STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008601	A. BUILDING: _____ B. WING _____	C 08/03/2017

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S 000	Initial Comments Complaint Investigation 1784254/IL95459	S 000		
S9999	Final Observations Statement of Licensure Violations 300.1210b) 300.1210d)3) 300.3240a) 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. 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: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee	S9999	**Attachment A** **Statement of Licensure Violations**	

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or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These Requirements are not met as evidenced by:

Based on interview and record review, the facility failed to monitor bowel movements and evaluate the resident's response to preventative efforts and treatment to avoid fecal impaction which affected one resident (R4) of 5 residents reviewed for bowel movements in a sample of 5 residents. This failure resulted in R4's emergent transfer to the hospital for treatment for a fecal impaction.

Findings include:

R4 is a 57 year old resident originally admitted to the facility on 9/10/2014 for long term skilled nursing and rehabilitation.

Facility face sheet dated 7/31/17 with diagnoses listed in part: "Multiple sclerosis, drug induced constipation, hypothyroidism, chronic embolism, personal history of urinary tract infections, resistance to multiple antibiotics, major depressive disorder, flaccid neuropathic bladder, type 2 diabetes mellitus, and neuromuscular dysfunction of bladder."

R4's Care Plan initiated 8/18/16 with target date of 5/15/17 states in part, "Focus: The resident is on lactulose therapy related to constipation; Goal: The resident will be free of discomfort and/or adverse reactions to this medication; Interventions: Administer medication as order, relay side effects to MD immediately; If resident is diabetic lactulose may alter blood sugar levels; Monitor and record bowel movements, include

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size, color and consistency; Notify MD and/or nurse of any of the following side effects, should they persist or worsen: Gas, bloating, burping, stomach rumbling/pain, nausea, cramping; Notify MD immediately should serious side effects occur: rash, itching/swelling, severe dizziness, trouble breathing, diarrhea, vomiting, muscle cramps/weakness, irregular heartbeat, mental/mood changes, seizures."

R4's additional Care Plan initiated 8/3/15 (revisions on 8/18/16 and 5/8/16) and target date of 5/15/17, states in part, "Focus: The resident is at risk for constipation related to decreased mobility, medication side effects. Goal: The resident will pass soft, formed stool at the preferred frequency of every 2-3 days through the review date. Interventions: Follow facility bowel protocol for bowel management; Monitor medications for side effects of constipation. Keep physician informed of any problems; Monitor/document/report to MD as needed signs/symptoms of complications related to constipation: Change in mental status, new onset: confusion, sleepiness, inability to maintain posture, agitation, Bradycardia (slow, low pulse). Abdominal distension, vomiting; Bowel sounds, diaphoresis, abdomen: tenderness, guarding, rigidity, fecal impaction."

MDS (Minimum Data Set) dated 4/24/17 (Section H for Bowel and Bladder) show R4's Bowel Continence scored at a "2" for frequently incontinent (2 or more episodes of bowel incontinence, but at least one continent bowel movement). This same MDS section shows R4 not on a formal toileting program used to manage the resident's bowel continence and also lists R4 as not having constipation.

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R4's Facility flowsheet dated 4/1/17 through 7/2/17 titled "BM Report" show the following: April 4th through April 7th (four days) and from April 13th through April 17th (five days), R4 did not have a bowel movement recorded.

In May, R4's "BM Report" shows that from May 1st through May 9th (nine days) and from May 18th through May23rd (six days), (R4) had no bowel movement recorded.

In June, R4's "BM Report" shows from June 5th through June 10th (six days) and June 15th through June 19th (five days) with no bowel movements recorded.

From June 30th up to R4's discharge of 7/2/17 to the hospital emergency room, there were no bowel movements recorded.

Interview with E2 (DON-Director of Nursing) on 8/2/17 at 11:20 AM states in part, "I've been the DON for about a week but the company is all the same with same procedures." (E2 was transferred from sister facility)
Asked about the BM Reports, E2 struggled to answer but stated, "It looks like report when resident has bowel movement but I can't be sure."

Asked what his expectation of his staff, E2 stated, "I expect that the C.N.A's notify the nurses who will notify the MD if residents are experiencing long periods with no bowel movements. As a nurse, I would check for fecal impaction and I could do manual removal of the fecal impaction. We should be doing this first."

Interview with E3 (ADON-Assistant Director of Nursing) on 8/2/17 at 11:20 AM states in part,

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"I've been the ADON for 7 to 8 months here and prior to that I worked three years as a floor nurse, so yes I'm very familiar with our forms and systems."

Asked about the facility BM Report, E2 stated, "I don't know the BM Report or what those numbers mean. We don't fill those out. I think the C.N.A.s do but they should be reporting it to the nurses.""

Interview with E5 (Restorative Director LPN-Licensed Practical Nurse) on 8/2/17 at 11:40AM states in part, "I've been the Restorative Director since February 2017. Prior to that I was a floor nurse since 2014."

Asked to interpret the facility bowel flowsheets E5 stated, "The zero (0) means there was no bowel movement that day; the "M" means a medium sized bowel movement and "1" means they had one bowel movement, and so on. The initial below it is the initial of the C.N.A.(certified nurse aide)."

Asked what happens to this information, E5 stated, "The C.N.A.s will mark it down on their shift and they should be telling the nurses."

Facility progress notes dated 7/2/17 at 10:00 AM written by E6 states in part, "Upon routine rounds, resident complained of abdominal pain on a scale of 8/10 and throwing up since yesterday. Assessment done, noted distended abdomen, rigid and hard on touch. Coffee ground emesis noted in a cup in moderate amount. Resident not in any respiratory distress. Alert and oriented, able to verbalize needs. PRN Norco given for pain. Vital signs.MD notified, with order to send resident to hospital ER. Order noted and carried out."

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At 11:10 AM, E6 documents, "Ambulance called with estimated time of arrival 20 minutes."

At 11:30 AM E6 documents, "Resident was taken to hospital on a stretcher, accompanied by two male crew. Endorse to 3-11 nurse to follow up with disposition."

Further review of facility progress notes show no other documentation related to R4's constipation nor nursing interventions to address R4 continuous nonmovement of her bowels.

Interview with E6 (RN-Registered Nurse) on 8/2/17 at 2:00PM states in part, "Yes I am the nurse that sent (R4) to the hospital. I got an order to send her. She had coffee ground emesis. She told me she was throwing up since yesterday but I don't know how many times. (R4) had it in a cup and showed me."

Asked if she received any nursing endorsements from the previous shifts about (R4), E6 stated, "No they didn't report anything to me."

Asked if she assessed (R4), E6 stated, "Yes, I took her vitals."

Asked what else she did, "I checked her bowel sounds and they were present."

Asked if she did any other assessment prior to contacting the doctor, E6 stated, "No sir, I called the doctor right away."

Asked if she knew when (R4) had her last bowel movement E6 responded, "No sir, I didn't ask her."

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Asked if the nursing aides mentioned anything to her about when her last bowel movement was, E6 responded, "No, they didn't tell me anything."

Facility policy and procedure dated May 5, 2015 titled, "Bowel and Bladder Retraining Program" states in part, "It is the policy of this facility to provide the resident the bowel and bladder program interventions as appropriate in order to help the resident regain the ability to control the bowel and bladder excretory functions. Procedures: Restorative nurse shall complete and review the resident's bowel and bladder evaluation and treatment plan to assess appropriateness and potential; Bowel and Bladder Training Program interventions shall be incorporated into the residents' plan of care; Nurse shall evaluate the resident's diet. Encourage fluid intake and to increase roughage in the diet unless contraindicated; Nurse shall encourage the resident to establish a structured schedule in toileting such as 2-3 hours, upon waking, before each meal, after a nap; Times or scheduled toileting approaches shall be indicted in the care plan; Provide assistance in toileting; encourage resident to the bathroom/toilet or use a bedside commode if appropriate; The Bladder and Bowel Retraining program shall be evaluated and adjusted at least weekly until a pattern has been established."

7/2/17 Hospital emergency department notes show R4 arriving in the Emergency Department at 12:07 PM by ambulance with chief complaint of "Emesis (vomitus), nausea, and abdominal pain with abdomen distended and rigid."

Hospital emergency department notes authored by Z1 (Emergency Department Doctor #1) on 7/2/17 at 12:31 PM states in part, "There is

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significant amount of stool present in the distal sigmoid colon and rectum with distention of the rectum up to 9.1 centimeters. Large colonic stool burden present in the cecum, ascending colon, and descending colon. There is gaseous distention of the transverse colon up to approximately 5.5 centimeters. Multiple non-distended fluid-filled loops of small bowel present. The stomach is distended with fluid and ingested material. There is reflux of fluid into the distal esophagus which is distended with fluid."

Very large colonic stool burden particularly in the distal sigmoid colon and rectum compatible with a fecal impaction.

Z1 denotes R4's diagnosis: "After the evaluation in the Emergency Department, my clinical impression is Upper GI (Gastro- Intestinal Bleed), Fecal Impaction, Sacral Osteomyelitis."

Z2 (Emergency Department Doctor #2) wrote on 7/2/17 at 4:22 PM, "Endorsed by AM physician. On exam, tachycardic (rapid heart rate), appears hypovolemic and endorses pain. Abdomen distended with typany concerning for bowel obstruction."

Surveyor contacted Z2 on 8/2/17 at 2:30 PM and read over the notes to refresh Z2's memory of his examination of (R4).

Telephone interview with Z2 states in part, "The abdominal distension doesn't happen overnight. Fecal impaction is a gradual event and can be prevented if the nursing home monitored her bowel movements, hydrated her, utilized preventative stool softeners, etc. which obviously they did not do as (R4) had extensive fecal matter in her entire colon and cecum (beginning of the

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large intestine)."

Attempted to call Z3 (attending physician) on 8/2/17 and 8/3/17 but no return call was received.

Interview on 8/3/17 at 12:25 PM with Z9 (Nurse Practitioner), states in part, "I do see (R4); she is one of my residents and I'm familiar with her. I asked for (R4) when I came to visit and the nurses told me she was sent to the hospital. (R4) is bed bound and the nurses would usually say if they have a bowel movement. They (the nurses) have to make sure she is moving her bowels and they have to know how often. You have to be a little concerned especially with somebody like her. If she did not have a bowel movement for 48 hours you can ask her if you can give her something to help her go to the bathroom. As a nurse you can ask me or the doctor to order a K.U.B. (lab test to assess the organs of urinary and gastrointestinal systems used to diagnose urinary disorders and causes of abdominal pain). The nurses have to tell me what's going on and I take action. They should have done that with (R4) that should have been caught if she was having that long period of no bowel movements."

(B)