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	146076	A. BUILDING _____ B. WING _____	C 05/19/2006

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HAWTHORNE INN OF CLINTON	1 PARK LANE WEST CLINTON, IL 61727

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F 309	Continued From page 11 information is entered in the computer each shift by the CNA shift supervisor and put on the "Vitals Results Form". On 5/10/06 at 2:45 PM E5, Assistant Administrator, who is in charge of the CNAs stated that she has checked all of the written bowel movement sheets for all the shifts between 2/16/06 and 3/10/06 and other than the BMs charted on 2/16/06, there are no other BMs recorded before hospitalized on 3/10/06 for R1. E 5 states that the CNAs forget to chart the BMs or ask the residents.	F 309		
F9999	FINAL OBSERVATIONS REPEAT TYPE "A" VIOLATION 300.1010h) 300.1210a) Section 300.1010 Medical Care Policies 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 of notification. Section 300.1210 General Requirements for Nursing and Personal Care	F9999		

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F9999	Continued From page 12 a) The facility must 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 assessment and plan of care. 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. These REGULATIONS are not met as evidenced by: Based on observation, record review and interview the facility to comply with its Plan of correction from the 7/29/05 survey by failing to ensure that licensed nursing staff assessed residents' changes of condition and timely notifying the residents' attending physicians of the changes. The specific failures were: A) Based on record review and interview, the facility staff failed to monitor the bowel elimination status and notify the physician that the prescribed treatment for bowels was not working for 1 of 2 residents (R2) that expired at the hospital with complications from a Bowel Obstruction. R2 went 6 days without a bowel movement (BM) before the Physician was notified and transferred R2 to the hospital with abdominal distention and abdominal pain. R2 expired at the hospital from Sepsis resulting from a Bowel Obstruction. B) Based on observation, record review, and interview, the facility staff failed to monitor the bowel movements for 1 of 1 residents reviewed (R1) that developed a fecal impaction. The last documented bowel movement for R1 was 2/16/	F9999		

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F9999	Continued From page 13 06, and R1 was hospitalized on 3/10/06 with a fecal impaction. Findings include: A). The Physician's Order Sheet dated 4/1/06 to 4/30/06 shows R2 had diagnoses that included Debility, History of Urinary Tract Infections, and Abdominal Pain. According to a Physician's Progress notes dated 1/19/06 written by Z1, R2's attending Physician, R2 was "admitted to this facility after hospitalization for partial small bowel obstruction." The Physician's Order Sheet dated 4/1/2006 - 4/30/2006 shows R2 had orders for Milk of Magnesia 30 cc (cubic centimeters) PRN (as needed) and may check for fecal impaction PRN Q (every) shift. The most recent assessment for R2 is a Quarterly MDS (Minimum Data Set) Assessment dated 2/3/06 which states that R2 needed limited assistance with toileting and was continent of bowel. The assessment also showed that R2 had a bowel movement at least every 3 days. The last Care Plan which has a review date of 2/2/2006 does not address R2's history of abdominal pain or history of a partial small bowel obstruction. A "Resident Progress Note" for R2 dated 4/30/06 at 5:12 PM written by E10, Licensed Practical Nurse (LPN), states "resident noted to have firm, distended abdomen, rectal vault exam negative for stool, resident complaining of pain to abdomen, MD (Medical Doctor) paged, received order to send to (hospital) for evaluation, POA (	F9999		

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Power of Attorney) contacted and is agreeable."

The hospital record shows that R2 was evaluated in the hospital emergency room on 4/30/06 at 5: 45 PM for a distended abdomen and no bowel movement at the nursing home for 5 days. This information was reported to the emergency room by the nursing home nurse. The emergency room physical examination showed under "Rectal - Hard stool present." The nursing assessment states "Abd (Abdomen) distended, firm--BS (Bowel Sounds) absent". The report continues to say that Z1 was consulted and wanted the family consulted regarding surgery. The POA (Power of Attorney) was consulted and wanted "Comfort Care" only. R2 was admitted to the hospital.

The hospital Nurse's Notes stated that R2 was admitted on 4/30/06 at 8:10 PM. The note stated "Abdomen hard et (and) tender upon palpation. No BM times 5 days. To have soap suds enemas (SSE) until clear." A note at 9:15 PM stated " SSE given. Also manually removal of lg (large) amt (amount) formed dk (dark) brown very hard rock-like stool (and) then returned light colored brown (water). More hard rock like stool removed from lower colon but smaller amt (amount)."

A note dated 5/2/06 at 11:00 AM stated "Called to room by CNA (Certified Nurses Aide). Pt (Patient) found unresponsive (without) heart beat, no respirations. Had had a large coffee ground emesis." A note written at 11:10 AM stated "(emergency room doctor) here to pronounce dead ."

There is a CT (Cat Scan) of the Abdomen and Pelvis without Contrast done on 5/1/06 that

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shows under "Impressions": "Significant dilatation of the colon from the right hemicolon down to the rectosigmoid with a considerable amount of fecal material retained. This may be secondary to chronic functional mega colon. Fecal impaction may be present. Possibility of underlying ileus cannot be excluded."

There is a "Discharge Summary" present in the hospital record written by Z1 that states that R2 was admitted to the hospital on 4/30/06 from a local nursing home. "Patient presented with abdominal pain and distention. The emergency room physician suspected a bowel obstruction." The note continues to state "Patient did have an abdominal CT which did not confirm a mechanical bowel obstruction. There was however a pressurable distention over proximal half of the colon. Patient WBC (White Blood Count) was 9,900 when she was admitted, BUN (Blood Urea Nitrogen) was 46, and creatinine 1.3. WBC went up to 20,500 on May 1,2006, and was over 30,000 the morning the patient died." (A hospital Lab Sheet shows the normal range for WBC is 4,000 to 10,000, the normal BUN is 7.0 to 18.0 and the normal creatinine is 0.4 to 1.6.) The section titled "Condition, Treatment, Final Disposition on Discharge and Prognosis" states " It is my medical opinion that the patient did indeed have bowel obstruction and subsequently she developed sepsis and expired."

On 5/10/06 at 10:10 AM during the tour of the facility E2, Registered Nurse (RN) was interviewed. E2 stated that the bowel movement information for all the residents is entered into the computer. E2 stated that the bowel protocol for the facility is if the resident has no bowel

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movement for 3 days, the day shift nurse gives the resident Milk of Magnesia. If the resident does not have a bowel movement, the second shift nurse gives the resident a Dulcolax Suppository; and if no bowel movement by the following day, the Physician is called. E2 stated that they usually get results with this protocol.

During this same interview E2 stated that R2 was hospitalized with abdominal pain and it was "gas ." E2 stated that she thought that R2 had a bowel movement the day before she went to the hospital. E2 stated that R2 did expire at the hospital when admitted for the abdominal pain. E 2 also stated the CNA's (Certified Nurses Aides) record the bowel movements on a BM sheet and the CNA shift coordinator puts these in the computer at the end of every shift on the "Vitals Sheet."

On 5/10/06 at 11:05 AM E6, Director of Nurses, stated that the facility adopted a bowel protocol (not written) in March 2006 when another resident, R1, developed a fecal impaction. E6 stated that if a resident does not have a BM after 3 days, the day shift nurse is to give the resident Milk of Magnesia, and the second shift nurse is to give the resident a Dulcolax Suppository if no BM from the Milk of Magnesia. If still no BM by the next day, the Physician is to be notified for additional orders such as enemas. E6 stated that resident's bowel problems are discussed every day in morning report. On 5/12/06 at 10:45 AM E 6 was again interviewed and stated that some Physicians did not want the facility bowel protocol for their residents and that Z1 did not agree to the protocol.

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On 5/10/06 at 10:21 AM, E4, CNA Shift Coordinator, stated that she is not aware of any residents recently with bowel problems. E4 stated that she is not aware of any residents that have had bowel obstructions. E4 showed surveyor the "BM Sheets" where the CNAs record the BMs. E 4 stated that she enters the information about the BMs in the computer at the end of her shift. Each shift uses a separate BM sheet and these are entered into the computer at the end of each shift by the CNA coordinator for that shift.

The bowel movement activity for R2 was reviewed. The computer sheet titled "Vital Results" for R2 states that R2 had a small bowel movement on 4/24/06 at 9:48 PM. A PRN Medication Notes sheet for R2 states that on 4/24 /06 at 8:00 AM, R2 was given Milk of Magnesia (MOM) 30 cc for constipation with large results.

The next entries on the PRN Medication Notes sheet state that R2 received MOM 30 cc on 4/28/ 06, 4/29/06, and 4/30/06 and the "Result" column for all these entries are blank. The nurses who administered the doses of MOM were E7, LPN; E 8, LPN; and E9, LPN. E7 was interviewed on 5/ 12/06 at 9:34 AM, E8 on 5/12/06 at 12:25 PM, and E9 on 5/12/06 at 12:30 PM. All of these nurses stated that if no results are recorded in the "Result" column than R2 did not have any BM results from the MOM. This is 6 days since any bowel movements are recorded in R2's record. There is no documentation in the Nurses Progress Notes that the Physician was ever notified or that R2 was ever checked for a fecal impaction.

Z1, Attending Physician for R2, was interviewed

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on 5/11/06 at 10:16 AM by phone. Z1 provided the following information: "(R2) was Septic because of a Bowel Obstruction. The Death Certificate has the cause of death as Sepsis. (R2) had a partial bowel obstruction in the past and it usually repeats itself. (R2) was high risk for bowel complications."

On 5/12/06 at 8:40 am Z1 called surveyor and wanted surveyor to relate to him the concerns with R2 since he had admitted R2 to the hospital as soon as the nursing home called and informed him that R2 was distended. Z1 was told the concerns relate to the fact that R2 developed Sepsis related to the Bowel Obstruction. According to the nursing home record, R2 had not had a bowel movement since 4/24/06 and was given MOM on 4/28/06 with no results, on 4/ 29/06 with no results, and again on 4/30/06 with no results. Z1 was also told that the previous partial bowel obstruction documented in the record was not addressed in the plan of care for R2. Z1 agreed that this was a concern. Z1 stated that he was not aware that R2 had not had a BM for that length of time and this was a delay in calling him about this. Z1 stated that he was "not aware of this."

Z1 was questioned about the Cat Scan report from the hospital dated 4/30/06 that stated that there was no evidence of mechanical bowel obstruction. Z1 stated that a mechanical obstruction is usually related to adhesions or tumors but could also be caused by impacted stool. Z1 stated that his clinical diagnosis of the cause of death was Sepsis related to the Bowel Obstruction.

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Z1 was also questioned about the facility's bowel protocol to use the MOM if no BM for 3 days and then a suppository if no results from the MOM. If still no results to notify the Physician. Z1 stated that he goes along with this protocol and that he never refused this protocol.

B) The Physician's Order Sheet dated 3/1/06 to 3/31/06 shows that R1 has Physician's orders for Colace 100 mg (milligrams) 2 tablets every HS (hour sleep); Milk of Magnesia (MOM) 30 cc (cubic centimeters) PRN (as needed); May check for fecal impaction PRN every shift. There is a written note on the bottom of this order sheet written by the Physician on 3/10/06 that states " Send to hospital for impacted feces via (by) ambulance."

An Assessment Report dated 3/8/06 shows under diagnosis that R1 has Constipation. This assessment shows that R1 needs one assist for transfers and to toilet; and under bowel continence shows usually continent - incontinent episodes less than weekly.

A quarterly MDS (Minimum Data Set) assessment dated 3/6/06 shows that R1 needs extensive assistance of 1 staff to transfer and toilet. This assessment shows that R1 is continent of bowel and has a bowel movement at least every 3 days. The last care plan which has a review date of 3/9/06 does not address that R1 has constipation or any other bowel problems.

A Resident Progress Note dated 3/10/06 at 8:36 PM by E10, LPN (Licensed Practical Nurse), states "this nurse contacted MD (Medical Doctor) concerning abdomen firmness and distention,

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F9999	Continued From page 20 MOM administered." There are no other entries in the Progress Notes. A hospital emergency department note states that R1 was seen in the emergency room on 3/10 /06 at 8:45 PM. R1 "c/o (complaining of) fecal impaction. Impaction noted tonoc (tonight) @ (at) N.H. (Nursing Home). Last documented BM @ NH was 2/16/06." The nursing assessment shows that the "Abdomen very distended (with) (decreased) BS (bowel sounds), Abd (abdomen) firm". The Physician's physical exam under " Rectal Exam" states "Rectum is full with formed stool". The diagnosis on this form is "Fecal Impaction" and R1 admitted to the medical unit. A Transfer Form dated 3/12/06 from the hospital states that the "Fecal Impaction (resolved)" and that R1 was returned to the nursing home. A computer form titled "Vitals Results" shows that R1 had 3 large bowel movements on 2/16/06 and those are the only bowel movements recorded on this form up to the time R1 was sent to the hospital with the impaction on 3/10/06. The only documentation on the PRN Medication Notes Form shows that R1 received Milk of Magnesia on 3/5/06 with "no results" written in the "Result" column. There is no evidence that R1 was ever checked for a fecal impaction until 3/10/06. There is a Physician's Progress Note written by R 1's Physician dated 2/21/06 but there is no other documentation in the Progress Notes that the Physician was notified regarding R1's bowels from this visit until R1 was transferred to the hospital on 3/10/06.	F9999		

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F9999	Continued From page 21 On 5/10/06 at 12:35 PM R1 was observed seated at a table in the dining room. R1 was feeding herself and had eaten about 1/2 of her meal. R1 did appear very thin. R1 stated that she did not feel well but could not describe what was wrong. R1 was asked some simple questions and could not answer correctly. R1 was again observed on 5/10/06 about 2:00 PM in the therapy room actively participating in therapy. On 5/10/06 at 1:40 PM E2, Registered Nurse/RN, and E3, Licensed Practical Nurse/ LPN, were interviewed about R1's documentation of BMs. E 2 stated that this is the last documentation of BMs for R1 (2/16/06); and that after this incident where R1 developed a fecal impaction, a new bowel protocol has been started. E2 stated that the staff were not always asking the residents each day if they had a bowel movement so this is where the problem was. E2 stated that now the CNAs fill in a sheet each day where they observe or ask the residents about BMs. E2 stated this information is entered in the computer each shift by the CNA shift supervisor and put on the "Vitals Results Form." On 5/10/06 at 2:45 PM E5, Assistant Administrator, who is in charge of the CNAs stated that she has checked all of the written bowel movement sheets for all the shifts between 2/16/06 and 3/10/06 and other than the BMs charted on 2/16/06, there are no other BMs recorded before hospitalized on 3/10/06 for R1. E 5 states that the CNAs forget to chart the BMs or ask the residents. (A)	F9999		