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F 363	Continued From page 21 the food processor. E5 stated she was using 20 breaded veal patties. She then added approximately 5 cups of brown gravy and finished processing. E5 then used a #10 dipper (1/3 cup) and dipped 12 scoops into a pan for kitchen one and seventeen dips into a pan for kitchen two. E5 stated she was serving three ounce portions. There was still a lot left in the food processor. E5 put the remaining pureed veal into a separate pan and sent it on the cart to with the kitchen two food. During the noon meal observation for dining room one on 2/15/12 at 11:45 am E5 served residents on Pureed Diets, R13, R14, R15, R32 and R17 the pureed veal using a 3 ounce volume dipper. Residents on Mechanical Soft diets received ground veal patty with a 3 ounce volume dipper. On 2/15/12 at 12:10 pm a breaded veal patty weighed 4 ounces, a serving of ground meat weighed 2 times, weighed 2 ounces, and 2 1/4 ounces, and a serving of pureed veal weighed 3 ounces. The residents on mechanical soft and pureed diets did not receive the full amount of protein as planned on the menu. The nutritional label for the breaded veal patty stated that one 4 ounce patty yields the equivalent of 2 ounces of protein. The staff in the kitchen two were using the correct serving size as planned on the menu. The extra serving of pureed veal were not served. On 2/15/12 at 12:30 pm Dietary Manager E2 counted 13 servings of pureed veal left over.	F 363		
F9999	FINAL OBSERVATIONS	F9999		

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F9999	Continued From page 22 LICENSURE VIOLATIONS : 300.1210a) 300.1210b) 300.1210d)1)2)3) 300.3220f) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.	F9999		

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F9999	Continued From page 23 d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. 2) All treatments and procedures shall be administered as ordered by the physician. 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. Section 300.3220 Medical Care f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These regulations are not met as evidenced by the following: Based on record review and interview, the facility	F9999		

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failed to provide appropriate monitoring and services to prevent development of fecal impaction for one of one resident sampled for fecal impaction (R12), resulting in hospital treatment for fecal impaction, in a sample of 25.

Findings include:

According to the Physician's Order Sheets for 1/2012 and 2/12, R12 has multiple diagnoses including End Stage Renal Disease, Diabetes, Coronary Artery Disease, Congestive Heart Failure, Hypertension, Spinal Stenosis, and Anemia. R12 receives Hemodialysis three times weekly per left arm arteriovenous fistula. R12's Minimum Data Set dated 1/7/12 assesses R12 with no cognitive impairment and requiring extensive to total assistance for activities of daily living, and incontinence of bowel and bladder.

Nurses Notes dated 1/18/12 at 10:30am states that R12 was "difficult to arouse and lethargic" and that R12 "denied pain until this nurse palpated abdomen then {complained of lower} right quadrant pain. . ." R12 was sent to the hospital where she was admitted for elevated cardiac enzymes and urinary tract infection.

The hospital Emergency Report dated 1/18/12 at 11:00am describes gastrointestinal assessment and symptoms as "abdominal pain, constipation, nausea, vomiting. . . Patient reports that she has had 'just streaks' of stool lately. Nursing home report states that patient has had no BM (bowel movement) x (times) 5 days. Patient reports that she had emesis x 2 this AM. Light brown in color. Patient continues to have intermittent nausea. . . ." At 3:15pm, this report states that there was no

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improvement in the abdominal pain, and she had "small amount of water and stool return with fleets enema. . ."

The hospital History and Physical dated 1/18/12 states that R12 was "complaining of abdominal pain for a few days." The Clinical Consultation by Z3 (physician) dated 1/18/12 states the reason for the consultation as "abdominal pain and apparent fecal impaction." The consult continues stating that R12 had a "CT (Computerized Tomography) scan of the abdomen which revealed tremendous distention of the rectum and also moderate distention of the left colon with a lot of hard stool. . . . Significant fecal retention is described, fecal impaction. Rectum is so much dilated occupying the entire_____ of the pelvic cavity." This consult's Impression and Treatment state "1. Fecal Impaction 2. Abdominal pain secondary to fecal impaction. . . . I digitally evacuated a lot of her hard stool and the patient should be able to pass the remaining ones with the help of enemas."

R12 stated on 2/15/12 at 9:45am that she has struggled "for months" with constipation. R12 stated she repeatedly told staff that "something was wrong" in that she would have some liquid stool after getting a laxative and then nothing. R12 stated that she felt like she was "blocked up" even when having some stools. R12 stated that no one has ever checked her or removed any stool digitally until done so by the doctor at the hospital. R12 states she is incontinent of stool and uses only a brief - she does not use a bedside commode or bedpan.

Physician's Progress Notes by Nephrology for

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4/29/11 include, "No real change, except for problems with constipation. she now has stool seeping. She seems to think she is impacted and stool is seeping around that. . . . .Patient needs to be checked for fecal impaction. I will send a note to the nursing home, then they can let {Z4 (attending Physician)}know if she is impacted." No Nurses Notes or Physician's Notes indicate whether this was ever done.

CNA (Certified Nurse Aide) Flow Sheet Reports for R12 where BMs are recorded were reviewed from 11/30/11 through 2/14/12. Most of the time, BMs are recorded every 2 to 3 days. From 12/18/11 to 12/27/11 only one "bowel incontinent event" is recorded on 12/21/11. From 1/9/12 through 1/18/12 (date of hospitalization), one "large bowel movement" is recorded on 1/11/12 and "2 small bowel movements" is recorded on 1/16/12. R12 returned to the facility on 1/23/12, but no BMs are recorded until 2/3/12.

R12's medication orders include Oxycodone (narcotic analgesic) every 4 hours PRN (as needed) dated 10/6/11. Oxycodone is known to cause constipation. R12 also has an order also 10/3/11 for Colace (stool softener) once daily as needed. R12 had no other orders for laxatives. The MAR (Medication Administration Record) for PRN medications for 12/11 show that R12 received Oxycodone 14 times. R14 received Colace once, on 12/30/11. The 1/12 MAR shows R12 received Oxycodone eight times prior to 1/18/12, and received no Colace.

The Protocol Bowel Program in R12's record, signed by Z3 (Physician) states "In order to prevent constipation and fecal impaction in the

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F9999	Continued From page 27 residents prone to chronic constipation and fecal impactions, the following procedures with be followed: . . . . Prune juice will be offered each evening. . . .if...no bowel movement for 2 days, 30cc (cubic centimeters) of Milk of Magnesia will be administered on the evening of the third day. 4. If...no bowel movement by the morning of the 4th day, the nurse will perform a digital examination of the rectum for the presence of fecal material. . . ." There is no evidence in the Nurses Notes, Physician's Orders or MARs that this protocol was implemented for R12. R12's previous Care Plan reviewed on 1/9/12 included the problem of potential for constipation, with approaches such as to assess usual patterns, habits and laxative use, and to give medications per Physician's Orders. There are no individualized approaches specific for R12's situation. The current careplan reviewed after the hospitalization dated 2/1/12 does not address the fecal impaction or the potential for constipation. On 2/16/12 at 10:00am, E2 (Assistant Administration) stated that she was not aware that a Fecal Impaction was diagnosed on the 1/18/12 hospitalization. All the above information was reviewed with E2, including hospital records and CNA BM records. E2 agreed that the Fentanyl and Oxycodone along with R12's other diagnoses put R12 at high risk for constipation. No additional information was provided. B 300.682a)1)2)3)4) 300.682h)	F9999		

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F9999	Continued From page 28 300.1210d)6) 300.3240a) Section 300.682 Nonemergency Use of Physical Restraints a) Physical restraints shall only be used when required to treat the resident's medical symptoms or as a therapeutic intervention, as ordered by a physician, and based on: 1) the assessment of the resident's capabilities and an evaluation and trial of less restrictive alternatives that could prove effective; 2) the assessment of a specific physical condition or medical treatment that requires the use of physical restraints, and how the use of physical restraints will assist the resident in reaching his or her highest practicable physical, mental or psychosocial well being; 3) consultation with appropriate health professionals, such as rehabilitation nurses and occupational or physical therapists, which indicates that the use of less restrictive measures or therapeutic interventions has proven ineffective; and 4) demonstration by the care planning process that using a physical restraint as a therapeutic intervention will promote the care and services necessary for the resident to attain or maintain the highest practicable physical, mental or psychosocial well being. h) The plan of care shall contain a schedule or plan of rehabilitative/habilitative training to enable the most feasible progressive removal of physical restraints or the most practicable progressive use of less restrictive means to enable the resident to attain or maintain the highest practicable physical,	F9999		

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F9999	Continued From page 29 mental or psychosocial well being. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These regulations are not met as evidenced by the following: Based on observation, record review and interview the facility utilized full bed siderails for three of five residents reviewed for physical restraints (R4, R6, R13) in a total sample of 25. The use of full siderails placed R4, R6 and R13 at increased risk for avoidable injury. R4 acquired rib fractures after falling from bed to the floor. Findings include: 1. R4's February 2012 Physician Order Sheet (POS) list diagnoses of Dementia, Encephalopathy, Diabetes Mellitus, Hypertension and Acute Confusional State. The annual Minimum Data Set (MDS) of 12/30/11 identified R4 with severe cognitive impairment, and requiring assist of one staff for transfers and ambulation. The assessment lists two falls since previous assessment with no injury. R4's Siderail Assessment dated 11/10/11 documents R4 utilizes one bedrail up for security. The siderail was assessed as an enabler. There was no physician's orders for siderails on the February, January 2012 or December 2011 POS.	F9999		

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R4's Care Plan dated 10/19/11 for Fall Risk due to impulsive behavior and poor safety awareness, unsteady gait did not address siderail usage in bed.

Nurse's Notes dated 11/29/11 document, "Resident climbed out of bed by herself and was walking down the hallway pushing her wheelchair, intercepted by CNA (Certified Nurse Assistant) and sat safely down in wheelchair." 11/29/11 Nurse's Notes document "resident more confused looking for family, put to bed 1 side rail left down with floor alarm placed." 12/18/12 notes continued attempts to get up from bed and out of wheelchair without assistance, will continue to monitor."

Nurse's Notes dated 1/08/12 at 2 AM document, "Resident floor alarm sounded and CNA went into room and found resident sitting on the floor. Resident said crawled off the end of her bed and fell. Complained of severe back pain. Dr called and received orders to send to (Emergency Room)." Nurse's Notes document on 1/08/12 at 9:30 am R4 was admitted with rib fracture and chest wall pain.

The hospital X-ray report of the right rib and chest dated 1/08/12 lists, "Fractures of the fourth, fifth and sixth ribs anterior axillary line. Some displacement of fractured fragments, suggestion of lung contusion."

The Incident Report Form-IDPH (Illinois Department of Public Health) Notification report dated 1/09/12 documents on 1/08/12 at 2 am the resident attempted to climb out of bed and fell to floor. The report documents "Siderails were up

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times two." The Incident/Accident Report dated 1/08/12 documents "Resident said she crawled off the end of the bed and fell on her back. Resident complained severe back pain that hurts so she can't lay on bed."

The facility final report dated 1/10/12 confirmed the above information and stated R4 returned with prn pain medicine and antibiotic for lung infiltrates. The report documents the Root Cause was "Altered thought process, confusion, impaired cognitive process related to Dementia, Impulsive Behaviors and poor safety awareness, unsteady gait and balance."

E3, Director of Nurse's stated on 02/16/12 at 11:00 am that she did the initial investigation of the 1/08/12 fall for R4 and that staff told her that both side rails were in use when the fall happened. E3 reviewed R4's record and did not find any orders for full siderails.

2. R6's POS dated 11-11-11, lists an admission date of 11-11-11 with diagnoses including Parkinson's Disease, Depression, Agitation, Obstructive Sleep Apnea, Colon Cancer and Prostate Cancer. R6's Nurse Notes on 11-12-11 at 7:50 A.M. lists at "7:00 A.M., resident's room-mate alerted staff that resident (R6) was laying on the floor." R6's Fall Risk Assessment signed 11-11-11 lists R6 at high risk for falls and with a history of falls prior to admission to the facility.

The facility's incident report of 11-12-11 described the incident "Alert, Oriented to person. (History of) falls at home. (Increased) confusion and agitation noted. (Resident) in bed (with) 2 full

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siderails. Climbed out foot of bed. Found on floor. Noted (Laceration) right eyebrow, right knuckles and left hand (with) right arm pain and right hip pain.

E3, Director of Nurses stated on 2-16-12 at 12:10 P.M. that R6 climbed over the foot of the bed on 11-12-11.

3. R13's POS for February 2012 documents the following diagnoses: Lung Cancer with Metastasis to the Brain, Diabetes Mellitus Type II, and Schizophrenia. The February 2012 POS did not order the use of full side rails.

R13's Physical Therapy Weekly Progress Report dated 02/13/12 documents that R13 ambulated 20-30 feet and transferred with stand by assistance. On 02/15/12 at 1:40pm, E10, CNA, stated that R13 transfers to the wheelchair and to the toilet with the assistance of one CNA.

Nurse's Notes dated 01/31/12 at 7:30am document that R13 "is a fall risk. Resident has an alarm in bed, but still tries to go out of bed per (the) foot of (the) bed."

R13's Fall Risk Assessment score dated 01/30/12 is 25 (Score above 10 represents high risk).

On 02/14/12 at 9:25am, 11:50am, 12:30pm, 1:30pm, and 3:00pm, R13 laid in her bed with two full side rails in the upright position. On 02/15/12 at 9:00am, 11:00am, 1:15pm, and 3:30pm, R13 laid in her bed with two full side rails in the upright position.

On 02/16/12 at 11:50am, E8, Registered Nurse

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F9999	Continued From page 33 (RN), stated that R13 fell in her room on 02/12/12 at 9:15am. and was found sitting near the foot of her bed. At that time E8 implemented use of two full side rails for R13 to prevent falls. On 02/16/12 at 11:50am, E8 stated that no less restrictive measure was employed prior to use of the two full side rails. On 02/17/12 at 9:35am, E3, Director of Nursing (DON), confirmed that no less restrictive measure was employed prior to use of two full side rails. The Pre-Restraining Assessment and Side Rail Assessment dated 01/30/12 were not complete and did not indicate a need for use of restraints. No Restraint or Side Rail Assessments were completed or revised after R13's fall of 02/12/12. The Consent for Restraint Use, which was not dated, indicated the use of the two full side rails was for the purpose of "safety precautions due to diminished mental awareness" and did not document medical symptoms. B	F9999		