STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G365	A. BUILDING _____ B. WING _____	C 07/02/2009

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ALDEN VILLAGE NORTH	7464 NORTH SHERIDAN ROAD CHICAGO, IL 60626

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 331	Continued From page 21 R2's "Information Tracking" sheet, dated May 2009, documented the frequency of R2's bowel movements. The tracking sheet identifies that staff are to, "Document the number of bowel movements the resident had throughout each shift. Inform nurse if the resident has diarrhea or no bowel movement within the last three days." The tracking sheet does not describe R2's bowel movements, e.g. size (small, medium or large), color and consistency (soft or hard). Examples include: - 5/13/09, 11pm - 7am "1" bowel movement is documented. 7am - 3pm, "1" bowel movement is documented. 3pm - 11pm "1" bowel movement is documented. - 5/14/09, 11pm - 7am "0" bowel movement is documented. 7am - 3pm, "0" bowel movement is documented. 3pm - 11pm, "0" bowel movement is documented. - 5/15/09, "1" bowel movement is documented for all 3 shifts. - 5/16/09, "1" bowel movement is documented for 2 shifts. - 5/17/09, "1" bowel movement is documented for all 3 shifts. None of the bowel movements are described to include the size, color and consistency. Based on review of the facility's "BM Monitoring" policy and the residents tracking sheet, there is no measure to evaluate a resident's bowel movement for constipation and or potential obstruction. E2 was interviewed 6/17/09 at 10:20am. E2	W 331		

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W 331	Continued From page 22 verified that R2's Information Tracking sheet, dated May 2009, does not identify / describe R2's bowel movements (size, color and consistency).	W 331		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 390.620a) 390.1030j)1) 390.1040j) 390.1040k)3) 390.3240a) Section 390.620 Resident Care Policies a) 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. These written policies shall be formulated with the involvement of the medical advisory committee and representatives of nursing and other services in the facility. 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. Section 390.1030 Physician Services j) Physician Notification 1) The facility shall immediately notify the physician of any significant accident, injury, or unusual 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	W9999		

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W9999	Continued From page 23 Section 390.1040 Nursing Services j) Nursing care (including personal, habilitative and rehabilitative care measures) shall be practiced on a 24 hour, seven day a week basis in the care of residents. Those procedures requiring medical approval shall be ordered by the attending physician. k) Nursing care shall include at a minimum the following: 3) All 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, nursing or psychosocial evaluation and treatment shall be provided. Section 390.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These Regulations were not met as evidenced by: Based on interview and record review, the facility failed to provide adequate nursing services for 1 of 1 client (R2) who expired on 5/21/09 when the facility failed to: 1. Ensure clients are assessed upon, and prior to, attending school when ill. 2. Ensure nursing adequately assesses, documents, and reports to the physician noted changes in level of consciousness, pain, and	W9999		

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W9999	Continued From page 24 signs of distress. 3. Ensure nursing recognizes and assesses clients with a change in condition. 4. Ensure a system for monitoring bowel movements, including documentation and evaluation of size, color, and consistency of bowel movement. Findings include: R2, per review of his 5/16/09 - 6/15/09 POS (Physician's Order Sheet), was a 9 year old male whose diagnoses include Profound Mental Retardation, Seizure Disorder, Central Hypotonia, Failure to Thrive, Obstructive Sleep Apnea, and Gastrostomy Tube. R2's 7/17/08 IPP (Individual Program Plan) identifies that R2 was non-verbal and non-ambulatory. A State of Illinois Certificate of Death, dated 5/23/09, notes R2 was pronounced dead on 5/21/09 at 9:25pm. Cause of death is identified as, "a. Shock, b. Sepsis, c. Bowel Obstruction." On 6/11/09 the facility provided surveyor an "Admit / Discharge Report" dated 5/1/09 - 6/30/09. During this time period R2 is identified as having expired on 5/21/09. The facility failed to provide documentation of nursing assessment, monitoring, and physician notification of R2 after a change in his medical condition which began on 5/19/09. The facility's policy titled, "Resident's Change in	W9999		

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W9999	Continued From page 25 Condition / Status," dated June 2008, was reviewed. The policy, in summary, notes the following: "A. POLICY: The facility will promptly notify the resident, attending physician or certified nurse practitioner and the responsible party of any changes in the resident's condition and / or status. B. PROCEDURE: 1. The appropriate staff will notify the resident's attending physician or nurse practitioner when: ... b. there is a significant change in the resident's physical, mental or psychosocial status; ... g. changes occur that affect the resident's current level of care ... 4. The staff will record in the resident's medical record any changes in the resident's medical condition or status. ... Resident Observation - Change of Condition Examples of a change in condition / status (list is not inclusive - examples only) - Abnormal lethargy - Pain ... Documentation must include: - Assessment and description of change in condition - Interventions - Referrals to interdisciplinary team - M.D. and family notification - Update residents care plan - Follow-up Documentation in the resident record must be continuous and on-going until the condition has resolved or improved. ... " The facility provided an Incident Report, dated 5/21/09, that identifies R2 was sent to the hospital as he was "pale looking and lethargic (and) low saturation (on) RA (room air) - 89%."	W9999		

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W9999	Continued From page 26 The Incident Report notes R2 was sent to a local hospital and then sent to a second hospital. E2 (Acting DON) was interviewed 6/17/09 at 10:20am. E2 stated that on 5/19/09 R2 was sent home early from school because the school nurse said his G-tube was leaking. E2 stated that R2 was again sent home from school on 5/20/09. A school nursing "Service Log for (R2) 5/7/09 - 6/24/09" was reviewed and the following was documented by Z2 (school nurse/LPN): - 5/19/09 "Alert. Responsive. Noted large amount of clear yellowish colored drainage coming from g-tube. Afebrile. T=97.3 ax. No s/s (signs or symptoms) of pain or discomfort noted. Notified Nurse (E15 LPN) at Alden Village North. 10:15 Alden Village North staff here to pick up pt. (patient)." - 5/20/09 Arrived at school. Skin color pale. Appeared to be dark circles under eyes. Skin warm and clammy. Sleeping. Intermittently moaning and groaning. T=98.6. 0945 Notified Nurse (E16 LPN) at Alden Village North to pick up pt. 1130 - Alden staff still not here for pick up. Tube feeding held. Pt. continues to moan and groan. Pt. laying on mat, curled up in fetal position. Pt. making gag - like sounds and gestures intermittently. Skin still clammy. Notified Alden Village North again. 1245 - Alden Village North staff here to pick up pt." Z2 was interviewed on 6/17/09 at 3:00pm via phone call. Z2 stated that on 5/19/09, in the morning, R2's G-tube was leaking. Z2 stated a clear to yellow transparent liquid was leaking	W9999		

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W9999	Continued From page 27 from R2. Z2 explained that the liquid was not coming from R2's tubing, rather it was coming out of his abdomen - where the G-tube is inserted. Z2 stated it was a large amount of fluid that was coming out of R2. Z2 stated, "It was coming out profusely, his pants and shirt were soaked." Z2 was asked if she assessed R2's vital signs. Z2 stated she documented R2's temperature, and he did not have an elevated temperature. Z2 was asked if she ausculted R2's abdomen to listen for bowel sounds. Z2 stated she does not have a stethoscope. Z2 stated that at that time R2's abdomen was not distended. Z2 stated staff from R2's residence picked R2 up at approximately 10:15am on 5/19/09. Z2 stated that on 5/20/09 R2 came back to school. Z2 stated, "I can't believe he came back. He was pale. His eyes were sunken like he was awake all night. He was shaking and grunting and in a fetal position." Z2 stated when she called R2's facility to pick him up from school, at 9:45am, the nurse at the facility argued with her and said to give him Tylenol. Z2 stated it took 3 hours for staff from the facility to pick up R2 on 5/20/09. Z2 stated R2 is scheduled to receive a 12 noon G-tube feeding. However she did not administer it on 5/20/09. Z2 was asked if she palpated R2's abdomen on 5/20/09. Z2 stated she did not palpate R2's abdomen because he was in too much discomfort. Z3 (teacher) was interviewed 6/19/09 at 10:45am via a phone call. Z3 verified R2 was sent home early from school on 5/19/09 at approximately	W9999		

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W9999	Continued From page 28 10:15am. Z3 stated R2 was sent home because a lot of fluid was leaking from around his G-tube. Z3 stated R2's G-tube itself was not leaking, the fluid was coming from R2's stomach where the tubing is inserted. Z3 stated R2's clothes were wet and the floor had to be mopped because the fluid pooled under R2's wheelchair. Z3 stated that on 5/20/09 when R2 arrived at school it was noticed right away that R2 ws not his usual self. Z3 stated that usually R2 is in constant motion and will vocalize. Z3 stated that R2 was lethargic, pale, and moaning. Z3 stated that R2 was put on a mat where he continued to moan. Z3 stated it took a long time for R2's staff to pick him up from school. E5 (Case Manager) was interviewed 6/17/09 at 11:15am. E5 verified that R2 is non-verbal and non-ambulatory. E5 stated R2 vocalizes and typically moves a lot (e.g. his arms flail). E5 was again interviewed 6/18/09 at 12:50pm. E5 was asked if R2 is moaning what that would indicate. E5 stated moaning for R2 indicates pain or something is wrong. E4 (RN) was interviewed 6/17/09 at 10:45am. E4 stated that when R2 is flailing/moving a lot that is normal for him. E4 stated that if R2 is moaning that represents pain. R2's nursing progress notes, from the facility, were reviewed. There is no nursing note entry for 5/19/09, the day R2 was sent home from school at approximately 10:15am due to leaking fluid from G-tube site. R2's name does appear, however, on a 24 hour nursing report dated 5/19/09.	W9999		

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W9999	Continued From page 29 A "Documentation Follow-Up Guide," initiated 5/19/09, notes the following: "5/19/09 - Shift 7 - 3, Nurse (Z2) at school sent (R2) home because his G-tube was leaking. It's still intact. Pls (please) check on it. 3 - 11, G-tube intact / patent. 11 - 7, G-tube intact / patent." Nursing staff failed to document that R2 was assessed and vitals were taken after he was sent home from school on 5/19/09 due to leakage at his G-tube site. E2 (Acting DON) was interviewed 7/1/09 at 1:50pm, via a phone call. E2 was asked what the nurse should assess and document in regards to R2 being sent home from school due to reports of a leaking G-tube on 5/19/09. E2 stated the nurse should do a body assessment which includes checking the G-tube site, checking the dressing at the G-tube site, checking for placement of the G-tube, and checking the abdomen. E2 stated the above should be charted in the nurses notes by the nurse. E2 was interviewed 6/17/09 at 11:00am. E2 verified that E15 did not document, in nursing notes that R2 was assessed after reports of a leaking G-tube at his school. On 5/20/09 E16 (LPN) documented the following in R2's nursing notes: "1pm, Pt. (patient) returned from school. Lethargic. Afebrile. Tylenol given (G-tube device changed from one type to another). Fluids given. Pt. with HOB (Head of Bed) elevated. Will cont. (continue) to monitor pt. 3pm, Pt. stable GTF (G-tube feeding) tol (tolerated) well. Pt. sleeping. Afebrile."	W9999		

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W9999	Continued From page 30 There is no evidence that R2 was assessed and vitals were taken after he was sent home from school on 5/20/09. E16 did not document if R2 was assessed for pain. E16 documented R2 was given Tylenol. However, E16 did not document the reason the Tylenol was given and if it was effective. R2's MAR (Medication Administration Record), dated 5/16/09 to 6/15/09, was reviewed and there are initials noting Tylenol was given once on 5/20/09. (Z2 documented 5/20/09 that R2 was moaning and groaning and curled up in a fetal position. Z2 also documented R2 was making gag-like sounds and gestures intermittently.) E16 was interviewed 6/30/09 at 11:20am via a phone call. E16 verified that she worked first shift (7am - 3pm) on Wednesday 5/20/09. E16 stated that on 5/20/09, in the morning, she received a phone call from R2's school nurse. The school nurse said that R2 was moaning and he needed to be picked up from school. E16 stated she told the school nurse that R2's case manager was not available, but she would try and find someone to pick up R2. E16 stated the school nurse called again and was upset about waiting for someone to pick up R2. E16 stated she told the school nurse to contact the facility's DON. E16 stated after the school nurse spoke to the DON, E5 (case manager) went to the school to pick up R2. E16 stated when R2 returned to the facility, she assessed him and observed him to be moaning. E16 stated she gave R2 Tylenol for moaning. Surveyor asked E16 how she interpreted R2's	W9999		

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W9999	Continued From page 31 moaning. E16 stated moaning for R2 means discomfort. E16 stated she also asked E6 (RN) to look at R2. E16 stated E6 did look at R2 and thought R2 "looked ok." Surveyor asked E16 if she notified R2's physician - due to R2 moaning and school reports of R2 looking pale, being lethargic, and curled up in a fetal position. E16 stated she did not notify R2's physician. Surveyor asked E16 if she assessed R2 and took his vital signs. E16 stated she did take R2's vitals, but she must have forgot to document them. Surveyor asked E16 if it was normal for R2 to moan. E16 stated that R2 is usually more playful. E16 was asked if she was aware of R2 ever moaning before. E16 stated, "Not that I know of." E16 was again asked why she did not notify R2's physician due to R2 moaning. E16 stated, "I assumed he looked well - and I was about to leave - and I endorsed to the next shift." E2 was interviewed 7/1/09 at 1:50pm, via a phone call. E2 was asked if the facility had a policy regarding if a client becomes ill while at school. E2 stated there is no policy. E2 explained that if the facility receives a phone call that a child is ill and it is urgent, then they will pick them up from the school. However, if there is a minor concern (e.g. as a scratch) the facility will be notified by the school and the child will be assessed when they return home.	W9999		

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W9999	Continued From page 32 E2 was also asked about the facility's system for nursing staff endorsing to the next shift regarding a client who has been identified as being ill. E2 stated if a nurse has endorsed an ill client to an on-coming shift, then the on-coming nurse would monitor and document in the nurses notes the clients status. E2 stated the physician would be notified if a client is really in discomfort and an identified condition (e.g. elevated temperature) continues. E2 was asked how R2 should be assessed if he is identified as moaning in pain. E2 stated that first the nurse should differentiate if R2 is moaning as a sign of pain or as normal for him. E2 stated if moaning is a sign of pain then the nurse should assess for the cause of the discomfort. E2 stated assessment for discomfort includes examining the body to determine the source of discomfort. There is no documented evidence R2 was assessed for discomfort after R2's school nurse notified the facility that R2 was moaning on 5/20/09. R2's nursing progress notes do not contain any documentation after 5/20/09 3pm until 5/21/09 at 6am. There is no nursing documentation for 5/20/09 the 3pm - 11pm shift. There is a documentation on a 5/20/09 24 hour nursing report (3pm - 11pm), written by E12 (RN) that notes: "T (temperature) = 99.7, pls (please) monitor, sleeping all the time." E5 (Case Manager) was interviewed 6/17/09 at 11:15am. E5 stated that on 5/20/09 he picked	W9999		

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W9999	Continued From page 33 R2 up from school. E5 stated that when he arrived at R2's school he observed R2 on a mat. E5 stated that R2's teacher told him that R2 was tired and out of it all day. R2 was also moaning. E5 stated R2's teacher told him that she felt something was not right with R2. E5 stated when R2 was transferred from the mat to his wheelchair he was moaning. E5 stated he then returned R2 to the facility, via his wheelchair (approximately 5 minute walk from school to facility). E5 stated when he returned to the facility he told E6 (RN) that R2 does not look good. On 5/21/09 E13 (LPN) documented the following in R2's nursing notes: "6am, Res (resident) had a fever Temp. 99.1, Tylenol was given. Temp went down to 97.7 Pls (please) continue to monitor. 7am, Res's GTF (Gastrostomy Tube Feeding) infusing well. Due meds given. Pushed fluids, Neb tx (nebulizer treatment) given. Res did not sleep too well during the night. Res. should stay away from school because after the tx. res. became sleepy. Temp at this time was 98.9. Pls. continue to monitor." R2's 5/16/09 to 6/15/09 MAR was reviewed. There is no documentation that E13 administered Tylenol and a nebulizer treatment (Albuterol 0.083% - 3ML). E13 was interviewed 6/19/09 at 12:10pm via phone call. E13 verified that she worked 11pm until 7am starting on 5/20/09. E13 stated she was informed that R2 was sent home from school that day (5/20/09) due to lethargy and an elevated temperature. E13 stated that during the	W9999		

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ALDEN VILLAGE NORTH	7464 NORTH SHERIDAN ROAD CHICAGO, IL 60626

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W9999	Continued From page 34	W9999		

night R2 was restless off and on all night long. E13 stated she administered Tylenol and gave R2 a nebulizer treatment with Albuterol. E13 stated R2 was more sleepy after his nebulizer treatment so she decided he should stay home from school.

E13 stated when the first shift nurse arrived (E9 - RN), she told her that if R2 continues with increased sleeping she should do something. E13 was asked why she did not notify R2's physician about his condition. E13 stated, "No reason." E13 then stated she endorsed to E9 R2's status.

E17 (CNA) was interviewed 6/30/09 at 2:45pm, via a phone call. E17 stated that he worked third shift the evenings of 5/19/09 and 5/20/09 (from 10pm until 6am). E17 verified he was the primary CNA responsible for R2 on both 5/19/09 and 5/20/09.

E17 stated that on 5/19/09 R2 was restless all night. E17 stated that R2 was tossing and moaning all night long.

E17 stated that on 5/20/09 R2 was again tossing and moaning all night long. E17 stated R2 did not sleep at all that night. E17 stated that R2, "looked really sick." E17 was asked if the nurse was aware that R2 looked really sick and was restless all night. E17 identified E13 the nurse working 3rd shift. E17 said E13 was aware of R2's status and she did check on him throughout the night. E17 stated he did not know if R2's doctor was notified of R2's status because he left at 6:00am.

On 5/21/09 E9 documented the following in R2's

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W9999	Continued From page 35 nursing notes: - "5/21/09 7:30am - Received resident up on chair. Pale looking and mild lethargic observed. Temp checked - 98.2 F - kept monitored." - "8am - Resident reassessed. Mild distress noted, v/s (vital signs) checked. T - 99.1 - P 80 - R21 - BP 100/60 - O2 sat. 89% RA (Room Air) O2 at 2 - 3 LPM (liter per minute) applied saturating 93%, abdomen distended, board like rigidity noted. Refer to MD and ordered to send to (hospital) for evaluation. DON (Director of Nursing) and Admin. made aware. Family notified." - "9am - P/U (pick up_ by ambulance - Will (follow up) at (hospital)." - "11:15am - Received a call from Z5 (physician) and informed to us that he will transfer the resident to (another hospital) for further evaluation Dx ?? - bleeding in the stomach. Family notified. DON and Admin. made aware." E9 was interviewed 6/18/09 at 1:30pm. E9 stated that she started her shift on 5/21/09 at approximately 7:25am. E9 stated that E13 endorsed to her that R2 was sick that night and he had received a prn (as needed) nebulizer treatment. E9 stated she then went with E13 to see R2. E9 stated R2 was pale looking, and at this time she asked E13 why R2 was not sent out to the hospital. E9 stated E13 did not answer her. E9 stated she then left R2 to prepare for the morning medication pass. E9 stated when she	W9999		

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W9999	Continued From page 36	W9999		

went back to R2's bedroom with E6 (RN). At this time E9 and E6 agreed R2 did not look good. E9 stated she palpated R2's abdomen and noted board-like rigidity. E9 called R2's physician and also told him R2's Oxygen saturation rate on room air was 89%. E9 stated she told R2's physician that she started R2 on oxygen, and that she was going to send him to the hospital. E9 stated that at approximately 9:00am the ambulance arrived to transfer R2 to the hospital.

E9 was asked if she called 911 as an emergency to transfer R2. E9 stated she did not think R2 was that bad.

R2's ambulance transport "Trip Details" report was reviewed. The ambulance company documented they received the emergency response call at 08:45 hours. The ambulance was dispatched to R2's residence at 08:46 hours. The paramedics arrived at R2's residence at 08:58 and departed with R2 at 09:34.

The paramedics documented R2's vitals at 09:00 as: B/P 112/52, pulse 160, respirations 28, and pulse ox at 96%.

R2's last vital signs taken at the facility were documented by E9 at 8:00am. At this time R2's pulse was documented to be 80. The paramedics documented R2's pulse to be 160 at 9:00am. There is no documentation that R2's vitals were being monitored, for one hour, prior to the paramedics arriving at 08:58 hours.

E6 (RN) was interviewed 6/17/09 at 11:23am. E6 stated he observed R2 the morning of 5/21/09 when he was doing his morning rounds. E6 stated he saw R2 at approximately

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W9999	Continued From page 37 7:30am/8:00am. E6 stated R2 was up in his wheelchair moaning and sweating. E6 stated R2's clothes were wet from sweating, and he told staff to change his clothes. E6 stated he observed R2's abdomen to be distended. E6 stated that R2's, "heart rate was up." E6 also stated that he suctioned R2 because of excessive drooling. E6 was asked if R2 was normally suctioned. E6 stated, "No." E6 was asked if he documented the above observations (sweating, need to be suctioned and elevated pulse). E6 stated he did not document his observations because he was not R2's primary nurse. Z4 (ER Physician) was interviewed 6/19/09 at 1:17pm, via phone call. Z4 stated when R2 arrived in the emergency room, on 5/21/09, he was pale and grey and in shock. Z4 stated R2 was put on a ventilator and ultimately R2 was transferred to another hospital because he needed a higher level of care. R2's medical records from the second hospital were reviewed and the following was documented: "Impression: (R2) is a 9 years old male with a h/o (history of) sz (seizures), GT/Nissen, unable to communicate, minimally interactive who presented to an OH (other hospital) in extremis with an acute abdomen, respiratory failure and hypotension likely secondary to a catastrophic GI event (probably obstruction and necrosis) now intubated on inotropes in extremely critical condition." "History of Present Illness: ... He (R2) presented	W9999		

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W9999	Continued From page 38 to an OH approximately 1 day h/o lethargy and fever and abdominal distention. At the OH he was noted to have blood output from his GT (G-tube), bloody diarrhea, a massively distended abdomen. He developed respiratory failure and was intubated. ... Pediatric surgery felt that this presentation of an acute abdomen is a potentially fatal event. While he is a candidate for surgery, (physician) informed the mother that he may not survive even if he could tolerate a surgical procedure. Given the extreme nature of the situation, the mother felt that it would not be in (R2's) best interest to pursue surgery. She said, 'He's been through enough.' ... " R2 was pronounced dead, per "State of Illinois Certificate of Death," at 9:25pm on 5/21/09. Z5 (Physician) was interviewed, via a phone call, 6/30/09 at 12:53pm. Z5 stated that he received a phone call regarding R2 on 5/21/09 in the morning. Z5 stated the nurse at R2's residence told him that R2 was diaphoretic and tachycardiac. Z5 stated he instructed the nurse to have R2 sent to the emergency room. Z5 stated he received R2 at the hospital. Z5 stated that R2's "belly was significant, board-like. He had blood in his G-tube and his vitals were abnormal." Z2 stated that R2 was stabilized and sent to a children's hospital for further care. Surveyor asked Z5 if he was notified, prior to 5/21/09 of any symptoms or medical issues that R2 was having. Z5 stated he was not called with any previous concerns regarding R2. Surveyor asked Z5 if R2 would have been	W9999		

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W9999	Continued From page 39 symptomatic prior to becoming critically ill on 5/21/09. Z5 stated that R2 may have had symptoms 1 to 2 days prior. Z5 stated the symptoms may have been difficult to recognize and it would depend on the skill level of the nurse assessing R2. Z5 stated it probably would have been better if R2's symptoms were recognized sooner. The facility Policy, titled "BM (bowel movement) Monitoring", dated October 2007 was reviewed. The policy notes the following: "A. POLICY: Residents are routinely monitored for abdominal distention, bowel sounds and signs and symptoms of impaction and / or other GI problems as needed by nursing staff. B. PROCEDURE: 1. Direct care staff observes and reports to nurses any abnormalities of bowel movements, abdominal distention or resident concerns regarding elimination. 2. Direct care staff will document BM's for individual residents as circumstances indicate. 3. Nurse will take appropriate action for excessive BM or constipation. 1. Listen for bowel sounds 2. Check for impaction if applicable 3. Notify M.D. as needed 4. Medicate as ordered 5. Documentation on resident information sheet" R2's "Information Tracking" sheet, dated May 2009, documented the frequency of R2's bowel movements. The tracking sheet identifies that staff are to, "Document the number of bowel movements the resident had throughout each shift. Inform nurse if the resident has diarrhea or no bowel movement within the last three days."	W9999		

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W9999	Continued From page 40 The tracking sheet does not describe R2's bowel movements, e.g. size (small, medium or large), color and consistency (soft or hard). Examples include: - 5/13/09, 11pm - 7am "1" bowel movement is documented. 7am - 3pm, "1" bowel movement is documented. 3pm - 11pm "1" bowel movement is documented. - 5/14/09, 11pm - 7am "0" bowel movement is documented. 7am - 3pm, "0" bowel movement is documented. 3pm - 11pm, "0" bowel movement is documented. - 5/15/09, "1" bowel movement is documented for all 3 shifts. - 5/16/09, "1" bowel movement is documented for 2 shifts. - 5/17/09, "1" bowel movement is documented for all 3 shifts. None of the bowel movements are described to include the size, color and consistency. Based on review of the facility's "BM Monitoring" policy and the residents tracking sheet, there is no measure to evaluate a resident's bowel movement for constipation and or potential obstruction. E2 was interviewed 6/17/09 at 10:20am. E2 verified that R2's Information Tracking sheet, dated May 2009, does not identify/describe R2's bowel movements (size, color and consistency). (A)	W9999		