STATE OF ILLINOIS
DEPARTMENT OF PUBLIC HEALTH
STATEMENT OF VIOLATIONS AND PLAN OF CORRECTION

PINE LAWN MANOR **0045708**

Facility Name **I.D. Number**

200 POPLAR DRIVE, SUMNER, ILLINOIS 62466
Address

Date of Survey: 04/06/2004

Complaint Investigation

As a result of a survey conducted by representative(s) of the Department, it has been determined the following violations occurred. Please respond to each violation. The response must include specific actions which have been or will be taken to correct each violation. The date by which each violation will be corrected must also be provided. Forms are to be submitted with the original signature.

IMPORTANT NOTICE: THE STATE AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED UNDER PUBLIC ACT 83-1530. DISCLOSURE OF THIS INFORMATION IS MANDATORY. THE FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

"A" VIOLATION(S):

350620a) **The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents, and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually.**

350.1220j) **The facility shall notify the resident's physician of any accident, injury, or 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.**

350.1230b)5)6)7 **Residents shall be provided with nursing services, in accordance with their needs, which shall include, but are not limited to, the following: The DON shall participate in:**
Training in habits in personal hygiene and activities of daily living.
Development of a written plan for each resident to provide for nursing services as part of the total habilitation program.
Modification of the resident care plan, in terms of the resident's daily needs, as needed.

350.1420a) **All medications shall be given only upon the written, facsimile or electronic order of a licensed prescriber. The facsimile or electronic order of a licensed prescriber shall be authenticated by the licensed prescriber within 10 calendar days, in accordance with Section 350.1610. All such orders shall have the handwritten signature (or unique identifier) of the licensed prescriber. (Rubber stamp signatures are not acceptable.) These medications shall be administered as ordered by the licensed prescriber and at the designated time.**

350.3240a) **An owner, licensee, administrator, employee, or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)**

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These REGULATIONS are not met as evidenced by:

Based on observation, interview, and file verification, the facility failed to provide individuals with adequate health care monitoring and follow-up services for individuals when they neglected to assess, monitor, and provide treatment for individuals with a history of constipation. The facility:

a) Neglected to assess abdominal status including monitoring abdomen size and firmness, bowel sounds, vital signs, food and fluid intake.

b) Neglected to assess the need for and administer PRN (as needed) medications as ordered by the physician.

c) Neglected to notify the physician of a change in condition.

d) Neglected to follow facility policies regarding the monitoring of bowel movements.

e) Neglected to include a health care plan for history of constipation in the Individual Program Plan.

f) Neglected to ensure individuals with a history of constipation are adequately hydrated.

Findings include:

The Admission Information Sheet states, R2 is a 31-year-old male who was admitted to this facility on 9/26/03 with a diagnosis of mild mental retardation, Cerebral Palsy, and Impulse Control Disorder. The Discharge Instructions which were provided to the facility upon admission state R2 was discharged on medications for behavior and a Dulcolax Suppository once/day as needed. The Medical History provided to the facility states R2 has mild abdominal distention and a small umbilical hernia.

Per observations made on 3/15/04 and 3/16/04, R2 was observed as ambulatory, verbal and was noted to have a large abdomen. R2 was observed with 1:1 staffing due to observed behaviors of verbal aggression, physical aggression and running. R2's targeted behaviors in his behavior management programs include: elopement, non-compliance, verbal aggression, and physical aggression by grabbing residents and staff by the throat or arms. R2 required medications for behavior control including Seroquel and Depakote.

On 3/17/04 in the afternoon, the surveyor noted that R2 had not been walking around the facility as he had been on previous days. E1 was asked by the surveyor where R2 was located. E1 stated that R2 was in bed because he didn't feel very well and needed to be "cleaned out."

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Upon arrival at the facility on 3/18/04, E1 approached the surveyor and stated that she had some bad news. E1 stated that R2 had become increasingly ill the previous evening and was sent to the hospital around 5:00 P.M. E1 further stated that R2 was transported to an area hospital, and was subsequently transferred to an out of state hospital. E1 stated that R2 had expired this morning around 5:00 A.M. and that she was informed by the hospital staff that R2 died from an abdominal obstruction and hypotension.

Per review of R2's Individual Program Plan (IPP) dated 10/22/03, it states he was receiving Miralax for constipation daily (discontinued 10/22/03 due to refusal), Senna tablets two times daily for constipation and a Fleets enema was ordered as needed for constipation. Per review of the current physician's orders and since admission, a Dulcolax suppository was ordered once per day as needed for constipation. Per review of R2's health care section of the Individual Program Plan, R2's history of constipation was not included. There are no recommendations by nursing included regarding monitoring and assessment of R2's history of constipation. Confirmed per interview with E7 on 3/25/04 at 2:20 P.M., that the individual program plan states what is located in the medical care plan (kept in the nurses station). E7 further stated the IPP states what an individual "is at risk for, that type of thing."

Per review of a facility form entitled the Monthly Nursing Physical Assessment dated 10/9/03, the Gastrointestinal section was marked "no" for diarrhea, the last laxative and last BM (bowel movement) sections are blank, as well as "yes" or "no" to constipation. The assessment dated 10/11/03 states "no" to constipation and diarrhea and the last laxative and last BM sections are blank. The assessment dated 10/22/03 states "yes" to constipation, "no"to diarrhea, "very active bowel sounds x (times) 4 quads (quadrants)." Additionally there is a comment of "Abd. (abdomen) very distended." The document states R2 refused the last laxative on 10/22/03 and the last BM is "unknown." The assessment dated 10/26/03 states "yes" to constipation, "no" to diarrhea, last laxative states refused and last BM is unknown. The assessment dated 10/29/03 states "no" to constipation and diarrhea and the last BM says "self" and the last laxative is blank. An assessment dated 11/21/03 states R2 has no constipation and abdomen remains distended. There are no further assessments until 12/17/03 and 12/19/03 which state R2 has no diarrhea or constipation and the areas with last laxative and BM are blank. Per review of facility records, there were no further nursing assessments as of 3/18/04.

Per review of the Individual Program Plan dated 10/23/03, there is no evidence of a Health Care Plan, nor are there recommendations by nursing regarding monitoring and assessment of R2's history of constipation included in the Individual Program Plan. However, the facility presented the surveyor with a form entitled "Interdisciplinary Health Care Plan" which is dated 9/26/03, which states, R2 "...1. The resident will not have any episodes of constipation during the next 90 days. 2. The resident will have a soft-formed stool every 3 days during the next 90 days." This document states, "Approaches: 1. Deliver medications as ordered.
2. Encourage fluid intake every hour while awake. 3. Monitor BM log - in (typed as written) no BM recorded over 3 days, administer PRN laxative. 4. Prune juice PRN. 5. Monitor for diarrhea. 6. Rectal checks PRN.
7. Assess if any complaints of upset stomach, vomiting, etc. 8. Dulcolax supp. dly (daily) PRN. Miralax qd (every day). Change (symbol used) to Senna 2 (symbol used) qd 10/22/03." The document then states,

"Reviewed/Reso form then directs the writer to indicate the date reviewed and the status of the goal. Per review of this lved: "This document there has been no review of R2's progress toward these goals as directed.

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Per review of the Bowel Movement Tracking Form dated 3/04, there is documentation of a bowel movement on 3/3/04 and something documented on 3/14/04 (which is illegible). Per review of the BM Tracking form there is no further documentation of bowel movements for R2 until 3/17/04. At the bottom of this form it states, "All these residents should be asked if they have had a BM or not + charted." Per review of the medication administration record, from 3/3/04 (last documented BM prior to 3/16/04) until 3/16/04 (when the physician specifically ordered), nursing staff did not administer the Dulcolax suppository (ordered since 9/26/03 to be given once daily PRN (as needed) for constipation, nor did the nursing staff administer a Fleets enema (ordered since 10/21/03 and to be given 1 rectally as needed) for constipation.

Per review of the Food/Beverage Intake Record dated 3/04, it states, from 3/4/04, R2 consistently refused at least 2 food items each meal daily until 3/14/04. On 3/14/04, R2 ate only his meat/egg and drank his juice for breakfast. For lunch on this date, R2 ate his entree, drank his drink, ate his bread and 1/4 of his starch (as identified on facility form). There is no documentation for the evening meal on this date of intake of food or fluids. On 3/15/04, R2 drank only his juice and ate his meat/egg for breakfast, ate well for lunch, drank only a glass of kool-aid and refused supper with no documentation of fluid intake. On 3/16/04, R2 refused breakfast, and there is no documentation of resident's food or fluid intake for lunch at the workshop for this day. There is only documentation that R2 ate his entree for supper. There is no documentation of any fluid intake on 3/16/04. There is no documentation regarding any food or fluid intake on 3/17/04. There is no evidence of nursing assessing R2's lack of fluid intake from 3/14/04 until 3/17/04.

Nurse's notes dated 3/6/04, state that R2's left testicle was noted to be only partly dropped down. Per the nurse's notes R2 was to be seen by the physician at his next appointment, and that R2 was to receive Ativan O.5 mg IM (intramuscularly) prior to this visit. Nurse's notes dated 3/11/04 state R2 has had an " increase (symbol for up) in behaviors last few days at of w/s (workshop)...". R2 was provided with 1:1 staff monitoring after attempting to choke the bus driver who drives to day training. Nursing notes on 3/12/04 state that R2 displayed some "loud disturbing behaviors". On 3/13/04, R2 attempted to elope from the facility. On 3/14/04 the nurse's notes state R2 was displaying "explosive behaviors" and Ativan 0.5 mg IM was administered. On 3/15/04 the nurse's notes state R2's medication for behavior (Seroquel) was increased and Haldol was initiated.

The nurse's notes dated 3/16/04 stated R2 returned from a physician's office visit at 5:10 P.M. (for assessment of testicle). From this office visit R2 was taken the area hospital for an Xray of his abdomen. R2 was then returned to the facility with orders to give "Fleets or Tap water enema this evening and a bottle of mag citrate this evening... If no (symbol for 0) results HS (hour of sleep), repeat procedure in A.M. R/T (related to) severly (severely typed as written) constipated." At 6:00 P.M., the nurse's notes state R2 consumed a bottle of magnesium citrate and at 8:00 P.M., a Fleets enema was given as per physician's orders. Per review of the medication administration record (MAR), there were no results recorded from the laxative or enema on 3/16/04. There is no evidence the laxative or enema were repeated, as ordered by the physician, if no results by bedtime on 3/16/04.

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Nursing notes dated 3/17/04 at 9:30 A.M. documentation state that the physician was notified that R2 "has had at least 3 large BM's + still continuing to have loose stools. "Per review of the MAR and nursing notes there is no assessment of R2's abdomen regarding distention, hardness, presence or absence of bowel sounds, vital signs, hydration status, or assessment for an impaction from 3/13/04 to 3/17/04. The nurse's notes state R2 was checked for an impaction at 5:10 P.M. on 3/17/04.

The nurse's notes state on 3/17/04, at 5:10 P.M., R2 was observed "very lethargic, needs assistance x (times) 2 with (symbol for) ambulation." Documentation states R2 is afebrile, pulse 133, respirations 16 and blood pressure 122/68. Breath sounds decreased. Bowel sounds absent in 3 quadrants and "faint-distant hypoactive in RUQ (right upper quadrant)." A rectal examination by the nurse noted no hard stool but loose stool noted. The physician was contacted and informed nursing staff to send R2 to the emergency room. The nurse's notes state R2 left the facility at 5:45 P.M. by means of an ambulance.

Per review of the emergency room record from the area hospital dated 3/17/04, R2 was initially assessed at 6:20 P.M. and found to be hypotensive with vital signs of, blood pressure 78/45, pulse 72 > 123 (range), respirations 16 and afebrile. The documentation at 6:21 P.M., states R2's abdomen is distended and taut with no active bowel sounds. IV (intravenous) fluids were started at wide open rate. At 8:30 P.M., a Foley catheter was inserted with dark brown urine returned. Per review of the abdominal Xray report, there is hand written documentation which states "Pneumoperitoneum". A Levine tube was passed to the stomach with a small amount of purplish liquid returned. At 8:50 P.M. documentation states, "pt's (patient's) condition deteriorating B/P down (symbol documented) Dopamine drip started...pt transferred to (name of hospital)." The emergency room transfer sheet from the area hospital to the out of state hospital states, "31 year old male was brought to ER (symbol for) with abd. distention...hypotension & tachycardia... diagnosed with constipation> recently treated...KUB (bedside) shows huge colon distended abd. tense. Bowel sounds absent...".

Per review of the Emergency Room Record from the area hospital dictation completed by Z1 (emergency room physician), the record states, "...Per the information from the ambulance crew, the patient had a hugely distended abdomen, but there was no pain in the abdomen and his abdomen was hard to touch...he was having hypotension with tachycardia...transferred to name (name of out of state hospital) for further evaluation..."

Per review of the Patient Assessment form dated 3/17/04 from the out of state hospital R2 was transferred on 3/17/04, R2 arrived at 10:15 P.M. per ambulance due to a distended abdomen. Blood pressure is 75/44, pulse 122, respirations 24. Abdomen is described as large, distended and hard with no bowel sounds heard. Per review of the out of state form (untitled) R2's Foley catheter was draining dark bloody urine. Record states a second IV was started and ran wide open. The assessment states at 10:40, R2's blood pressure went up to 182/93 after 1800 cc's (cubic centimeters) were infused. IV fluid rate was decreased. At 11:20 P.M. R2's blood pressure was 88 - 90 doppler, pulse 118 and respirations 24. Dopamine drip was then increased due to low blood pressure. Documentation states at 11:45 P.M., R2's blood pressure was 80 doppler and oxygen saturation was down to 90 percent. R2's oxygen was increased and a rectal tube was inserted. Per review of the physician's progress notes, R2 was transported to the Intensive Care Unit of the hospital at this time.

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Per review of the History/Physical Examination completed by Z2 (physician at out of state hospital) and dated 3/17/04, this report states R2 had "...Marked abdominal distention, probably secondary to colonic pseudo-obstruction or distal sigmoid color or rectal obstruction...Hypotension, most probably secondary to severe hypovolemia due to colonic distention. However, Urosepsis cannot be ruled out. The patient will be admitted to the ICU (Intensive Care Unit) for aggressive fluid resuscitation..." Xray report dated 3/18/04 states the Impression as: "...There is an abnormal bowel gas pattern with a distended loop of bowel on the left more likely related to the descending colon with a large amount of stool and bowel gas...The appearance suggests a possible ileus with chronic constipation however, a lower colonic obstructing lesion cannot be excluded on these images. Clinical correlation recommended."

The patient assessment form further states while R2 was in the Xray department for an abdominal film, R2 became non-responsive with a cardiac arrest. Resuscitation efforts were not successful and the time of death is identified per the Medical Emergency Code form as 6:47 A.M. (5:47 Illinois time) on 3/18/04.

Per review of Z2's progress note dated 3/18/04, it states, "Potential cause of his death include persistent severe hypotension, probably secondary to severe hypovolemia from markedly distended colon. The possibility of septic shock cannot be completely ruled out...However, there is the possibility he could have had urosepsis...".

Per interview with Z3 (R2's attending physician), by telephone on 3/18/04 in the morning, Z3 stated that the facility staff brought R2 for an office visit regarding concern about R2's testicles on 3/16/04. Upon assessment of R2, Z3 stated that he did not see a concern regarding R2's testicles. However he noticed that R2's abdomen was very distended. Z3 stated R2 was taken to the area hospital for an Xray of the abdomen with the results showing no free air, but heavily constipated. Z3 stated that he asked E8 (social worker from the facility who transported R2 to the Dr. visit), if she felt R2 should be admitted to the hospital. Per interview with E8 on 3/23/04, E8 stated that she stated to Z3 that the facility would do as he ordered. E8 further stated that Z3 then had a phone discussion with Xray staff on duty and it was decided that R2 would be returned to the facility. Z3 stated that orders for laxatives and enemas were given to the nursing staff and nursing staff were to contact the physician if there was no bowel movement. Z3 further stated that he directed the nursing staff to contact him if R2 did not have bowel movements. Z3 stated that based on the phone call he received from the nursing staff in the morning on 3/17/04, he thought R2 was doing better. Z3 said around 5:00 P.M. on this same date, he received a telephone call from the nursing staff saying that R2's abdomen was still distended. When the physician asked if R2 had a bowel movement, Z3 stated that the nursing staff told him he did last night. Z3 stated he informed the nursing staff to send R2 to the emergency room. When Z3 was asked by the surveyor whether R2 should have been monitored for bowel movements prior to this episode of constipation, Z3 responded yes. When Z3 was asked by the surveyor whether laxatives should be given as ordered based on nursing monitoring bowel movements, Z3 stated "that's why they are ordered." Z3 stated there were standing orders for laxatives. Z3 further stated if the facility staff had not brought R2 to my office for something else, I would not have found his distended abdomen. Z3 stated, "They should have monitored. That is true."

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Per interview with Z2 (attending physician at out of state hospital) on 3/19/04 at 1:25 P.M. by telephone, Z2 stated that R2's abdomen was quite distended and this individual was "quite dehydrated". Z2 stated that R2 was given fluids and a Dopamine drip for hypotension. Z2 further stated that R2 "probably had a constipation problem for quite a long time." Z2 stated that R2 was sent to the Xray department for an Xray of the abdomen and became asystolic and expired.

Per review of facility policy, the Bowel and Elimination Policy and Procedure states, "Bowel elimination will be monitored on all residents every shift by direct care staff. All bowel movements (BM and lack thereof) will be recorded every shift on a monthly BM record by staff. Direct care staff will record each BM size on BM record each time it occurs. For clients who are independent in toileting, staff will question clients as to when they had BM and size each shift and record client response on BM record. Documentation on BM record may occur immediately after occurrence, anytime during shift, or at end of shift being worked. Nurses will review BM record each shift during report to ascertain any client who has not had BM at least every 9th (ninth) shift. Any client who has not had a BM after the end of the 9th shift since last BM will receive appropriate treatment measures as ordered by the physician. No later than the end of 10th (tenth) shift since last BM occurrence. After receiving the ordered treatment for no BM, the client will be monitored for BM each shift. If no BM in three (3) additional shifts after appropriate ordered treatment measures have been carried out, the physician will be notified for any further treatment orders. Any client with a known history of unusual BM patterns will have a care plan in their record with appropriate interventions and goals in place...". There is no evidence that the facility implemented this policy for R2.

Upon review of facility BM records, the lack of monitoring bowel movements and providing physician prescribed treatments are noted for R#'s 1, 3, 4, 8, 10, 11, 13, 18, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, and 34.

The nursing staff neglected to ensure R2 was monitored on a daily basis for bowel movement activity, neglected to administer medications and treatments as ordered by the physician for lack of bowel activity, neglected to assess abdominal status including monitoring bowel sounds, vital signs, appetite and hydration status, neglected to develop a plan of care for constipation and neglected to notify the physician of the change in condition of bowel status.

(A)