STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145524	A. BUILDING _____ B. WING _____	**03/04/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GENERATIONS AT RIVERVIEW	**500 CENTENNIAL DRIVE EAST PEORIA, IL 61611**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** Based on observations, interview, and record review, the facility failed to follow their policy by preparing medications in advance and leaving them in the medication cart until administering them, and documenting that medications were administered before they were actually given for five of 10 residents (R9, R10, R11, R12 and R13) reviewed for medications in a sample of 13. Findings include: The facility's Administration of Medication policy dated May 2017 documents: Medications may not be prepared in advance. On 3-4-20 at 9:10 am, V6, RN/Registered Nurse was noted to have medication cups filled with medications, with R9, R10, R11, R12 and R13's names on the cups, in her medication cart. On 3-4-20 at 9:10 am, V6 took out R9's medication cup from the cart and gave them to R9. V6 then gave R10 his medications at 9:35 am, R11's medications were administered at 9:37 am, R12's medications at 9:55 am and R13's medications at 10:00 am all from the previously prepared medication cups stored in the medication cart. On 3-4-20 at 9:10 am, V6 stated she was running behind and had already set up some of the 8:00 am morning medications but had not yet given them. V6 stated she was storing them in the cart until after breakfast or when she had time to give them. V6 stated she had already signed off on all the medications for these residents before she gave them. On 3-4-20 at 1:20 pm, V2 DON/Director of Nursing stated nursing staff should not administer medications that have been previously prepared and stored in a medication cup in the medication cart. V2 also verified V6 should not have documented that her medications were given before she actually gave them.
F 0759 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure medication error rates are not 5 percent or greater.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to have a medication error rate below 5%. There were 34 opportunities for error with ten errors found resulting in a 29% medication error rate for R1, R2, R3, R4, and R5 reviewed for medication pass in a sample of 13. Findings include: The facility's Administration of Medication policy dated May of 2017 documents the following: Medications may not be prepared in advance and must be administered within one (1) hour of scheduled administration time. Should there be any doubt concerning the administering of medication(s), the physician's orders [REDACTED]. 1. On 3-3-20 at 10:00 am, V5 RN/Registered Nurse was administering medications to R2. V5 gave R2 Vitamin D3 1000 Units one tablet. R2's POS (physician's orders [REDACTED]. 2. On 3-3-20 at 10:10 am, V5 RN gave R3 the [MEDICAL CONDITION] medication [MEDICATION NAME] 200 mg (milligrams) and the antibiotic [MEDICATION NAME] 300 mg. R3's POS for (NAME)2020 documents both these medications are ordered three times a day to be given at 8:00 am, 1:00 pm, and 8:00 pm. R3's MAR (Medication Administration Record) documents both medications were given again at 1:00 pm, less then three hours after the medications were first given. On 3-4-20 at 3:00 pm, DON/Director of Nursing stated R3's [MEDICATION NAME] and [MEDICATION NAME] should not have been given so close together. On 3-4-20 at 3:50 pm, V8, R3's physician's nurse, stated it was not ideal and not optimal that R3's medications were given less than three hours apart. 3. On 3-3-20 at 10:45 am, V5, RN set up Fish Oil 500 mg, 2 tablets and a Daily Vitamin with Iron stating they were for R4. V5 then entered R4 and R5's room and proceeded to hand R4's medication to R5. R5 had the medication in his hand ready to take it when R5 was stopped by V5, after prompting from the surveyor. V5 verified she was giving R4's medications to R5. 4. On 3-3-20 at 12:10 pm, V5, RN gave R5 a Multivitamin with iron and Tylenol 1000 mg. R5's POS for (NAME)2020 documents R5 is to receive a Multivitamin without iron and Tylenol 1000 mg three times a day at 8:00 am, 1:00 pm and 8:00 pm. R5's MAR (Medication Administration Record) documents R5 received only two doses of the Tylenol, one at 12:10 pm and the another at 8:00 pm. 5. On 3-4-20 at 10:55 am, V6, RN gave R1 Vitamin D3 1000 units one tablet. R1's POS for (NAME)2020 documents R1 is to receive Vitamin D3 400 units, two tablets. R1's POS also documents [REDACTED]. On 3-3-20 at 2:30 pm and 3-4-20 at 3 pm, V2, DON/Director of Nursing stated R1's [MEDICATION NAME] and Calcitonin were not available for administration and she could not find out why. V2 verified the above medications were not given per physician's orders [REDACTED].

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE