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{W 331}	Continued From page 23 since the facility has not fully implemented their plan and has not had an opportunity to evaluate it's effectiveness.	{W 331}		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.620a) 350.1210 350.1220j) 350.1230d)1) 350.3240a) 350.3750 Section 350.620 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. 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 350.1210 Health Services The facility shall provide all services necessary to maintain each resident in good physical health. Section 350.1220 Physician Services j) 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	W9999		

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W9999	Continued From page 24 more within a period of 30 days. Section 350.1230 Nursing Services d) Direct care personnel shall be trained in, but are not limited to, the following: 1) Detecting signs of illness, dysfunction or maladaptive behavior that warrant medical, nursing or psychosocial intervention. Section 350.3240 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) Section 350.3750 Consultation Services and Nursing Services Residents needing nursing care shall be admitted to an ICF/DD of 16 Beds or Less only if the facility has adequate professional nursing services to meet the resident's needs. Arrangements shall be made through formal contract for the services of a licensed nurse to visit as required. A responsible staff member shall be on duty at all times who is immediately accessible, and to whom residents can report injuries, symptoms of illness, and emergencies (see Section 350.810(a)). The consultant nurse shall provide consultation on the health aspects of the individual plan of care and shall be in the facility not less than two hours per month. These Regulations were not met as evidenced by: Based on observation, interview and record review, the facility has failed to ensure that	W9999		

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W9999	Continued From page 25 individuals are provided with nursing services in accordance with their needs when they failed to monitor for medical needs of constipation for 1 of 1 individual outside the sample (R5) who was hospitalized with a fecal bowel obstruction, having the potential to impact 4 of 4 individuals outside the sample with diagnoses of Chronic Constipation (R6, R7, R8 and R9). A) Prior to R5's hospitalization, nursing staff failed to monitor and ensure that: 1. Staff maintained bowel movement records; 2. Staff monitored food and fluid intake; and 3. As needed medications were administered as physician ordered for constipation. B) After R5's hospitalization, the nursing staff failed to: 1. Complete an initial admission assessment inclusive of bowel sounds and level of pain; 2. Provide nursing documentation regarding R5's first twenty-four hours back in the facility; and 3. Notify the physician regarding episodes of vomiting and significant changes in R5's condition. C) Within 24 hours of R5's readmission to the facility, R5 began experiencing episodes of vomiting and staff failed to call 911 after failed attempts to reach the nurse on call. Findings include: The Physician's Orders sheet dated 04/16/09 thru 05/15/09 (most current on file) identifies that R5 is a 75 year old male who functions at a severe level of mental retardation and has	W9999		

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W9999	Continued From page 26 diagnosis which includes Chronic Constipation. R5 also has orders for two Docusate Sodium 100 mg capsules daily for constipation and for 15 ML of Lactulose solution once daily for constipation. A) Prior to R5's hospitalization, nursing staff failed to monitor for medical needs of constipation. In reviewing R5's Nurse's Notes, it was noted that he had been admitted to the hospital on 11/27/08 for "...weakness et (and) constipation...." Further review of these notes identifies that R5 returned back to facility on 11/29/08. A Nursing Care Plan dated 11/24/08 states: Nursing Diagnosis : Alteration in Elimination related to constipation Expected Outcome: R5 will have a bowel movement at least every three days Nursing interventions: *Medications routinely and prn (as needed) as prescribed by physician *Monitor food and fluid intake *Encourage fluids *Diet as ordered *Notify physician if no BM within 3 days with current med regimen *Monitor BM's (This report was updated without changes on 03/05/09 by Z1 (Registered Nurse Consultant). 1. Daily Bowel Movement records are not maintained, nor is there a system in place for direct care staff to report the lack of bowel	W9999		

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W9999	Continued From page 27 movements to nursing staff. In reviewing the documentation on the Bowel Movement Schedule sheet(s), no schedule sheets were noted for the months of December 2008 through April 2009 which would indicate that R5's bowel movements were being monitored on a daily basis. During this review, only one Bowel Movement Schedule for the month of May 2009 was located. This schedule identifies that R5 had only four documented bowel movements from 05/01 through 05/24/09 (one on 05/04, one on 05/11 and two on 05/18/09). No further bowel movements were noted on this schedule. No documentation was noted identifying that staff had notified nursing staff of R5's lack of bowel movements. E4 (Licensed Practical Nurse - LPN) was interviewed by telephone on 06/17 /09 at 11:00 A.M. and stated, "The staff keep a record of everyone's bowel movements. Staff should be telling the nurse if anyone hasn't had a bowel movement after three days...." When E4 was asked by the surveyor how nursing reviews the bowel movement records, E4 stated, "We don't. Staff turn those sheets over to the QMRP at the end of the month." E2 (QMRP) was then interviewed by telephone on 06/17/09 at 11:05 A.M. and stated, "Staff turn the Bowel Movement Schedules into me at the end of every month. When E2 was asked by the surveyor if these schedules are made available to the nursing staff, E2 stated "No." E2 also stated, "We have five individuals with diagnosis of Chronic Constipation (R5, R6, R7, R8 and R9)	W9999		

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W9999	Continued From page 28 who are to have bowel movement records. During this interview E2 confirmed that no bowel movement records were available for R5-R9 for the months of December 2008, and January, February, March and April 2009. E5 (Direct Care Staff) was interviewed on 06/16/09 at 3:09 P.M. and stated, "...Staff maintain the bowel movement sheets. We document for R6, R7, R8 and R9... and R5. I now know that we are to notify the nurse if these individuals do not have a bowel movement in three days. I did not know prior to 06/10/09 that we were to let the nurse if they didn't have a bowel movement." 2. Staff failed to monitor R5's food and fluid intake and failed to address recommendations to increase fiber and fluids. R5's Annual Nutritional Assessment dated 03/17/09 identifies that R5 needs "High fibre with 1500 -2000 ml (milliliters) of fluid. Recommendations were made which include, "Add fibre and 5-6 cups fluids - water and diet beverages...." In reviewing R5's Nurse's Notes and Physician Order Sheets, no documentation is noted to indicate that the dietician's recommendations from 03/17/09 were addressed. The facility's Food Intake logs were reviewed. These logs identify the names of all the individuals of the facility, the percentage of foods they consumed at the breakfast, lunch and dinner meals as with the amount of fluids that were consumed during the respective meal. Only three logs were located by the facility for the timeframe	W9999		

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W9999	Continued From page 29 of January 2009 to present (03/11, 03/13 and 05/13/09). No further logs were noted or located by the facility for the days of the months of January, February, March, April, May and or June 2009. In reviewing the three Food Intake Logs that had been dated and or completed by the facility, the following was noted: Food Intake Log dated 03/11/09: No documentation is noted regarding the amount of food and or fluids that R5 consumed during the breakfast, lunch or dinner meals. Additionally no documentation was noted for any of the individuals of the facility. Food Intake Log dated 03/13/09: Staff documented that R5 ate 100% of his breakfast meal. No documentation was noted for R5's fluid intake for this meal. No further documentation is noted regarding any food and or fluids consumed for the lunch and dinner meal for R5 and or any other individual of the facility. Food Intake Log dated 05/13/09: Staff documented that R5 ate 100% of his breakfast and lunch and consumed 600 cc's (cubic centimeters) of fluid at breakfast and 480 cc's of fluid at lunch. No documentation was noted for the dinner meal. E13 (Food Service Supervisor- FSS) was interviewed by telephone on 06/18/09 at 12:42 P.M. and stated, " No, I didn't find any other Food Intake Log forms other than the ones that were found..." Z1 (RN Consultant) was interviewed by	W9999		

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W9999	Continued From page 30 telephone on 06/17/09 at 8:07 A.M. and stated, "Staff should have been monitoring and encouraging fluids. Nursing staff should have called the physician when they received the dietician's recommendation to increase his fiber and fluids. R5's nursing plan states that staff are to monitor R5's food and fluid intake and encourage fluids to assist in preventing constipation." 3. As needed medications were not administered as physician ordered for constipation. Further review of R5's Physician's Orders sheet dated 04/16/09 thru 05/15/09 (most current on file) identifies PRN (As needed) orders for two tablespoons of Milk of Magnesia for constipation. This order also states that the physician is to be notified for further orders if R5 has had no bowel movements in three days. In reviewing the Medication Administration Records from 01/15/09 thru 05/24/09, there are no entries/initials that would identify that R5 ever received Milk of Magnesia on an as need basis for constipation. Z1 (RN Consultant) was interviewed by telephone on 06/17/09 at 8:07 A.M. and stated, "Nursing should have been monitoring R5's bowel movements and administered Milk of Magnesia if he didn't have a bowel movement in a three day period. If he didn't have a bowel movement within twenty four hours of the Milk of Mag (Magnesia) then they should have given additional medications if ordered, or notified the physician for further orders...." Further review of the Nurse's Notes identifies that	W9999		

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W9999	Continued From page 31 R5 was hospitalized on 05/24/09 due to fecal impaction. R5's Nurse's Notes dated 05/24/09 state, "6:45 A.M. Res (resident) admitted to *** (initials of hospital) Dx (diagnosis) fecal impaction." In reviewing R5's (hospital) Discharge Summary dated 06/04/2009 the following was noted: Admission diagnosis: Vomiting History of Present Illness: R5 was admitted (5/24/2009) with symptoms of vomiting. The CT scan of the abdomen showed air fluid levels in the small bowel probably suggestive of small bowel obstruction. Hospital Course: We placed an NG (Nasal Gastric) tube; started him on IV (Intravenous) fluids. The surgeon saw the patient. Patient was treated conservatively. Initially he improved but then he again started getting worse. He had a lot of difficulty controlling his blood pressure. We had to start him on multiple medications for blood pressure including Clonidine, beta blockers, ace inhibitors, diuretics and calcium channel blockers. Patient initially improved but again he got worse so we had to place an NG tube again. We decided to put the NG tube again today. The repeat x-rays shows ileus pattern with dilated small bowel and large bowel... Patient has been here for eight to ten days and there has not been any improvement in his symptoms. They want the patient to be transferred. His white white count has slightly gone up. He was receiving empiric antibiotics for elevated white count. His white count has gone up so we are going to transfer him...."	W9999		

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W9999	Continued From page 32 Final Diagnosis: 1. Persistent paralytic ileus with possible mechanical obstruction... Addendum: Patient is now being transferred to *** (name of hospital)... He has been here for the last ten days. We are trying to treat his ileus/mechanical obstruction problem. Three times we have failed. After initial improvement with NG tube placement patient starts having abdominal distention when we start oral diet. We placed an NG tube yesterday. He drained more than 1,000 ml. Today in the morning I noticed that patient is having some coffee ground liquid coming out of the NG tube. Most likely traumatic from multiple NG tube placements... We will go ahead and transfer the patient to **** (name of hospital) since the are no beds available at **** (name of hospital) and patient's condition is not improving." Further review of R5's medical records identifies that he was transferred to **** (name of hospital) on 06/04/09. R5's hospital records identified that he remained in the hospital from 06/04 - 06/10/09. Upon his admission, a CT (Computerized Axial Tomography) scan (dated 06/04/2009) of the abdomen and pelvis (with oral and intravenous contrast) showed, "1. Colonic fecal stasis ascending and descending colon. There is mild gaseous distension of transverse colon. 2. Dilation of the small bowel from the abdomen into the left pelvis where there is a transition	W9999		

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W9999	Continued From page 33 zone. Finding are compatible with a distal small bowel obstruction. There is no free intraperitoneal air or fluid..." Further review of R5's Radiology Exams Results identifies, 06/05/2009 6:41 A.M. X-ray exam of the abdomen... Findings: A single supine radiograph of the abdomen was submitted, There is an NG tube with the tip projected in the expected location of the mid body of the stomach. There is mild gaseous distention involving both large and small bowel. A moderate amount of retained fecal material is apparent throughout the colon. There is contrast material within the mid to distal small bowel... Impression: 1. NG tube with the tip projected in the approximate location of the midbody of the stomach. 2. Continued evidence of a partial small bowl obstruction with interval decrease in the amount of gaseous distention compared with patient's prior radiograph. There is evidence of moderate fecal stasis with contrast material in the distal small bowel. 06/05/2009 9:32 A.M. PICC (peripherally inserted central catheter) line inserted for long term central venous access. 06/05/2009 2:41 P.M. X-ray exam of the abdomen... Findings: Motion artifacts degrades multiple images. Nasogastric tube is seen in the stomach. Colonic fecal stasis is seen in the right colon. When compared to the prior examination of earlier the same day contrast within the small bowel is now seen in the right colon. Impression: There is limited evaluation due to motion. Contrast previously noted in the small bowel has progressed into the right colon.	W9999		

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W9999	Continued From page 34 06/07/2009 8:53 A.M. X-ray Exam: Acute abdominal series... Impression: ... 3. Majority of gas appears to be within the colon. Correlate clinically regarding partial small bowel obstruction... 06/09/2009 6:33 A.M. X-ray Exam: One view abdomen dated 06/09/09... Impression: 1. Nonspecific bowel gas pattern with no evidence of bowel obstruction... The Nurse's Notes dated 06/10/09 identifies that that R5 was readmitted back to the facility. Nursing documentation states, "... 5 P.M. Transport home per staff E2." B) After R5's hospitalization, nursing staff failed to complete an initial assessment upon readmission, failed to provide nursing documentation regarding R5's condition and failed to notify the physician of significant changes in his condition. 1. Nursing failed to complete an initial admission assessment inclusive of bowel sounds and level of pain. In reviewing R5's record, no nursing assessment was found within this record, indicating that nursing completed a full body assessment at the time of his readmission back to the facility inclusive of, vitals, skin integrity, bowel sounds, and or level of pain. E3 (Assistant Administrator) was interviewed by telephone on 06/18/09 at 1:10 P.M. and stated, "R5 was not to have returned back to the facility until he was reevaluated. E11 (LPN) sent E2	W9999		

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W9999	Continued From page 35	W9999		

(QMRP) to pick him up. At that point, we were unsure if we would be able to meet his needs... I told E11 to do a full body assessment on R5, including vitals, weight and to notify the doctor. She told me that she had spoken with E10 (Facility's medical Director) and that he had given orders to discontinue his indwelling catheter and approved the use of a wheelchair and gait belt. His diet orders were to be the same. I thought she would get orders to increase R5's level of supervision for medical reasons. I also thought she would do a pain assessment since he was getting Morphine in the hospital. I am aware that she (E11) did not document anything in R5's record."

E10 (Facility's Medical Director) was interviewed by telephone on 06/18/09 at 9:00 A.M. and stated, "I was contacted by nursing staff at the time R5 was readmitted back to the facility." When E10 was asked by the surveyor if he would have expected nursing to have documented that they had completed a full body assessment at the time R5 was readmitted back to the facility, E10 stated, "Yes."

2. Nursing staff failed to provide nursing documentation regarding R5's condition during the first twenty four hours after returning from the hospital.

R5 was observed at the facility on 06/11/09 during the lunch meal. R5 was observed sitting in a wheelchair. He was slow to respond when asked basic questions by the surveyor. R5 would respond with a simple answer of "yeah" or "no" with much encouragement from the surveyor to answer. E11 (LPN) assisted R5 to eat his lunch and was observed feeding him and holding his

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W9999	Continued From page 36 cup for him to drink. R5 required continued verbal prompts to eat and swallow his foods and drink. In reviewing R5's Nurses Notes for 06/10 and 06/11/09, no nursing documentation was noted regarding his health status and/or condition during this time frame. E10 (Facility's Medical Director) was interviewed by telephone on 06/18/09 at 9:00 A.M. and stated, "Yes" when asked by the surveyor if he would have expected nursing to have documented R5's health status and/or condition during the first twenty four after his readmission to the facility. Z1 (RN Consultant) was interviewed by telephone on 06/17/09 at 8:07 A.M. and stated, "During the first twenty four hours of admission, the nurses should have monitored and provided documentation on R5's condition at least on every shift. After being hospitalized for three weeks with a bowel obstruction, the nurses should have been monitoring his bowel sounds, bowel patterns and elimination and his food and fluid intake. If R5 had any episodes of vomiting, I would have expected nursing to immediately contact the physician and send him to the emergency room for further evaluation...." 3. Nursing staff failed to notify the physician regarding episodes of vomiting and significant changes in R5's condition. Further review of R5's record identifies that after the 06/10/09 5:00 P.M. entry, no further nursing documentation was made in R5's record until 06/12/09, when nursing staff noted that he was	W9999		

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	14G355	A. BUILDING _____ B. WING _____	R 06/30/2009

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ORCHARD COURT	1430 STATE ROUTE 127 SOUTH JONESBORO, IL 62952

(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
W9999	Continued From page 37 weak and lethargic and had been vomiting throughout the night. This Nurse's Notes entry stated, "06/12/09 8:00 A.M. V/S (Vital signs) 97 (temperature) 80 (pulse) 18 (respirations) 104/68 (Blood pressure) Lungs clear BS (Bowel Sounds) sluggish upper lobes absent in lower. Responding to verbal stimuli, lethargic appetite fair at breakfast. Staff reports res.(resident) had several emesis yesterday..." No documentation was found in R5's records identifying the date and or time when he began experiencing emesis and or that nursing had notified the physician of a change in R5's condition. C) Within 24 hours of R5's readmission to the facility, R5 began experiencing episodes of vomiting and staff failed to call 911 after failed attempts to reach the nurse on call. The facility's "Policy and Procedure for On-Call Procedures" dated 08/01/08 states, "If the Nurse on Call cannot be reached when a medical issue arises, CALL 911." In reviewing the facility's Preliminary Reporting Form dated 06/13/09, staff failed to follow the facility's policy for On-Call procedures after failed attempts to reach E12 (LPN). The facility's Preliminary Reporting Form dated 06/13/09 that was written by E9 (Direct Care staff) stated, "I E9 was doing a bed check on R5. I seen him vomit and starting to choke it was still not digested. E12 said he had vomited 2X that night. I called nurse 2X (two times) she did not	W9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G355	A. BUILDING _____ B. WING _____	R 06/30/2009

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W9999	Continued From page 38	W9999		

answer so I called the person on call (E2-Resident Services Supervisor) she told me to call E3 (Assistant Administrator)" E9 signed this form on 06/13/09 but wrote, "Incident happen(ed) on 06/10/09."

A Witness Statement completed by E8 (Direct Care staff) dated 06/13/09 for 06/11/09 states, "E9 asked me to come look at R5 he was covered in puke. We were unable to get him out of bed; we cleaned him up and changed his bedding without getting him out of bed. E9 tried to call the nurse on duty (E11). She didn't answer the phone he then called E2 who was on call she said to call the assistant administrator (E3) who came in to check on R5...." E8 also wrote, "E9 and I were concerned about R5 he was released from the hospital earlier that day."

An Incident Report dated 06/12/09 8:00 A.M. states, "Res lethargic, color gray, skin dry. Res answers to verbal stimuli. Very weak. BS (bowel sounds) sluggish upper quads absent lower quads." This report also identifies that the physician was notified and that R5 was sent to the local emergency room for evaluation.

E10 (Facility's Medical Director) was interviewed by telephone on 06/18/09 at 9:00 A.M. and stated, "In this situation, since R5 had been home less than twenty four hours after being in the hospital for three weeks for a bowel obstruction, they should have called the nurse when he started vomiting. If the direct care workers were unable to contact the nurse, they should have called me at some point that night. I would have recommended that they send him to the emergency room for evaluation.."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W9999	Continued From page 39 R5's Nurse's Notes identifies that at 9:50 A.M. on 06/12/09, 911 was notified of the need to transfer R5 to the local emergency room. The Emergency Physician Record dated 06/12/09 states, "Chief Complaint: Nursing home can not care for him(?)..." Further review of R5's Hospital records dated 06/12/09 identifies that Special Instructions were made for placement in a nursing home with recommendation for endoscopy evaluation. (A)	W9999		