| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6004428 | A. BUILDING: _____ B. WING _____ | C 05/26/2023 |

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| HILLSBORO REHAB & HCC | 1300 EAST TREMONT STREET HILLSBORO, IL 62049 |

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| S 000 | Initial Comments<br><br>Complaint Investigation 2343981/IL159805 | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations:<br><br>300.610 a)<br>300.1010 h)<br>300.1210 b)<br>300.1210 d)1)<br><br>Section 300.610 Resident Care Policies<br>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.<br><br>Section 300.1010 Medical Care Policies<br>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 plan of care for the care or treatment of such accident, injury or change in condition at the time | S9999 | Attachment A<br>Statement of Licensure Violations | |

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| S9999 | Continued From page 1<br>of notification.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br>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.<br>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:<br>1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.<br><br>These requirements are not met as evidenced by:<br><br>Based on interview and record review, the facility failed to ensure medications were given as ordered for 1 of 7 residents (R2) reviewed for significant medication errors in the sample of 18. This failure resulted in R2 having a seizure and being sent to the hospital for evaluation.<br><br>Findings include:<br><br>R2's Face Sheet, print date of 05/15/23, documents R2 has a diagnosis of Conversion disorder with seizures or convulsions.<br><br>R2's Minimum Data Set (MDS), dated 04/19/23, | S9999 | | |

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| S9999 | Continued From page 2<br>documents R2 is severely cognitively impaired and has a seizure disorder.<br><br>R2's Care Plan, print date of 05/15/23, documents the resident has Seizure Disorder and interventions include but are not limited to "Give medications as ordered."<br><br>R2's Physician's orders, dated 01/26/18, documents R2 is to receive Zonisamide Capsule 100 MG (milligrams), Give 1 capsule by mouth two times a day for seizures.<br><br>R2's Medication Administration Record (MAR), dated 05/03/23 at 8:00 AM, documents #5 (Hold-see progress notes).<br><br>R2's Health Status Note, dated 05/03/23 at 9:43 AM, documents, "Writer contacted Critical Care pharmacy to check status on Zonisamide refill. Per pharmacy #60 was shipped to facility and signed for on 4/20/23."<br><br>R2's Administration Note, dated 5/3/2023 9:52 AM, documents, "(R2's) Zonisamide was unable to be located- not available in stat safe."<br><br>R2's MAR, dated 05/04/23 at 8:00 PM, documents R2 was given his Zonisamide 100 mg.<br><br>R2's Health Status Note, dated 05/04/23 at 8:18 PM, documents, "Pharmacy and DON (Director of Nursing) aware Zonisamide 100 mg capsule not available on 05/04/2023 at 8:18pm. Incorrect documentation."<br><br>R2's MAR, dated 05/05/23 at 8:00 AM, documents Zonisamide #6 (other- see progress notes). | S9999 | | |

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R2's Administration Note, dated 05/05/23 at 8:43 AM, the facility is still waiting on the medication from the pharmacy.

R2's MAR, dated 05/06/23 at 8:00 AM, documents Zonisamide #6 (other- see progress notes).

R2's Administration Note, dated 05/06/23 at 1:01 PM, documents Zonisamide capsule medication not available, awaiting pharmacy.

R2's MAR, dated 05/06/23 at 8:00 PM, has no documentation noted for R2's Zonisamide medication.

R2's MAR, for the dates of Sunday 05/07, Wednesday 05/10, and Friday 05/12/23 at 8:00 AM, documents Zonisamide #6 (other- see progress notes).

R2's Administration Note, dated 05/07/23 at 10:26 AM, and 05/10/23 at 10:36 AM, documents medication not available waiting on the pharmacy.

R2's Administration Note, dated 05/12/23 at 8:57 AM, documents, "Facility still out of medication - not available in stat safe - writer called critical care to request a fax to be sent so facility can approve payment for this medication d/t (due to) card of medication that facility reports facility rcvd (received) has not been located."

R2's Health Status Note, dated 5/12/2023 at 12:27 PM, documents Note Text: "writer paged to 300 hall and notified that resident was currently having a seizure. Resident noted to be staring off and having difficulty speaking. Resident's wife by his side and had noted upon entering his room

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and notified staff. Resident having some shaking throughout body. Resident's wife noted hx (history) of improvement with supplemental oxygen. Supplemental oxygen initiated via nc (nasal canula). Resident primarily mouth breathing at this time and oxygen mask applied. Resident's vs (vital signs) stable. Resident has a hx (history) of seizures. Three nurses at bedside monitoring. Decision was made to send to ER (Emergency Room) d/t resident not coming out of seizure as quick as previous seizures."

On 05/17/23 at 9:37 AM, V4, Licensed Practical Nurse (LPN), stated she wasn't sure what day it was that she was unable to locate R2's Zonisamide. She said she searched the medication cart and could not find it anywhere, she looked for it in the stat safe and could not find it, so she called the pharmacy about it, and they told her the medication was sent and signed off on 04/20/23. V4 said she left a note for the Assistant Director of Nursing (ADON) to get permission for the facility to pay for it. She said she thought the ADON was going to come in on that day, but ended up not coming in. She said she then didn't work on that hallway again for a while, but when she did, she was still unable to locate the medication. V4 said she then called the pharmacy and requested a fax so the facility could cover the cost. She said she then had the Administrator sign off on it so the pharmacy could deliver the medication. She said after everything was requested and before the medication was delivered, R2 had a seizure and was sent out to the ER.

R2's Health Status Note, dated 5/12/2023 at 1:44 PM, documents, "per local hospital ER, they cannot allow resident to return to facility until we have Zonisamide available."

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| S9999 | Continued From page 5<br><br>R2's ER Record, dated 05/12/23, documents chief complaint seizure like, and discharge diagnosis of Status post seizure due to subtherapeutic medication level.<br><br>R2's ER Lab Report, date collected 05/12/23 at 1409 (2:09 PM), documents Zonisamide level < (less than) 2 low, Range 10.00-40.00.<br><br>R2's Medication Error Details Report, report date of 05/15/23 at 9:00 AM, documents "medication was not administered on 5/3 at 8 AM, 5/5 at 8 AM, 5/6 at 8 AM, 5/7 at 8 AM, 5/10 at 8 AM, and 5/12 at 8 AM Resident was sent to ER for eval (evaluation) and treat (treatment) on 5/12/23. Error Type missed dose; error detected at 05/03/23 8:00 AM. Physician notified none called (nurse did not notify physician until 05/12/23)."<br><br>On 05/16/23 at 8:25 AM, V3, R2's wife stated the only time R2 has seizures is when he misses his seizure medication. She said this happened last year when he missed doses of his Depakote.<br><br>On 05/16/23 at 9:10 AM, V8, LPN, stated she worked a day or 2 when R2 was out of his Zonisamide, and she made a note it was not available, but that it had been ordered. She said if R2 had the medication available it should have been on the cart.<br><br>On 05/17/23 at 12:55 PM, V2, Regional Nurse, stated she would expect the nurse to look for the medication on the cart, if they were unable to find it on the cart, the nurse should call the pharmacy and check to see if they delivered it, if not call and order it, call the DON, ADON, Administrator, then call and notify the doctor, ask them if they want to hold the medication or see if they want to | S9999 | | |

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substitute with another medication, assess the patient, and notify the Power of Attorney (POA) or responsible party.

On 05/16/23 at 12:52 PM, V10, Nurse Practitioner, stated, "Yes it could be the reason, but it's hard to say if (R2) going without his Zonisamide would have caused him to have a seizure. (R2) has been on other seizure medication and had seizures." V10 stated even if she were to have the lab results back from the hospital, it could be possible there was something else wrong with R2. V10 stated she would expect the nurse, "with any medication that was ordered, if it wasn't given, to document it and give a reason it wasn't given. If the medication wasn't available, there needs to be certain steps taken to see what the problem is. If the medications are not given, it should be documented at the time it wasn't given and not later, and I would expect the provider to be notified." V10 stated she wasn't informed of R2 not receiving his Zonisamide until (05/15/23) when she walked into the facility.

On 05/16/23 at 2:10 PM, V12, Pharmacist, stated any missed doses of a seizure medication will increase the risk for a breakthrough seizure. He said, "You would not want to miss any scheduled doses of any medication especially a seizure medication."

The facility Policy and Procedure for Administration of Medication, revise date of 04/21, documents "B. The nurse's station shall have necessary items and equipment available for proper administration of medications, and current standards of practice should be followed. C. Immediately after a drug is ingested, it should be recorded on the MAR: 1. If for any reason a physician's order cannot be followed, the

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| S9999 | Continued From page 7<br>physician shall be notified as soon as is reasonable. A notation shall be made on the nurse's progress notes in the patient's clinical record. 2. Nursing staff will report immediately to the attending physician any medication errors, or adverse drug reactions." It further documents "E. The facility shall check the Physician's Order Sheet and MAR against the current Physician's Orders, to assure proper administration of medication to each resident."<br><br>(A) | S9999 | | |