STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145316	A. BUILDING _____ B. WING _____	C 04/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE WILMINGTON	**555 WEST KAHLER WILMINGTON, IL 60481**

(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
F 000	INITIAL COMMENTS Complaint 2171927/IL132008	F 000		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, the facility failed to assess and intervene when 1 resident (R1) with a history of constipation had no documented bowel movement for a period of 5 days. The facility also failed to consistently and accurately track continent residents bowel movements by failing to ensure that staff were knowledgeable about the tracking program. These failures resulted in 1 resident, (R1) becoming severely impacted, sustaining a perforated rectum and requiring emergent resection of the colon and an ileostomy. These failures affected 1 of 5 residents reviewed for bowel elimination/tracking. Findings include: R1's admission face sheet reflects that R1 is 54 years old with diagnoses including encounter for surgical aftercare following surgery on the digestive system, encounter for attention to	F 684	Please accept the following as the facility□s credible allegation of compliance. This plan of correction does not constitute any admission of guilt or liability by the facility and is submitted only on response to the regulatory requirements. How corrective action will be taken for those affected by the alleged deficient practice: R1 has since been discharged. How will the facility identify other residents having the potential to be affected by the same deficient practice: All residents of the facility have the potential to be affected by the same deficient practice. The measures the facility will take, or systems the facility will alter to ensure that	4/20/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 04/16/2021

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F 684	Continued From page 1 ileostomy; acute embolism and thrombosis of deep veins of left upper extremity; lack of coordination; sacral pressure ulcer stage 3; dysphagia; sepsis; Gastrointestinal hemorrhage; anemia; perforation of intestine; peritonitis; schizo-affective disorder, bipolar type; anxiety disorder, hypothyroidism; Diabetes; post traumatic stress disorder; Hypertension; atherosclerotic heart disease; asthma, constipation; benign prostatic hypertrophy. R1's MDS (Minimum Data Set) of 2/16/21 reflects a BIMS (Brief Interview for Mental Status) of 14 R1's Physician's orders in effect at the time of his discharge to the hospital on 3/7/21 include numerous medications to treat his medical conditions, along with several psychotropic medications to treat his schizo-affective disorder, mood disorder and anxiety, as follows: Fluvoxamine maleate 50 mg BID (twice daily); Fluphenazine HCL 1 mg TID (3 x daily); Lorazepam 1 mg BID; Olanzapine 20 mg at H.S. (bedtime). PRN (as needed medication orders) included Milk of Magnesia 30 ml (milliliters) daily as needed for constipation, R1's regular medications included an order for Miramax powder 17 grams daily for constipation. R1's diet at that time was LCS (low concentrated sweets), regular texture, regular consistency. R1's care plan with a last reviewed date of 2/18/21 reflects that R1 has a potential for constipation related to having hard stools and the use of psychotropic medication. The date initiated for this particular focus area is 10/25/18 with a revision date of 2/17/21. Interventions include to follow facility bowel protocol for bowel management; to monitor medications for side effects of constipation; to keep the physician	F 684	the problem will be corrected and will not occur: Staff will be re-educated on consistently and accurately tracking continent/incontinent residents bowel movements and will be knowledgeable with the tracking program. Quality assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: Director of Nursing and/or designee will perform weekly audits for 1 month to ensure accurate tracking of bowel movements, then every two weeks for 1 month, then monthly for 4 months. Director of Nursing and or designee will continue to educate staff monthly x 3 months to ensure knowledge and understanding of the bowel tracking program. Observations noted during monitoring will be discussed at QA Committee. Concerns will be discussed among the members, a plan of action is devised, and the past plans of actions evaluated by the Quality Assurance Committee, for 3 months or as needed.	

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F 684	Continued From page 2	F 684		

informed of any problems and monitor/document/report prn (as needed)to nurse-signs and symptoms of complications related to constipation. This care plan also reflects an ADL (Activities of Daily Living) self-care performance deficit related to his psychiatric diagnoses, and notes that R1 is continent of bowel and bladder. This focus area was revised 2/17/21 with a target date of 6/29/21. Under toilet use, the care plan intervention documents "supervision". Because of his mental health issues, R1 resided in the behavioral health unit of the facility.

Nursing note from 3/7/21 timed at 11:00 AM reflects that R1 put on his call light and complained of chest pain. At that time, he was noted to have a moderate amount of bright red blood in the toilet and in the bed with him, which was coming from his rectum. R1's physician was contacted and R1 was sent to the hospital for evaluation.

Hospital records reflect a complicated course for R1. Emergency Room records dated 3/7/21 reflects that R1 presented with rectal bleeding and a 5 day history of abdominal pain. (there was no mention of where this information was obtained). R1 was found to have a tender abdomen and chest x-ray showed probable free air. A Cat Scan revealed free abdominal air and R1 was taken for emergency exploratory surgery. It was felt that R1 was most likely septic from a perforated viscous.

Operative report from 3/7/21 notes the following procedures done: exploratory laparotomy; rectosigmoid resection; removal of multiple large hard balls of stool in the peritoneal cavity and the

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pelvis; drainage of pelvic abscess; end colostomy; Hartman's procedure and peritoneal lavage. Upon entering of the abdominal cavity, the following was found: "the whole belly was filled with purulent fluid...multiple very hard, large balls of stool lying in the pelvis...there were very large holes in the distal sigmoid colon and the mid rectum...this is obviously related to severe constipation and this has eroded through the colon being ongoing for a few days. There is complete necrosis of the rectum with abscesses and foul smelling drainage. ..at least 10 balls were removed... the rectum... is completely perforated almost circumferentially from the stool,... the whole colon was filled with rock hard stool. Ideally he would need a subtotal colectomy and ileostomy but he is very ill and septic ...would add another several hours to the procedure ...abdominal cavity irrigated...abscesses in the pelvis were drained and necrotic tissues were debrided. ..may have to go back in and do re-exploratory laparotomy and remove whole of colon but will try medical management to get whole of colon cleaned out with (bowel prep medication), laxatives and Miralax..rocks of stool noted throughout the transverse colon, throughout the descending colon, splenic flexure and even the right colon...removing all would have taken too much time..."

On 3/8/21, R1 again was taken for emergency exploratory laparotomy to place a wound vacuum.

3rd Operative Report (not dated, possibly 3/11/21, dictated date) reflects procedures done were exploratory laparotomy; removal of wound vac; subtotal colectomy; ileostomy. "...the whole of the large bowel had rock hard stool, all the way from cecum to colostomy...colostomy never put out

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F 684	Continued From page 4 any stool despite bowel prep...not possible to clean this colon...best option is subtotal colectomy...it was a massive colon filled with rock hard stool, probably over 10 pounds...". Hospital discharge summary reflects R1 was discharged on 3/23/21, with the following diagnoses: Acute left upper extremity DVT (deepvein thrombosis) Septic shock due to peritonitis perforated rectum status post explorative laparotomy dysphagia schizophrenia possible pneumomediastinum Pelvic abscess persistent fever diabetes; hypothyroidism; chronic bronchitis R1 was re-admitted to the facility on 3/23/21. On 3/29/21 at 10:25 AM V2 (ADON) stated that prior to R1 being discharged to the hospital, R1 was alert to name, place and time but he needed reminders or cueing for hygiene. He was able to self-toilet and feed himself. He was usually cooperative and walked independently. His behaviors included yelling and punching things like walls. He was usually reliable when staff spoke to him, His current status is that he is alert to his name and he knows where he is. He remains in bed and uses his call light for assistance. He is incontinent of bladder and has an ileostomy which staff take care of. He is able to use a urinal. He has gotten stronger and more alert since admission and can move both arms, He is able to speak, and sometimes he makes sense, but other times does not.	F 684		

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V2 stated that the facility does track BMs (bowel movements) and continent residents are questioned about their BMs. It should be happening on every shift and as needed, and the information gets recorded in their electronic charting system. Typically it is CNAs (Certified Nursing Aids) that do this tracking but nurses are able to do it also. If there is any reason to not trust what a resident is telling them, they can tell the residents that staff want to see their BMs once they have had one. If a resident hasn't had a BM for a couple of days, the nurse should assess them, which would include evaluating their abdomen, by listening to bowel sounds and palpation of the abdomen, The nurse should also check to see if they have an order for a medication to help facilitate a BM and if they do, to give it. If they don't, the nurse can check the facility's standing orders and give them something.

On 3/30/21 at 12:35 PM V8 (CNA) stated that continent residents are to be asked daily about their BMs. If there is no BM for 48 -72 hours, they are to let the nurse know so the resident can be given something to help them. In the bowel tracking program, there are multiple columns, two labeled continent and incontinent. Her understanding is that continent just means they are aware of when they have to have a BM and can control it. She does not use the continent column to indicate when a resident has had a BM. If there is documentation of a BM, there should be further documentation of description, such as amount and consistency. After reviewing R1's bowel tracking from 2/28/21 through 3/7/21. V8 stated that she only saw evidence of BMs for R1 on 1 day, 3/1/21. V8 noted multiple checks under the "not applicable" column for R1 but

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could not say what that means, because everyone goes to the bathroom, There is a specific column for ostomies so this column would not be marked for that.

On 3/30/21 at 12:10 PM, V7 (Restorative CNA) stated R1 had good days and bad days, and at times was delusional, and he couldn't stay focused at those times. V7 stated that although she is a restorative CNA she does work the floor at times and is familiar with R1 and the bowel tracking program. She asks the resident if they have had a BM and charts it. Some residents self-toilet and they take them at their word. R1 would generally answer questions. According to V7, when the Bowel and Bladder section opens up on the computer, the first question they are to answer is if the resident is continent or incontinent. Her understanding is that if she marks continent, it means the resident has had a BM. Further questions to be answered include questions on amount and consistency. Bowel tracking is to be done once a shift. She has been told that residents should not go longer than 72 hours without a BM. She reviewed bowel tracking for R1 from 2/28/21-3/7/21. She noted there were many checks under the column titled "Not Applicable " but she could not explain what that column meant or what it should be used for.

On 3/30/21 at 11:10 AM, V 6 (CNA) stated she has worked on the behavioral unit for several months and is familiar with R1. With regards to BM tracking, they don't usually see the residents BMs. Many of the residents tell them when they have had a BM. She also asks about it during rounds and documents it in the computer. Some residents are good about telling you but if they're not she at least documents continent or

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incontinent, because she knows that about the residents. V6 stated she doesn't know what the "not applicable" column is used for. She doesn't ask about amount and consistency because they usually won't tell her. She was not told to chart "continent" in place of a BM. When she checks "no BM" she gets that from the resident. R1 is usually responsive and answers questions although he can have bad days. V6 stated she cared for R1 on the day he was discharged to the hospital. He only complained of chest pain, and she noted blood in the toilet and the bed She told the nurse right away. The nurse checked him and sent him to the hospital.

Bowel tracking record for R1 from 2/28/21 and 3/7/21 only reflects documentation of R1 having 2 small bowel movements on 3/1/21, described as soft. There are no documented bowel movements for R1 after 3/1/21. Under the column titled "no bowel movement", there are at least one check per day, and sometimes more, indicating no BMs for 3/3/21, 3/4/21. 3/5/21 and 3/6/21 There are no progress notes indicating any assessment of R1's abdomen, There is no indication that bowel sounds were checked or R1's abdomen was palpated. There are no notes indicating R1's physician or nurse practitioner were called. R1's March MAR (Medication Administration Record) reflects no prn doses of Milk of Magnesia were given.
:
Facility policy titled "Bowel Elimination Protocol" states..'residents who have had no BM for 48 hours will be observed for signs and symptoms of constipation which may include but is not limited to bowel sounds, abdominal distention, watery stool, nausea/vomiting, etc. and review of record. If signs and symptoms of constipation are

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presMS acent, may offer non-pharmacological interventions such as prune juice, natural laxative or encourage increased fluids. Residents who have had no BM for 72 hours will be considered for pharmacological intervention of increased non-pharmacological interventions. If resident continues to have no BM after additional interventions, notify MD for further instructions".

On 3/29/21 between 1:30 PM and 1:45 PM, R2 - R5 were interviewed. R2 stated that the facility staff ask him about his BMs "off and on". R3 stated "they don't ask me". R4 stated staff haven't asked him about his BMs recently;" they used to but not anymore". R5 stated staff used to ask about BMs, but not anymore. R2-R4 have BIMS scores of 15 for cognition; and R5 has a BIMS score of 13 on most recent MDS.

On 3/30/21 at 1:50 PM, V9 (Nurse Practitioner)stated that she saw R1 for a telehealth visit at the end of February and he had no complaints, although he is not always reliable due to delusions and hallucinations. Typically a person with such a large impaction would be having abdominal pain and possibly nausea and vomiting. Psychiatric medications can cause constipation.. She typically won't let a resident go more than 4 days without a BM before she orders something for them.

On 3:30 PM at 2:45 PM V10 (Nurse Practitioner for V13-MD for R1) stated she saw R1 for 2 telehealth video visits, one the end of February and one after his re-admission, On the first call, he answered questions with yes/no answers, He appeared anxious but expressed no concerns at that time She specifically asks about diarrhea or constipation and he denied both. With the amount

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F 684	Continued From page 9 of impaction he had, she would expect someone to have nausea/vomiting, loss of appetite, abdominal distention and probable pain with palpation of the abdomen. Their abdomen might be very hard or it might be tender. Psychiatric medications can be constipating. It is important to track BMs and there should be some intervention after 72 hours with no BM. R1's perforated bowel with resultant surgeries and peritonitis are the direct result of his impaction; impactions are preventable with good bowel management. Despite multiple attempts, V13 (R1's facility MD) did not return calls and could therefore not be interviewed. V14, R1's surgeon was away from his office and could not be reached for interview.	F 684		
F9999	FINAL OBSERVATIONS Complaint Investigation 2171927/IL132008 STATEMENT OF LICENSURE FINDINGS: 300.610 a) 300.1010 h) 300.1210 d)3) 300.3240 a) Section 300.610 Resident Care Policies a)The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part.	F9999		

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The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

Section 300.1010 Medical Care Policies

h)The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.

Section 300.1210 General Requirements for Nursing and Personal Care

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:

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 300.3240 Abuse and Neglect

a)An owner, licensee, administrator, employee or

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F9999	Continued From page 11 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 interviews and record reviews, the facility failed to assess and intervene when 1 resident (R1) with a history of constipation had no documented bowel movement for a period of 5 days. The facility also failed to consistently and accurately track continent residents bowel movements by failing to ensure that staff were knowledgeable about the tracking program. These failures resulted in 1 resident, (R1) becoming severely impacted, sustaining a perforated rectum and requiring emergent resection of the colon and an ileostomy. These failures affected 1 of 5 residents reviewed for bowel elimination/tracking. Findings include: R1's admission face sheet reflects that R1 is 54 years old with diagnoses including encounter for surgical aftercare following surgery on the digestive system, encounter for attention to ileostomy; acute embolism and thrombosis of deep veins of left upper extremity; lack of coordination; sacral pressure ulcer stage 3; dysphagia; sepsis; Gastrointestinal hemorrhage; anemia; perforation of intestine; peritonitis; schizo-affective disorder, bipolar type; anxiety disorder, hypothyroidism; Diabetes; post traumatic stress disorder; Hypertension; atherosclerotic heart disease; asthma, constipation; benign prostatic hypertrophy. R1's MDS (Minimum Data Set) of 2/16/21 reflects a	F9999		

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F9999	Continued From page 12 BIMS (Brief Interview for Mental Status) of 14 R1's Physician's orders in effect at the time of his discharge to the hospital on 3/7/21 include numerous medications to treat his medical conditions, along with several psychotropic medications to treat his schizo-affective disorder, mood disorder and anxiety, as follows: Fluvoxamine maleate 50 mg BID (twice daily); Fluphenazine HCL 1 mg TID (3 x daily); Lorazepam 1 mg BID; Olanzapine 20 mg at H.S. (bedtime). PRN (as needed medication orders) included Milk of Magnesia 30 ml (milliliters) daily as needed for constipation, R1's regular medications included an order for Miramax powder 17 grams daily for constipation. R1's diet at that time was LCS (low concentrated sweets), regular texture, regular consistency. R1's care plan with a last reviewed date of 2/18/21 reflects that R1 has a potential for constipation related to having hard stools and the use of psychotropic medication. The date initiated for this particular focus area is 10/25/18 with a revision date of 2/17/21. Interventions include to follow facility bowel protocol for bowel management; to monitor medications for side effects of constipation; to keep the physician informed of any problems and monitor/document/report prn (as needed)to nurse-signs and symptoms of complications related to constipation. This care plan also reflects an ADL (Activities of Daily Living) self-care performance deficit related to his psychiatric diagnoses, and notes that R1 is continent of bowel and bladder. This focus area was revised 2/17/21 with a target date of 6/29/21. Under toilet use, the care plan intervention documents "supervision". Because of his mental	F9999		

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health issues, R1 resided in the behavioral health unit of the facility.

Nursing note from 3/7/21 timed at 11:00 AM reflects that R1 put on his call light and complained of chest pain. At that time, he was noted to have a moderate amount of bright red blood in the toilet and in the bed with him, which was coming from his rectum. R1's physician was contacted and R1 was sent to the hospital for evaluation.

Hospital records reflect a complicated course for R1. Emergency Room records dated 3/7/21 reflects that R1 presented with rectal bleeding and a 5 day history of abdominal pain. (there was no mention of where this information was obtained). R1 was found to have a tender abdomen and chest x-ray showed probable free air. A Cat Scan revealed free abdominal air and R1 was taken for emergency exploratory surgery. It was felt that R1 was most likely septic from a perforated viscous.

Operative report from 3/7/21 notes the following procedures done: exploratory laparotomy; rectosigmoid resection; removal of multiple large hard balls of stool in the peritoneal cavity and the pelvis; drainage of pelvic abscess; end colostomy; Hartman's procedure and peritoneal lavage. Upon entering of the abdominal cavity, the following was found: "the whole belly was filled with purulent fluid...multiple very hard, large balls of stool lying in the pelvis...there were very large holes in the distal sigmoid colon and the mid rectum...this is obviously related to severe constipation and this has eroded through the colon being ongoing for a few days. There is complete necrosis of the rectum with abscesses

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and foul smelling drainage. ..at least 10 balls were removed... the rectum... is completely perforated almost circumferentially from the stool,... the whole colon was filled with rock hard stool. Ideally he would need a subtotal colectomy and ileostomy but he is very ill and septic ...would add another several hours to the procedure ...abdominal cavity irrigated...abscesses in the pelvis were drained and necrotic tissues were debrided. ..may have to go back in and do re-exploratory laparotomy and remove whole of colon but will try medical management to get whole of colon cleaned out with (bowel prep medication), laxatives and Miralax..rocks of stool noted throughout the transverse colon, throughout the descending colon, splenic flexure and even the right colon...removing all would have taken too much time..."

On 3/8/21, R1 again was taken for emergency exploratory laparotomy to place a wound vacuum.

3rd Operative Report (not dated, possibly 3/11/21, dictated date) reflects procedures done were exploratory laparotomy; removal of wound vac; subtotal colectomy; ileostomy. "...the whole of the large bowel had rock hard stool, all the way from cecum to colostomy...colostomy never put out any stool despite bowel prep...not possible to clean this colon...best option is subtotal colectomy...it was a massive colon filled with rock hard stool, probably over 10 pounds...".

Hospital discharge summary reflects R1 was discharged on 3/23/21, with the following diagnoses:
Acute left upper extremity DVT (deepvein thrombosis)
Septic shock due to peritonitis

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F9999	Continued From page 15 perforated rectum status post explorative laparotomy dysphagia schizophrenia possible pneumomediastinum Pelvic abscess persistent fever diabetes; hypothyroidism; chronic bronchitis R1 was re-admitted to the facility on 3/23/21. On 3/29/21 at 10:25 AM V2 (ADON) stated that prior to R1 being discharged to the hospital, R1 was alert to name, place and time but he needed reminders or cueing for hygiene. He was able to self-toilet and feed himself. He was usually cooperative and walked independently. His behaviors included yelling and punching things like walls. He was usually reliable when staff spoke to him, His current status is that he is alert to his name and he knows where he is. He remains in bed and uses his call light for assistance. He is incontinent of bladder and has an ileostomy which staff take care of. He is able to use a urinal. He has gotten stronger and more alert since admission and can move both arms, He is able to speak, and sometimes he makes sense, but other times does not. V2 stated that the facility does track BMs (bowel movements) and continent residents are questioned about their BMs. It should be happening on every shift and as needed, and the information gets recorded in their electronic charting system. Typically it is CNAs (Certified Nursing Aids) that do this tracking but nurses are able to do it also. If there is any reason to not trust what a resident is telling them, they can tell the residents that staff want to see their BMs once they have had one. If a resident hasn't had	F9999		

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a BM for a couple of days, the nurse should assess them, which would include evaluating their abdomen, by listening to bowel sounds and palpation of the abdomen, The nurse should also check to see if they have an order for a medication to help facilitate a BM and if they do, to give it. If they don't, the nurse can check the facility's standing orders and give them something.

On 3/30/21 at 12:35 PM V8 (CNA) stated that continent residents are to be asked daily about their BMs. If there is no BM for 48 -72 hours, they are to let the nurse know so the resident can be given something to help them. In the bowel tracking program, there are multiple columns, two labeled continent and incontinent. Her understanding is that continent just means they are aware of when they have to have a BM and can control it. She does not use the continent column to indicate when a resident has had a BM. If there is documentation of a BM, there should be further documentation of description, such as amount and consistency. After reviewing R1's bowel tracking from 2/28/21 through 3/7/21. V8 stated that she only saw evidence of BMs for R1 on 1 day, 3/1/21. V8 noted multiple checks under the "not applicable" column for R1 but could not say what that means, because everyone goes to the bathroom, There is a specific column for ostomies so this column would not be marked for that.

On 3/30/21 at 12:10 PM, V7 (Restorative CNA) stated R1 had good days and bad days, and at times was delusional, and he couldn't stay focused at those times. V7 stated that although she is a restorative CNA she does work the floor at times and is familiar with R1 and the bowel

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tracking program. She asks the resident if they have had a BM and charts it. Some residents self-toilet and they take them at their word. R1 would generally answer questions. According to V7, when the Bowel and Bladder section opens up on the computer, the first question they are to answer is if the resident is continent or incontinent. Her understanding is that if she marks continent, it means the resident has had a BM. Further questions to be answered include questions on amount and consistency. Bowel tracking is to be done once a shift. She has been told that residents should not go longer than 72 hours without a BM. She reviewed bowel tracking for R1 from 2/28/21-3/7/21. She noted there were many checks under the column titled "Not Applicable " but she could not explain what that column meant or what it should be used for.

On 3/30/21 at 11:10 AM, V 6 (CNA) stated she has worked on the behavioral unit for several months and is familiar with R1. With regards to BM tracking, they don't usually see the residents BMs. Many of the residents tell them when they have had a BM. She also asks about it during rounds and documents it in the computer. Some residents are good about telling you but if they're not she at least documents continent or incontinent, because she knows that about the residents. V6 stated she doesn't know what the "not applicable" column is used for. She doesn't ask about amount and consistency because they usually won't tell her. She was not told to chart "continent" in place of a BM. When she checks "no BM" she gets that from the resident. R1 is usually responsive and answers questions although he can have bad days. V6 stated she cared for R1 on the day he was discharged to the hospital. He only complained of chest pain, and

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she noted blood in the toilet and the bed She told the nurse right away. The nurse checked him and sent him to the hospital.

Bowel tracking record for R1 from 2/28/21 and 3/7/21 only reflects documentation of R1 having 2 small bowel movements on 3/1/21, described as soft. There are no documented bowel movements for R1 after 3/1/21. Under the column titled "no bowel movement", there are at least one check per day, and sometimes more, indicating no BMs for 3/3/21, 3/4/21. 3/5/21 and 3/6/21 There are no progress notes indicating any assessment of R1's abdomen, There is no indication that bowel sounds were checked or R1's abdomen was palpated. There are no notes indicating R1's physician or nurse practitioner were called. R1's March MAR (Medication Administration Record) reflects no prn doses of Milk of Magnesia were given.
:
Facility policy titled "Bowel Elimination Protocol" states..'residents who have had no BM for 48 hours will be observed for signs and symptoms of constipation which may include but is not limited to bowel sounds, abdominal distention, watery stool, nausea/vomiting, etc. and review of record. If signs and symptoms of constipation are presMS acent, may offer non-pharmacological interventions such as prune juice, natural laxative or encourage increased fluids. Residents who have had no BM for 72 hours will be considered for pharmacological intervention of increased non-pharmacological interventions. If resident continues to have no BM after additional interventions, notify MD for further instructions".

On 3/29/21 between 1:30 PM and 1:45 PM, R2 - R5 were interviewed. R2 stated that the facility

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staff ask him about his BMs "off and on". R3 stated "they don't ask me". R4 stated staff haven't asked him about his BMs recently;" they used to but not anymore". R5 stated staff used to ask about BMs, but not anymore. R2-R4 have BIMS scores of 15 for cognition; and R5 has a BIMS score of 13 on most recent MDS.

On 3/30/21 at 1:50 PM, V9 (Nurse Practitioner)stated that she saw R1 for a telehealth visit at the end of February and he had no complaints, although he is not always reliable due to delusions and hallucinations. Typically a person with such a large impaction would be having abdominal pain and possibly nausea and vomiting. Psychiatric medications can cause constipation.. She typically won't let a resident go more than 4 days without a BM before she orders something for them.

On 3:30 PM at 2:45 PM V10 (Nurse Practitioner for V13-MD for R1) stated she saw R1 for 2 telehealth video visits, one the end of February and one after his re-admission, On the first call, he answered questions with yes/no answers, He appeared anxious but expressed no concerns at that time She specifically asks about diarrhea or constipation and he denied both. With the amount of impaction he had, she would expect someone to have nausea/vomiting, loss of appetite, abdominal distention and probable pain with palpation of the abdomen. Their abdomen might be very hard or it might be tender. Psychiatric medications can be constipating. It is important to track BMs and there should be some intervention after 72 hours with no BM. R1's perforated bowel with resultant surgeries and peritonitis are the direct result of his impaction; impactions are preventable with good bowel management.

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F9999	Continued From page 20 Despite multiple attempts, V13 (R1's facility MD) did not return calls and could therefore not be interviewed. V14, R1's surgeon was away from his office and could not be reached for interview.	F9999		