

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14G058	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/21/2012
NAME OF PROVIDER OR SUPPLIER PARENTS & FRIENDS OF THE SLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1450 CASEYVILLE AVENUE SWANSEA, IL 62226		
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W 331	Continued From page 21	W 331			
W9999	<p>FINAL OBSERVATIONS</p> <p>LICENSURE VIOLATIONS</p> <p>350.620a) 350.1210 350.1230d)1)2)3) 350.3240a)</p> <p>Section 350.620 Resident Care Policies</p> <p>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</p> <p>Section 350.1210 Health Services</p> <p>The facility shall provide all services necessary to maintain each resident in good physical health.</p> <p>Section 350.1230 Nursing Services</p> <p>d) Direct care personnel shall be trained in, but are not limited to, the following:</p> <p>1) Detecting signs of illness, dysfunction or maladaptive behavior that warrant medical,</p>	W9999			

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W9999	<p>Continued From page 22 nursing or psychosocial intervention.</p> <p>2) Basic skills required to meet the health needs and problems of the residents.</p> <p>3) First aid in the presence of accident or illness.</p> <p>Section 350.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) (A, B)</p> <p>These requirements were not met as evidenced by:</p> <p>Based on record review, interview and observation the facility failed to ensure that nursing services provided adequate nursing evaluation, monitoring and follow up of bowel habits for 2 of 2 individuals in the sample (R1 and R3) who developed bowel impaction's. R3 was hospitalized and discharged back to the facility. R1 was hospitalized and expired in the emergency room from respiratory distress. The facility failed to take appropriate actions to ensure that an effective bowel management system has been developed and implemented when the facility did not:</p> <p>1. Ensure a thorough nursing evaluation of R1 and R3's gastrointestinal status.</p> <p>2. Ensure documentation of Bowel Monitoring is descriptive as to size, color, consistency and frequency.</p>	W9999			

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W9999	<p>Continued From page 23</p> <p>3. Ensure nursing reviews bowel monitoring records to assess for changes in individual's bowel status.</p> <p>4. Ensure that staff have been trained on signs and symptoms of bowel impaction, abnormal bowel movements, and changes in individuals bowel habits that are to be reported to nursing.</p> <p>5. Ensure that direct care staff report changes in individual's bowel habits to nursing immediately.</p> <p>6. Revise the facility's Bowel Monitoring Policy to ensure thorough monitoring of individuals bowel habits.</p> <p>The facility's failures to ensure adequate nursing evaluation, monitoring and follow up of bowel habits have the potential to affect 65 additional individuals outside the sample (R4- R68) who are on scheduled and/ or PRN (as needed) medications to ensure normal bowel habits.</p> <p>Findings Include:</p> <p>1. Individual Program Plan/ IPP (dated 6/7/12) identifies R1 as a 45 year old individual who functions at the Profound range of Mental Retardation with additional diagnoses of Apert's Syndrome, Multiple Congenital Deformities, Gait Disorder and Neurogenic Bladder. R1 is nonverbal and does not indicate yes or no. R1 makes some sounds and uses his own gesture system. The IPP also states that R1 has prescribed Senna 8.6 mg (milligram) take 2</p>	W9999			

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W9999	<p>Continued From page 24</p> <p>tablets twice daily to help facilitate regular bowel movements. The IPP states, "R1 is prone to constipation and remains on laxatives to promote regular bowel movement. The Team recommends no further intervention/ treatment other than staff should continue to monitor his bowel movements and report any unusual bowel movements, or if he has no bowel movements for three day, notify nursing." Under the section titled, "Behavior" the IPP states, "R1 may try to manipulate staff to assist him in the restroom, so he can flush items. Staff should monitor this behavior and provide supervision when utilizing the restroom."</p> <p>Physician's Orders (dated 6/20/12) states that R1 has prescribed the following PRN (as needed) medications for constipation: Milk of Magnesium concentrated Strawberry Take 10 ml (milliliter) by mouth as needed for constipation (if no BM in 2 days), Bisacodyl 5 mg (milligram) Take 2 tablets as needed for constipation and Enema Ready to Use Fleets Enema rectally every 3 days PRN.</p> <p>Facility's Notification to Illinois Department of Public Health (dated 7/1/12) states, "This is to report that R1 was transferred to (local community hospital) Emergency Room due to abdominal (abdomen/ sig) being distended on 7/1/2012 at 6:00 am." (typed as written) The report further states, "R1 died at (hospital) at 9:43 am with a diagnosis of probable bowel obstruction with respiratory distress."</p> <p>Ambulance's "Billing Review" (dated 7/7/12) states the 911 call was made at 5:45 AM and the ambulance arrived on scene at 5:59 AM. The Initial Assessment identifies that R1's airway was</p>	W9999			

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W9999	<p>Continued From page 25</p> <p>partially obstructed/ drooling with rapid labored breathing and that lung sounds were wet bilaterally. The initial assessment also states that R1's abdomen was hard/ rigid to all four quadrants. Under the Narrative History Text section, the report states, "Staff states that PT (patient) had 2 bouts of diarrhea throughout the night, staff states that the PT abdomen is now distended and the PT is having labored breathing."</p> <p>R1's Radiology Report (dated 7/1/12) states, "Chest Portable Impression: 1. Low lung volumes with probable bibasilar atelectasis. Elevation of the left hemidiaphragm likely due to marked gastric distention."</p> <p>R1's Radiology Report (dated 7/1/12) states, "Examination: Supine portable abdomen. Findings: There is diffuse gaseous dilation of large and small bowel. In addition, there is more marked gaseous distention of the stomach which fills the left upper quadrant and epigastrium. No discrete free air or pneumatosis is identified. There is no mass lesion or obvious organomegaly. No suspicious calcifications are appreciated. This could either represent a diffuse ileus or low colonic obstruction. Given the greater dilation of the stomach, a concomitant gastric outlet obstruction may also be contributor."</p> <p>Emergency Department Detail Patient Summary (dated 7/1/12) states that R1 was mechanically ventilated at 7:19 AM and expired at 9:43 AM. The report further states under section titled Clinical Impression Respiratory failure/ Abdominal Pain. The report identifies that this death was not a coroner's case.</p>	W9999			

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W9999	Continued From page 26 Emergency Room Visit Report (dated 7/1/12) states, "Clinical Impression: Respiratory Failure, Abdominal pain. Disposition: Expired." Medical Certificate of Death (date issued 7/11/2012) states that R1 died on 7/1/12. Under "Cause of Death" the death certificate states, "a. Colonic Obstruction b. Acute Respiratory Failure c. Mental Retardation." In an interview with Z2/ Physician on 9/7/12 at 1:25 PM, when asked what the cause of R1's death was, Z1 stated, "Bowel obstruction." In review of R1's Nurse's Notes (8/26/11- 7/1/12) the following entries are the only written evidence related to assessing bowel habits/ gastrointestinal status: 9/28/11- BS (bowel sounds) present X 4 10/18/11- BS (present) X 4. Abd (abdomen) soft and nondistended. Periods of inc (incontinent) of B & B (bowel and bladder). 1/29/12 - BS X 4 Quads. Continent of B&B. 3/26/12- BS present X 4. 4/28/12 -BS present X 4, (no) abd (abdominal) distention noted. Appetite good. 6/25/12 - BS present X 4, Abd soft. Continent of B & B with occasional episodes of urinary incontinence. 7/1/12- 5:35 AM-VS (vital signs 98.1, 78, 16,	W9999			

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W9999	<p>Continued From page 27</p> <p>122/76 . Abd (abdomen) distended. B. S. (bowel sounds) diminished. Client gesturing to abd (abdomen) Stools observed X 2 in the noc (night). Upon digital inspection (no) impaction felt.</p> <p>In review of R1's Nurse's Notes (8/26/11- 7/1/12), there was no written evidence that nursing fully assessed R1's gastrointestinal status by reviewing R1's bowel habits to assess for signs of constipation. There was no written evidence that R1's PRN medications were administered for constipation.</p> <p>House 4 Daily Log (dated 6/29/12) under Medication Notes states, "R1 has diarrhea nursing notified while in pod."</p> <p>E9/ Direct Support Person's witness statement (dated 7/2/12) states, "On June 29th 2012, when R1 came home from work he had an bowel accident on himself. I immediately gave him a shower. A few hours later he ate dinner. R1 seem fine and normal he ate normal. After he left the dinner table I saw him go towards his bedroom and then to his bathroom were he was on the toilet. He had a bowel movement again." (typed as written)</p> <p>E14/ Direct Support Person's witness statement (no date) states, "On June 29 R1 had a large BM (bowel movement) on himself also in the chair that was in his room. "</p> <p>In review of R1's nurse's notes there was no written evidence that nursing had assessed R1's status after staff reported R1 having 2 loose stools on 6/29/12.</p>	W9999			

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W9999	<p>Continued From page 28</p> <p>Written Statement written by E5/ Licensed Practical Nurse (no date) states, "On June 29th (at 4:30 PM, staff reported that client was having loose stools (times) 2." The statement further states, "This nurse entered client's bathroom and noted normal, soft BM (bowel movement) smeared on the toilet and walls. Clients abdomen was soft and non- distended."</p> <p>In an interview with E5 on 8/31/12 at 1:45 PM, E5 stated that she was called to R1's house due to staff stating that R1 had diarrhea. When asked if she had reviewed R1's bowel monitor, E5 stated "No." When asked if R1 has a behavior of smearing stool, E5 stated, "I was told that he does." E5 confirmed that she has been responsible to complete R1's quarterly reviews for approximately two years. E5 confirmed that she could provide no written evidence that she had thoroughly assessed or continued to monitor R1's status.</p> <p>In an interview with E13/ Qualified Support Professional on 9/7/12 at 1:15 PM, when asked if R1 has a history of smearing bowel movement, E13 stated, "He has not done that since I've been here." E13 stated that he's been at the facility for approximately one and a half years. When asked if R1 is incontinent of bowel, E13 stated, "No, R1 had occasional urinary incontinence."</p> <p>In an interview with E2/ Director of Nursing on 8/31/12 at 12:25 PM, when asked if Bowel Movement Chart would be reviewed by nursing when an individual has loose stools, E2 stated, "Nurse will check Bowel Movement Chart to make sure it's not coming around a blockage." When asked if there was any documentation</p>	W9999			

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W9999	<p>Continued From page 29</p> <p>related to E5 assessing R1 after direct care staff reported loose stools, E2 stated, "If reported to nurse and it was normal, they wouldn't write it. If it's loose then they would document." E2 confirmed there was no written evidence that E5 had thoroughly assessed R1's gastrointestinal status on 6/29/12 when direct care staff reported that R1 had loose stools.</p> <p>Witness Statement written by E8/ Direct Support Person (no date) states that on 6/30/12, R1 had a large bowel movement before and after dinner. E8 states that R1 layed (sig) down around 6:00 PM was awakened at 7:35 PM to shower and went back to bed. E8 states that R1 asked E8 to put his blanket on him.</p> <p>In in interview with E8 on 8/31/12 at 2:25 PM, when surveyor asked what type of bowel movement R1 had on 6/30/12 as to consistency, E8 demonstrated with her hands that bowel movement was large in circumference and stated, "I had to flush the toilet twice." E8 stated that R1 also had a little in his pants. When asked if R1's stools are hard, E8 stated, "Sometimes pebbles here and there."</p> <p>In an interview with E13/ Qualified Support Professional on 9/7/12 at 1:15 PM, when surveyor asked if R1 would lay down after coming home from day training, E13 stated, "That would be unusual, he's usually active."</p> <p>Witness statement written by E11/ Direct Support Person (dated 7/1/12) states, "At 2 am while doing bed check I noticed that R1 had BM (bowel movement) in his bed." The report states that E11 showered R1 and put R1 back to bed and</p>	W9999			

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W9999	<p>Continued From page 30</p> <p>that she reported the loose stool to the nurse when the nurse came to pass medications and asked if anything was going on with R1.</p> <p>In an interview with E11 on 8/31/12 at 2:45 PM, when surveyor asked about R1's status on the night of 6/30/12 going into 7/1/12, E11 stated, "About 2 AM on Sunday (7/1/12) he had a real bad loose stool in bed. I gave him a shower and put him back to bed." E11 further stated, "When the nurse came to pass meds she went in his room and came out. She asked if R1 had been sick. I reported at that time that he (R1) had a really large loose stool. Never done that before." E11 confirmed that the nurse passed medications around 5:30 AM to pass medications.</p> <p>In an interview with E6/ Licensed Practical Nurse on 8/31/12 at 1:15 PM, when the surveyor asked when direct care staff should report loose bowel movements, E6 stated, "If loose twice will call the nurse" E6 confirmed that she was not notified immediately of R1 having a large loose stool in his bed at 2:00 AM, until around 5:30 AM when she asked E13 if R1 had been sick during the night."</p> <p>In an interview with E2/ Director of Nursing on 8/31/12 at 12:25 PM, when asked when would staff report loose stools to nursing, E2 stated, "Immediately." When asked what direct care staff would report to nursing related to bowel movements, E2 stated, "No BM for three days, blood, loose stools, large amount, abnormal odors and hard stools."</p> <p>In an interview with Z1/ Physician on 9/7/12 at 1:25 PM, when asked what direct care staff</p>	W9999			

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W9999	<p>Continued From page 31</p> <p>should report to nursing related to abnormal bowel movements, Z1 stated, "Stools that are too hard, loose stools, no bowel movements, distention." When asked if loose bowel movements should be reported to nursing, Z1 stated, "Yes due to diarrhea stools may seep around a blockage."</p> <p>Reviewed R1's Bowel Movement Chart (dated June 2012) which states staff are to document the following related to bowel movements: size (S= small, M=medium, L= large, XL= extra large), loose stool (LS) , smear (SMR) and color. The grid to document has columns with the headings of Day, Evening and Night. The area to documents the bowel movements for each shift is approximately one half inch wide. This form does not state that staff are to document the number of bowel movements an individual has within their shift. The monitor does not identify that bowel movement's consistency of anything outside of loose are to be documented. The monitor utilized by the facility is not thoroughly descriptive as to color, consistency and frequency.</p> <p>In an interview with E2/ Director of Nursing on 8/31/12 at 12:25 PM, E1 confirmed that the facility's Bowel Movement Chart that is currently being utilized does not identify frequency or consistency outside of loose stool . When asked if direct care staff are to document color of the bowel movements, E1 stated, "We haven't been."</p> <p>In review of R1's Quarterly Health Assessments (dated 8/31/11, 11/30/11, 2/26/12 and 5/28/12) states bowel sounds times four quadrants under section titled abdomen. There was no further written evidence that R1's bowel habits are being</p>	W9999			

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W9999	<p>Continued From page 32 monitored to assess gastrointestinal status.</p> <p>In review of R1's Medication Administration Records for 2/12, 3/12, 4/12 and 6/12, there was no evidence that R1 was administered any PRN medications for constipation. Per interview with E2/ Director of Nursing on 9/7/12 at 2:35 PM, facility was unable to provide the Medication Administration Record for PRN's for the month of May 2012 for R1.</p> <p>In review of R1's Nurse's Notes (dated 8/26/11-7/1/12), there was no further written evidence that R1's bowel habits are being monitored to assess gastrointestinal status.</p> <p>2. Individual Program Plan/ IPP (dated 3/8/12) identifies R3 as a 27 year old individual who functions at the severe range of Mental Retardation with additional diagnoses of Cerebral Palsy, Anemia and Epilepsy. The IPP states that R3 is able to communicate with the use of signing and can ambulate independently in the house using handrails in the hallway and furniture to stabilize his gait. The IPP states that R3 has prescribed Lactulose 30 cc three times daily to be utilized as a laxative agent to lessen symptoms associated with constipation. The IPP also states, "R3 requires 1:1 (one to one) assistance to tend to his toileting needs and wears adult incontinence briefs at all hours of the day. R3 is on a toileting schedule that will continue at this time. Staff should continue to check/ change him at regular intervals at night."</p> <p>Physician's Orders (dated 3/25/12) states that R3 has prescribed the following PRN (as needed) medications for constipation: Milk of Magnesium</p>	W9999			

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W9999	<p>Continued From page 33</p> <p>30 ml (milliliter) every day for constipation, Bisacodyl 5 mg (milligram) Take 2 tablets as needed for constipation and Bisacodyl 10 mg suppository (unwrap and insert 1 suppository rectally every 3 days if no BM (bowel movement.)</p> <p>Facility's Notification to Illinois Department of Public Health (dated 4/7/12) states that R3 was sent to (local community hospital) on 4/6/12 due to vomiting and admitted with a diagnosis of "Impaction."</p> <p>R3's Patient Transfer Form (dated 4/6/12) under section titled "Final Diagnosis" states, "lg (large) emesis of bile (at) lunch, lethargic, pale, loss of appetite."</p> <p>Nurse's Notes (dated 12/16/11-4/6/12) the following entries were the only written evidence related to monitoring of R3's bowel habits/ gastrointestinal status.</p> <p>12/16/11- Appetite good. BS X 4 Quads (bowel sounds times four quadrants). Incontinent of B&B (bowel and bladder).</p> <p>3/24/12- BS X 4 Quads. Incontinent B & B. Abd (abdomen) soft et (and) non distended).</p> <p>4/5/12- 8:30 PM Client on bed resting V.S. (vital signs) 98.1-76-20-110/70 (no) signs of any distress. Denies any discomfort. Will monitor.</p> <p>4/6/12 8 AM client ate all of breakfast- 100 % and ate supper last nite (sig/ night). No distress noted, ambulating around house, denies any pain/ discomfort.</p>	W9999			

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W9999	<p>Continued From page 34</p> <p>4/6/12 12:00 noon Client ret (returned) to facility. Day training called and stated client had emesis X 1. 12:15 PM -B/P (blood pressure) 145/80 P(pulse) 102 T(temperature) 96.9 ax (axillary). Called Z2/ Physician.</p> <p>12:30 PM-Order from Z2, to send client out for ER eval (emergency room evaluation).</p> <p>4/6/12- 10:00 PM- Admitted to RM (room) 222/bed 2 DX (diagnosis) Impaction.</p> <p>In review of R3's Nurse's notes 12/16/11- 4/6/12 there was no written evidence that nursing fully assessed R3's gastrointestinal status by reviewing R3's bowel habits to assess for signs of constipation. There was no written evidence that R3's PRN medications were administered for constipation. There was no evidence that nursing assessed R3 for abdominal distention, bowel sounds, impaction or reviewed bowel monitoring record prior to or on 4/6/12 when R3 was sent home from day training with emesis to assess for possible bowel obstruction.</p> <p>In review of Nursing Notes (dated 4/11/12- 8/29/12) after being discharge back to the facility on 4/11/12 following a bowel obstruction , R3 was returned home from day training on 5/2/12 due to client complaining of stomach/ not feeling well. Nursing documented that Mylanta was administered for complaints of stomach. Per documentation R3 had an extra large bowel movement on 5/4/12 at 1:45 AM and a large bowel movement again a 5:45 AM on 5/4/12. There is no written evidence that nursing fully assessed gastrointestinal status or continued to monitor to rule out a possible impaction or constipation.</p>	W9999			

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W9999	Continued From page 35 Reviewed R3's Bowel Movement Chart (dated April 2012) which states staff are to document the following related to bowel movements: size (S= small, M=medium, L= large, XL= extra large), loose stool (LS) , smear (SMR) and color. The grid to document has columns with the headings of Day, Evening and Night. The area to documents the bowel movements for each shift is approximately one half inch wide. This form does not state that staff are to document the number of bowel movements an individual has within their shift. The monitor does not identify that bowel movement's consistency of anything outside of loose are to be documented. The monitor utilized by the facility is not thoroughly descriptive as to color, consistency and frequency. In an interview with E2/ Director of Nursing on 8/31/12 at 12:25 PM, E1 confirmed that the facility's Bowel Movement Chart that is currently being utilized does not identify frequency or consistency outside of loose stool . When asked if direct care staff are to document color of the bowel movements, E1 stated, "We haven't been." In review of R3's Quarterly Health Assessments (dated 1/15/12, 4/13/12 and 7/20/12) states bowel sounds times four quadrants under section titled abdomen. There was no further written evidence that R3's bowel habits are being monitored to assess gastrointestinal status. In review of R3's Medication Administration Record (dated 3/1/12- 4/6/12) there was no evidence that R3 received a PRN medication for constipation.	W9999			

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W9999	<p>Continued From page 36</p> <p>In review of R3's Nurse's Notes (dated 12/1611-8/29/12),there was no further written evidence that R1's bowel habits are being monitored to assess gastrointestinal status.</p> <p>3. On 9/7/12 the facility provided the surveyor with a list of individuals who currently receive scheduled and/ or PRN (as needed) medications to facilitate bowel movements. This list is handwritten on a facility's "Nurse's Notes" (no date) which lists 65 individuals (R4- R68) currently who have prescribed medications for bowel management who reside at the facility.</p> <p>In an interview with E5/ Licensed Practical Nurse on 8/3/1/12 at 1:45 PM, when asked if she reviews the Bowel Movement Chart for the individuals, E5 stated, "Don't usually look at the BM chart. The staff in the house report to us. We have 50 clients. There's no time." E5 confirmed that she does not review the Bowel Movement Chart when she does the quarterly reviews.</p> <p>In an interview with E10/ Licensed Practical Nurse on 8/31/12 at 2:00 PM, when surveyor asked when the Bowel Monitor Charts would be reviewed, E10 stated "The DSP's (Direct Support Persons) will report to us if no BM in 3 days." E10 confirmed that she does not look at the Bowel Movement Charts.</p> <p>In observation on 9/7/12 from 11:55 AM- 1:30 PM, the current Bowel Movement Charts that staff are to document bowel movements on are kept as follows: House 5 - found in three ring binder program books in which you had to flip through multiple pages to locate; House 7- found in individual thin hard back binder books with</p>	W9999			

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W9999	<p>Continued From page 37</p> <p>other programs you had to flip through; House 4-found in the individual thin hard back binder books with programs, Schloeman House-found in three ring binder books in which you had to flip through multiple pages to locate the monitor sheets. This process took surveyor a considerable amount of time to review bowel monitoring records due to having to locate books and flip through pages to find the Bowel Monitor Charts.</p> <p>In an interview with E1/ Administrator on 9/7/12 at 9:45 AM, when asked what type of training direct care staff have received related to abnormal bowel movements, signs and symptoms of bowel obstruction and reporting of abnormal bowel habits to nursing, E1 stated they received the initial DSP(Direct Support Person). E1 provided surveyor with training that was completed on 4/12/12 ,after R3 was admitted for bowel obstruction. E1 confirmed that the 4/12/12 training consisted only of training staff that "a smear is not a bowel movement" and to immediately report to nursing if R3 did not have a bowel movement for 3 days. E1 confirmed that the facility was unable to provide evidence of additional training related to signs and symptoms of bowel obstruction, abnormal stools and that staff are to report a change in bowel habits to nursing.</p> <p>Facility's policy titled "Bowel Movements" (no date/ provided to surveyor on 8/31/12) states the following:</p> <p>Policy: In the event a client has not had a bowel movement for 3 days, Nursing will be notified and the Standing Physician Orders for constipation</p>	W9999			

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W9999	<p>Continued From page 38 will be followed.</p> <p>Procedure: At the first of month each client will have a bowel movement chart. The DSP's (Direct Support Persons) are to mark the appropriate size, (following the key) and initial where it says staff signature. For those clients who are independent with toileting DSP's are to ask the client every shift if they had a BM. If the client has not had a bowel movement in 3 days nursing is to be notified immediately. The Shift Leads and QSP's (Qualifies Support Professionals) are to check the bowel movement charts every 3 days to ensure proper documentation and notification is being followed.</p> <p>In review of facility's policy for monitoring of bowel movements, the policy does not identify that staff are to report any changes in bowel habits, only that the staff are to report no BM for three days. The policy does not identify that nursing is to monitor bowel movement chart to assess for changes in bowel habits.</p> <p>In an interview with E1/ Administrator on 9/7/12 at 9:45 AM, E1 informed surveyor that the facility started working with the pharmacy to come up with a new Bowel Monitoring recording sheet. The facility will be making changes in their policy. E1 confirmed that these changes were prompted by this survey and that the changes have not been implemented as of this time. E1 confirmed training has not been implemented on these changes.</p> <p>(A)</p>	W9999			