send out resident. Administrator and DON [Director of Nursing] also made aware d/t being a new admit with sudden change. Hospital called with report."

Local hospital documentation, encounter date 10/3/21, document, "Neurology consult hospitalization. (R7), who was admitted yesterday to [nursing home]. According to the nurse, he was not taking his medication recently. I resumed his medication by the phone including [Levetiracetam]. At night, patient was transferred to the emergency room because of seizure-like activity. He was having a seizure during transfer and he was given IV [intravenous] Midazolam and he had seizure in the emergency room, and he was given IV Lorazepam. Patient has a history of brain aneurysm, status post-surgery; alcoholic liver cirrhosis with behavior disturbance; spinal stenosis at L4-L5 level; benign prostatic hypertrophy; type 2 diabetes mellitus; obstructive sleep apnea; previous history of stroke and hyperlipidemia as well as a history of gout. Patient was seen already by neurology service. CAT [Computerized Tomography] scan of the head showed nothing acute, but postoperative changes in the right frontal lobe. When I saw the

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patient, he was not communicating well, but he was comfortable in bed"; and "Reason for Consultation: Seizure. According to the record the daughter states that he had aneurysm causing a seizure as his last seizure was approximately 1 year ago, She noted that after the seizure he takes a couple days to return to his normal baseline he does have paralysis afterwards causing difficulty with speech".

On 10/6/21, at 10:05 a.m., V2/DON confirmed R7 was admitted from home and should have received R7's Levetiracetam and Oxcarbazepine due to R7's history of seizures and TBI [Traumatic Brain Injury]. V2 stated, "There was a breakdown in communication with the Nurse Practitioner and the admitting Nurse". V2 confirmed R7 should have had medication orders in place, but the Medical Doctor did not return the facility phone call, requesting the medication orders, for 24 hours. V2 also confirmed R7 missed Levetiracetam and Oxcarbazepine medications on 10/2/21 at 8:00 p.m., and again on 10/3/21 at 8:00 a.m. and 8:00 p.m.

On 10/6/21, at 12:00 p.m., V3/Registered Nurse stated that V3 was R7's admitting nurse. V3 confirmed that on 10/2/21, R7 arrived at the facility, from home, without admission orders; V3 contacted V4 (Advanced Nurse Practitioner), who was present in the facility, for medication and admission orders; [According to V3], V4 stated, "(V4) can't touch this case" and left without giving orders; V3 then left a message for V5/Medical Doctor to order medications as the Nurse Practitioner refused to take over care of the patient; and it was not until the afternoon of 10/3/21 that V5 returned the message left the previous day and then ordered R7's medications; V3 confirmed taking the Physician's order for

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S9999	Continued From page 6 R7's anti-seizure medications as documented in V3's Progress notes dated 10/3/21 at 1:55 p.m. and entered in to the EMR orders 10/3/21 at 4:16 pm; V3 was aware that R7 needed anti-seizure medications; and V3 confirmed R7 did not receive any anti-seizure medications as they were not ordered and did not receive any ordered anti-seizure medications prior to R7 having a seizure and being send to the local hospital on 10/3/21. On 10/6/21, at 1:10 p.m., V4/Advanced Nurse Practitioner confirmed: being in the facility when R7 was admitted and deferring R7's care to V5 even though V4 was on call and in the facility; V4 confirmed that V4 did not order medications or assess the resident prior to leaving the facility. On 10/6/21, at 12:06 p.m., V6/Medical Doctor-Neurologist stated, regarding R7's anti-seizure medications, "(It was) critical to have those seizure medications ordered and administered" and that by "missing those doses [3 total doses] lead to (R7's) seizure" and hospitalization. On 10/8/21, at 8:30 a.m., V2 confirmed, with new admissions from home, Nurses are to put orders in under V5 and the Advanced Practice Nurses are to review and sign off; V2 verified that V4 failed to sign off and that V4 stated, "Not to input orders as she would not sign off on them"; V2 stated that the nurses should have kept calling V5 until they reached him, but they didn't; V2 also stated that the Nurses should have reached out to the pharmacy where R7's medications were filled, but they didn't; V2 stated that R7 was admitted with no admission orders.	S9999		

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