| DEPARTI                  | MENT OF HEALTH AN  | ID HUMAN SERVICES   |                     |     |  | FORM | M APPROVED                 |
|--------------------------|--|---|---------------------|-----|--|------|----------------------------|
| CENTER                   | S FOR MEDICARE &   | MEDICAID SERVICES   |                     |     |  |      | D. 0938-0391               |
| -                        | DF DEFICIENCIES  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | , í                 |     | ONSTRUCTION  | COMF | SURVEY<br>PLETED           |
|                          |  | 14G338  | B. WING             |     |  |      | C<br>/22/2016              |
| NAME OF PI               | ROVIDER OR SUPPLIER  | -   |                     | STR | REET ADDRESS, CITY, STATE, ZIP CODE  |      |                            |
| EOSTEDR                  | URG TERRACE  |   |                     | 461 | 7 WONDERLAND DRIVE   |      |                            |
|                          |  |   |                     | AL  | FON, IL 62002  |      |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | ĸ   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD E<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY) |      | (X5)<br>COMPLETION<br>DATE |
| W 000                    | INITIAL COMMENTS   |   | wc                  | 000 |  |      |                            |
|                          | INCIDENT INVESTION   | 15 ===>>IL 82354  |                     |     |  |      |                            |
| W 154                    |  | TREATMENT OF CLIENTS  | W 1                 | 154 |  |      |                            |
|                          | violations are thoroug   |   |                     |     |  |      |                            |
|                          | Based on interview a<br>has failed to thorough<br>action to prevent reoor<br>their investigation for<br>sample (R1) who exp<br>taken to the hospital I<br>excessive sweating a<br>Emergency Room (El<br>obstruction. The facil | R) with a small bowel<br>ity failed to ensure that:   |                     |     |  |      |                            |
|                          | policy for Nurse on C<br>12/05/14 when they f  | competencies in the facility's<br>all with a revised date of<br>ailed to document each entry<br>the nurse and relay all<br>on 12/21/15; |                     |     |  |      |                            |
|                          | policy for Residential<br>Threatening Medical<br>individuals in need of  | competencies in the facility's<br>Options Non-Life<br>Emergencies to insure that<br>Emergency Room services<br>1 or ambulance services; |                     |     |  |      |                            |
|                          | <ol> <li>The facility's current<br/>is adequate in monitodiagnosis of constipation</li> </ol>  |   |                     |     |  |      |                            |
|                          | Findings include:  |   |                     |     |  |      |                            |
| LABORATORY               | DIRECTOR'S OR PROVIDER/S   | SUPPLIER REPRESENTATIVE'S SIGNATURE   | =                   |     | TITLE  |      | (X6) DATE                  |

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 02/16/2016

|                          | -   | ID HUMAN SERVICES<br>MEDICAID SERVICES  |                     |  |  | FORM              | ): 02/16/2016<br>APPROVED<br>0. 0938-0391 |
|--------------------------|---|---|---------------------|--|--|-------------------|---|
| STATEMENT (              | DF DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | · · /               | E CONSTRUCTION                           |  | (X3) DATE<br>COMP | SURVEY<br>LETED                           |
|                          |   | 14G338  | B. WING             |  | -  |                   | C<br>22/2016                              |
| NAME OF PI               | ROVIDER OR SUPPLIER   |   |                     | STREET ADDRESS, CITY, STA                | ATE, ZIP CODE  |                   |   |
| FOSTERB                  | URG TERRACE   |   |                     | 4617 WONDERLAND DRIVE<br>ALTON, IL 62002 | E  |                   |   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | (EACH CORREC<br>CROSS-REFEREN            | PLAN OF CORRECTION<br>TIVE ACTION SHOULD BI<br>ICED TO THE APPROPRIA<br>EFICIENCY) |                   | (X5)<br>COMPLETION<br>DATE                |
| W 154                    | Continued From page   | 21  | W 154               | 1  |  |                   |   |
|                          | that R1 is a 61 year o<br>which includes severe<br>Congenital Heart Dise<br>Impulse Control Disor   | ed 12/01-12/31/15 identifies<br>Id male with diagnoses<br>e intellectual disability,<br>ease, Coronary Disease,<br>rder and Constipation.   |                     |  |  |                   |   |
|                          | 2015 which is complete<br>persons (DSPs) idented<br>12/20/15. The nurse were received for limit<br>push fluids. On 12/21,<br>contacted because of<br>instructions were received<br>at 8:00 P.M. staff com<br>to inform her that R1 were<br>stomach ache and of<br>this entry a notation s<br>times". Instructions were<br>the ER (Emergency F | ifies that R1 had diarrhea on<br>was contacted and orders<br>odium and to monitor and<br>/15 the nurse (E3)) was<br>R1 having a headache and<br>eived to give Tylenol. Later<br>tacted the on call nurse (E3)<br>was complaining of a<br>a head ache. On the side of<br>tates, "called repeatedly 5<br>ere received to send R1 to<br>Room). |                     |  |  |                   |   |
|                          | states that R1 arrived<br>This report states. " R<br>(Emergency Departm<br>report of diaphoresis,<br>(complaints of) LUQ<br>without vomiting No<br>vomiting. Refused din<br>atypical for this patier<br>about 19:30 (7:30 P.M<br>pain with lump and dia<br>sweating) since this n<br>A report entitled, "Stu                                  | (left upper quadrant) pain<br>history of fever, chills,<br>iner this evening which is<br>it. Sx (symptom) onset<br><i>I</i> .) 9:25 P.M. c/o LUQ<br>aphoresis (excessive<br>horning.  |                     |  |  |                   |   |

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|                          | -  | ID HUMAN SERVICES<br>MEDICAID SERVICES  |                     |  |   | FORM              | 2: 02/16/2016<br>APPROVED<br>0: 0938-0391 |
|--------------------------|--|---|---------------------|--|---|-------------------|---|
| STATEMENT (              | DF DEFICIENCIES<br>CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                     | ECONSTRUCTION                          |   | (X3) DATE<br>COMP | SURVEY<br>LETED                           |
|                          |  | 14G338  | B. WING             |  | _   | (<br>01/:         | C<br>22/2016                              |
| NAME OF PI               | ROVIDER OR SUPPLIER  |   | S                   | STREET ADDRESS, CITY, ST               | TATE, ZIP CODE  |                   |   |
| FOSTERB                  | URG TERRACE  |   |                     | 617 WONDERLAND DRIV<br>ALTON, IL 62002 | Έ   |                   |   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | (EACH CORRE<br>CROSS-REFERE            | S PLAN OF CORRECTION<br>CTIVE ACTION SHOULD B<br>NCED TO THE APPROPRIA<br>DEFICIENCY) |                   | (X5)<br>COMPLETION<br>DATE                |
| W 154                    | <ul> <li>1:36 AM). This report</li> <li>"Findings There is s<br/>and fluid filled small b<br/>the distal small bowel<br/>rectum Impression:<br/>mechanical small bowel<br/>lower quadrant transit<br/>represent distal ileum</li> <li>The facility's on-call n<br/>states, "</li> <li>"5:00 R1 client has he<br/>stable from this morni<br/>pressure)146/80 and<br/>as directed on MAR (n<br/>record)</li> <li>8:54 R1 staff reports of<br/>157/101, temp norma<br/>client has been sitting<br/>are 18. Staff report cli<br/>No SOB (shortness of<br/>consciousness), clien<br/>Send to ER for evaluat</li> <li>E4 (DSP) was intervie<br/>P.M. and confirmed th<br/>12/21/15. E4 stated, "<br/>home about 2:00 P.M<br/>refused dinner. He co<br/>and Tylenol was order<br/>taken and his blood p<br/>was found laying on th<br/>is not typical behavior</li> </ul> | ospital (dated 12/22/15 at<br>states,<br>eeverely distended stomach<br>owel with decompression of<br>as well as the color and<br>High-grade partial<br>vel obstruction with right<br>tion point, suspected to<br>"<br>ursing notes for 12/21/15<br>eadache, VS (vital signs)<br>ng. b/p (blood<br>140/84. OK to give Tylenol<br>medication administration<br>clients b/p is elevated<br>1 97.3 Pulse is 117 and<br>no exertionrespirations<br>ent is sweating profusely.<br>f breath) or LOC (loss of<br>t s alert sitting in chair.<br>ation"<br>ewed on 12/29/15 at 2:30<br>hat she was working on<br>'On 12/21 I think R1 came<br>He took a nap and<br>omplained of a headache<br>rs. Later R1's vitals were<br>ressure was high. R1 also<br>he bathroom counter which | W 154               |  |   |                   |   |

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| HUMAN SERVICES   |   |   |   | FORM  | ): 02/16/2016<br>/ APPROVED<br>) 0938-0391  |
|--|---|---|---|---|---|
| ) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | , í   |   |   | (X3) DATE<br>COMP   | SURVEY<br>LETED   |
| 14G338   | B. WING   |   |   |   | C<br>22/2016  |
|  |   | ST  | TREET ADDRESS, CITY, STATE, ZIP CODE  |   |   |
|  |   | 46  | 617 WONDERLAND DRIVE  |   |   |
|  |   | AI  | LTON, IL 62002  |   |   |
| MENT OF DEFICIENCIES<br>JST BE PRECEDED BY FULL<br>IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG   | ĸ   | (EACH CORRECTIVE ACTION SHOULD  | BE  | (X5)<br>COMPLETION<br>DATE  |
| n 12/21/15 R1 wasn't<br>was going through the<br>hat he had the touch of<br>n and when he came<br>he complained of his<br>ig. We also noticed that<br>not sure who called the<br>hat she (E3) told them to<br>e emergency".<br>t Person) was<br>at 2:10 P.M. and<br>vorking on 12/21/15. E6<br>been going through the<br>l individuals vomiting,<br>lasting 24-48 hours. On<br>his supper. He was<br>ind indicating it was<br>didn't have any diarrhea<br>n't eat. He layed down<br>out 5 P.M. R1, got up<br>s head. His vitals were<br>e nurse. She ordered<br>. Afterwards he just laid<br>.M. R1 came out and<br>e was sweating and we<br>sure was high. We<br>(E3) and she didn't<br>nes. I started panicking<br>I of her (E3). I called E2<br>unager) and I later found<br>hone with another facility.<br>he told us to send him to<br>ny van to take R1 to the | W1  | 154   |   |   |   |
|  | DICAID SERVICES<br>PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br>14G338 | DICAID SERVICES         ) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:       (X2) MULT<br>A. BUILDIN<br>IDENTIFICATION NUMBER:         14G338       B. WING | DICAID SERVICES         PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:         14G338         B. WING         14G338         B. WING         44         A         14G338         B. WING         15         DENTIFYING INFORMATION)         PREFIX         TAG         W 154         12/21/15 R1 wasn't         was going through the         I individuals vomiting,         asting 24-48 hours. On         bis supper. He was         ndi ndicating it was <td>DICAID SERVICES            PROVIDERSUPPLIERCIA<br/>IDENTIFICATION NUMBER:             146338             146338             146338             STREET ADDRESS, CITY, STATE, ZIP CODE             4617 WONDERLAND DRIVE             ALTON, IL 62002             Rent of DEFICIENCIES             ST BE PRECEDED BY FULL             PREFIX             TAG             PREFIX             TAG             PREFIX             TAG             PREFIX             PROVIDER'S PLAN OF CORRECTIVE ACTION AND CORRECTION             PREFIX             TAG             PROVIDER'S PLAN OF CORRECTIVE ACTION IN EGONE             PAL             PROVIDER'S PLAN OF CORRECTIVE ACTION BIOLD             PROVIDER'S PLAN OF CORRECTIVE ACTION IN EGONE             PAL             PERCEDED BY FULL             PREFIX             PROVIDER'S PLAN OF CORRECTIVE ACTION PHOLD             PROVIDER'S PLAN OF CORRECTIVE ACTION PHOLD             PROVIDE</td> <td>JUMAN SERVICES     FORM       DICAID SERVICES     OMB NC       IDEMTIFICATION NUMBER:     A BUILDING     (3) DATE       146338     B. WING     COME       146338     B. WING     (1)       146338     B. WING     (2)       146338     B. WING     (1)       146338     B. WING     (2)       146338     B. WING     (2)       1472115     B. WING     (2)       12221/15 R1 wasn't     (2)     (2)    <t< td=""></t<></td> | DICAID SERVICES            PROVIDERSUPPLIERCIA<br>IDENTIFICATION NUMBER:             146338             146338             146338             STREET ADDRESS, CITY, STATE, ZIP CODE             4617 WONDERLAND DRIVE             ALTON, IL 62002             Rent of DEFICIENCIES             ST BE PRECEDED BY FULL             PREFIX             TAG             PREFIX             TAG             PREFIX             TAG             PREFIX             PROVIDER'S PLAN OF CORRECTIVE ACTION AND CORRECTION             PREFIX             TAG             PROVIDER'S PLAN OF CORRECTIVE ACTION IN EGONE             PAL             PROVIDER'S PLAN OF CORRECTIVE ACTION BIOLD             PROVIDER'S PLAN OF CORRECTIVE ACTION IN EGONE             PAL             PERCEDED BY FULL             PREFIX             PROVIDER'S PLAN OF CORRECTIVE ACTION PHOLD             PROVIDER'S PLAN OF CORRECTIVE ACTION PHOLD             PROVIDE | JUMAN SERVICES     FORM       DICAID SERVICES     OMB NC       IDEMTIFICATION NUMBER:     A BUILDING     (3) DATE       146338     B. WING     COME       146338     B. WING     (1)       146338     B. WING     (2)       146338     B. WING     (1)       146338     B. WING     (2)       146338     B. WING     (2)       1472115     B. WING     (2)       12221/15 R1 wasn't     (2)     (2) <t< td=""></t<> |

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|                          | -  | ID HUMAN SERVICES<br>MEDICAID SERVICES   |                   |                       |  |            | FORM              | D: 02/16/2016<br>APPROVED<br>D: 0938-0391 |  |  |  |
|--------------------------|--|--|-------------------|-----------------------|--|------------|-------------------|---|--|--|--|
| STATEMENT C              | DF DEFICIENCIES<br>CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | i í               |                       | E CONSTRUCTION   |            | (X3) DATE<br>COMP | SURVEY<br>LETED                           |  |  |  |
|                          |  | 14G338   | B. WING           |                       |  |            |                   | C<br>22/2016                              |  |  |  |
| NAME OF P                | ROVIDER OR SUPPLIER  |  |                   | 5                     | STREET ADDRESS, CITY, STATE, ZIP CO  | DE         |                   |   |  |  |  |
| FOSTERB                  | URG TERRACE  |  |                   | 4617 WONDERLAND DRIVE |  |            |                   |   |  |  |  |
|                          |  |  |                   |                       | ALTON, IL 62002  |            |                   |   |  |  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG |                       | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTIC<br>CROSS-REFERENCED TO TH<br>DEFICIENCY | N SHOULD B |                   | (X5)<br>COMPLETION<br>DATE                |  |  |  |
| W 154                    | hurt" There is no fur<br>spot/lump until mentic<br>12/21/15.   | ot on his side and said it<br>ther mention of this<br>oned within the ER report for  | w                 | 154                   |  |            |                   |   |  |  |  |
|                          | <ol> <li>DSPs are required<br/>phone report to the Pri<br/>Call (if after hours) in<br/>involving a client:</li> <li>Physical complaints<br/>etc.)</li> <li>DSPs should allow<br/>return a message. If r<br/>within 15 minutes, sta<br/>and allow 15 minutes<br/>7. If no response after<br/>the Director of Nursing<br/>left with the DON and<br/>within 15 minutes, sta<br/>and allow 15 minutes<br/>8. If no response after<br/>contact the DON, staf<br/>call for further assista<br/>10. All attempts to con<br/>documented on the N</li> <li>E3 was interviewed o<br/>telephone and confirm<br/>on call on 12/21/15. If<br/>me initially and told m<br/>of a headache and tha<br/>normal limits. Tylenol<br/>me a second time and<br/>abnormal, his respirat<br/>was sweating profuse</li> </ol> | <ul> <li>414 states, Procedure:</li> <li>to make an immediate</li> <li>rimary Nurse on Nurse on</li> <li>the following situations</li> <li>s (i.e.: chest pain, nausea,</li> <li>15 minutes for the Nurse to</li> <li>no response is received</li> <li>of a response.</li> <li>er the second attempt to call</li> <li>g (DON). If a message is</li> <li>no response is received</li> <li>off will place a second call</li> <li>for a response.</li> <li>r the second attempt to</li> <li>ff will place a second call</li> <li>for a response.</li> <li>r the second attempt to</li> <li>ff will place a second call</li> <li>for a response.</li> <li>r the second attempt to</li> <li>ff will place a second call</li> <li>for a response.</li> <li>r the second attempt to</li> <li>ff will call/page the RSM on</li> <li>nce</li> </ul> |                   |                       |  |            |                   |   |  |  |  |

Facility ID: IL6013973

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|                          |  | ID HUMAN SERVICES<br>MEDICAID SERVICES   |                     |                                       |   | FORM              | ): 02/16/2016<br>APPROVED<br>). 0938-0391 |
|--------------------------|--|--|---------------------|---------------------------------------|---|-------------------|---|
| STATEMENT C              | DF DEFICIENCIES<br>CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     | PLE CONSTRUCTION                      | _   | (X3) DATE<br>COMP | SURVEY<br>LETED                           |
|                          |  | 14G338   | B. WING             |                                       |   |                   | C<br>22/2016                              |
| NAME OF PF               | ROVIDER OR SUPPLIER  |  |                     | STREET ADDRESS, CITY,                 | STATE, ZIP CODE   |                   |   |
| FOSTERB                  | URG TERRACE  |  |                     | 4617 WONDERLAND DE<br>ALTON, IL 62002 | RIVE  |                   |   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | (EACH COR                             | R'S PLAN OF CORRECTION<br>RECTIVE ACTION SHOULD B<br>RENCED TO THE APPROPRIA<br>DEFICIENCY) |                   | (X5)<br>COMPLETION<br>DATE                |
| W 154                    | recalled staff mention<br>stated that she did no<br>E7 (Director of Nursin<br>01/12/16 at 12:59 P.M<br>document each time to<br>the nurse. E7 stated,<br>policy states that they<br>confirmed during this<br>received a call from the<br>unable to contact E3 of<br>2) The facility's Resid<br>Threatening Medical In<br>review date of 01/201<br>purpose of this policy<br>appropriate first aid set<br>threatening medical s<br>section, #6 states, "If<br>Room is necessary, set<br>ambulance service to<br>E6 (DSP - Direct Sup<br>interviewed on 12/29/<br>" that when E3 (LPM<br>told us to send him (Fictor)<br>company van to take<br>During the interview v<br>asked why staff transp<br>and she stated that sh<br>had not called an amb<br>Emergency Room. | When E3 was asked if she<br>ing a lump on R1's side she<br>t recall.<br>(g) was interviewed on<br>A. and stated that staff are to<br>that they attempt to contact<br>If E3 did not answer, the<br>or are to call me. E6<br>interview that she never<br>the facility when staff were<br>on 12/21/15.<br>(ential Options Non-Life<br>Emergencies policy with a<br>2 states that it is the<br>to provide residents with<br>ervices for non-life<br>ituations. The Procedures<br>transfer to the Emergency<br>ttaff will contact 911 or the<br>provide the transfer".<br>(port Person) was<br>15 at 2:10 P.M. and stated,<br>N) called (on 12/21/15) she<br>R1) to ER. We used the | W 15                | 54                                    |   |                   |   |
|                          | does not identify the o  |  |                     |                                       |   |                   |   |

If continuation sheet Page 6 of 15

| CENTER                   | S FOR MEDICARE &  |  |                   |     |  |          | FORM<br>OMB NC    | ): 02/16/2016<br>1 APPROVED<br>0. 0938-0391 |
|--------------------------|---|--|-------------------|-----|--|----------|-------------------|---|
|                          | DF DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | , í               |     |  |          | (X3) DATE<br>COMP | LETED                                       |
|                          |   | 14G338   | B. WING           |     |  |          |                   | 22/2016                                     |
| NAME OF P                | ROVIDER OR SUPPLIER   |  |                   | S   | TREET ADDRESS, CITY, STATE, ZIP CODE   |          |                   |   |
| FOSTERB                  | URG TERRACE   |  |                   |     | 617 WONDERLAND DRIVE<br>ALTON, IL 62002  |          |                   |   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE APF<br>DEFICIENCY) | IOULD BE |                   | (X5)<br>COMPLETION<br>DATE                  |
| W 154                    | the month of Decemb<br>The Medication Admin<br>12/21/15 identifies that<br>has had a bowel move<br>of the initiated entries<br>had a bowel moveme<br>thru the 21st.<br>R1's BM (Bowel Move<br>month of December 2<br>movements are docut<br>the size/amount of the<br>Contrary to the MAR,<br>not have a bowel mov<br>12/13, 12/15, 12/18 n<br>The bottom of the she<br>(approximate) and if t<br>large (more than 3 cu<br>cups) and/or S-small<br>does not provide an a<br>the color of the BM. r<br>BM (hard, soft formed<br>fluid/watery).<br>R1's Emergency Roo<br>states that at 3:37 A.N<br>NG (nasogastric tube<br>large bloody, coffee g<br>(loss of consciousness<br>effort. Pt without palp<br>mask respirations hin<br>of dark liquid and veg<br>well as CPR (cardio p | y is using and/or the<br>e noted with staff's<br>'s BM monitoring sheets for<br>er 2015.<br>histration Record for 12/1 -<br>at staff are to ask R1 if he<br>ement at 9:00 P.M Review<br>, staff documented that R1<br>nt every day from the 1st<br>ement) Charting for the<br>1015 identifies that bowel<br>ment by staff and indicate<br>e bowel movement.<br>this chart states that R1 did<br>vement on 12/02, 12/10,<br>or 12/21/15.<br>eet states: Amount<br>he bowel movement was: L-<br>ps), M- medium (about 2<br>(less than 1 cup). This form<br>irea for staff to document<br>hor the consistency of each | W                 | 154 |  |          |                   |   |

Facility ID: IL6013973

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|                          | -   | D HUMAN SERVICES  |                   |     |  | FORM              | D: 02/16/2016              |
|--------------------------|---|---|-------------------|-----|--|-------------------|----------------------------|
| STATEMENT C              | DF DEFICIENCIES<br>CORRECTION   | MEDICAID SERVICES<br>(X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:            | · · ·             |     | E CONSTRUCTION   | (X3) DATE<br>COMP | LETED                      |
|                          |   | 14G338  | B. WING           |     |  |                   | C<br>22/2016               |
| NAME OF PR               | ROVIDER OR SUPPLIER   |   |                   | S   | STREET ADDRESS, CITY, STATE, ZIP CODE  | <u> </u>          |                            |
| FOSTERB                  | URG TERRACE   |   |                   |     | 617 WONDERLAND DRIVE<br>ALTON, IL 62002  |                   |                            |
|                          |   |   |                   |     |  |                   |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION) | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD E<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY) | 3E                | (X5)<br>COMPLETION<br>DATE |
| W 154                    | Continued From page   |   | w                 | 154 |  |                   |                            |
|                          |   | ed with return of copious   |                   |     |  |                   |                            |
|                          |   | n efforts unsuccessful and at 0322 (3:22 A.M.)". The                                  |                   |     |  |                   |                            |
|                          | Hospital Report of De<br>identifies, Impression:  | ath dated 12/22/15  |                   |     |  |                   |                            |
|                          | identifies, impression.   |   |                   |     |  |                   |                            |
|                          | , ,   | ative Case Summary dated  |                   |     |  |                   |                            |
|                          | secured from all staff  | at witness statements were present on 12/21/15.                                       |                   |     |  |                   |                            |
|                          |   | this report indicates that  |                   |     |  |                   |                            |
|                          |   | rse on call but does not  |                   |     |  |                   |                            |
|                          |   | e did not initially respond or<br>ment each call placed as                            |                   |     |  |                   |                            |
|                          | per facility policy. Thi  | •   |                   |     |  |                   |                            |
|                          | identifies that R1 was  | transported to the  |                   |     |  |                   |                            |
|                          |   | ut does not indicate that   |                   |     |  |                   |                            |
|                          | for an ambulance to ti  | van as opposed to calling   |                   |     |  |                   |                            |
|                          |   | per facility policy. After the  |                   |     |  |                   |                            |
|                          | •   | ospital records in January  |                   |     |  |                   |                            |
|                          | 2016, there is no doc<br>information was review   |   |                   |     |  |                   |                            |
|                          | constituted committee   |   |                   |     |  |                   |                            |
|                          | adjustments were ma   | de to their bowel monitoring  |                   |     |  |                   |                            |
|                          |   | individuals with diagnosis  |                   |     |  |                   |                            |
| W 331                    | of Constipation.<br>483.460(c) NURSING  | SERVICES  | w                 | 331 |  |                   |                            |
|                          | The facility must provi<br>services in accordance   | ide clients with nursing<br>e with their needs.                                       |                   |     |  |                   |                            |
|                          | Based on interview a<br>has failed to ensure th<br>nursing services in ac<br>for 1 of 1 individual in | cordance with their needs   |                   |     |  |                   |                            |
|                          |   |   |                   |     |  |                   |                            |

Facility ID: IL6013973

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|                          | -   | D HUMAN SERVICES<br>MEDICAID SERVICES  |                     |     |   | FORM | D: 02/16/2016<br>APPROVED<br>D. 0938-0391 |
|--------------------------|---|--|---------------------|-----|---|------|---|
|                          | DF DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | · /                 |     |   |      | SURVEY<br>PLETED                          |
|                          |   | 14G338   | B. WING             |     |   |      | 22/2016                                   |
| NAME OF P                | ROVIDER OR SUPPLIER   |  |                     | S   | TREET ADDRESS, CITY, STATE, ZIP CODE  |      |   |
| FOSTERB                  | SURG TERRACE  |  |                     |     | 617 WONDERLAND DRIVE<br>ALTON, IL 62002   |      |   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIZ<br>TAG | ×   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPF<br>DEFICIENCY) | BE   | (X5)<br>COMPLETION<br>DATE                |
| W 331                    | hospital by staff with I<br>sweating and diagnos<br>(ER) with a small bow<br>nursing staff failed to<br>Persons (DSPs):<br>1) Demonstrate comp<br>policy for Nurse on Ca<br>12/05/14 when they fa<br>of attempts to contact<br>relevant information to<br>2) Demonstrate comp<br>policy for Residential<br>Threatening Medical<br>I individuals in need of<br>are transferred via 91<br>and not the facility va<br>3) That the facility's cr<br>protocol is adequate i<br>diagnosis of constipat<br>Findings include:<br>The Physician's Orde<br>Treatments sheet dat<br>that R1 is a 61 year o<br>which includes severe<br>Congenital Heart Dise<br>Impulse Control Disor<br>R1's Emergency Roo<br>states that at 3:37 A.N<br>NG (nasogastric tube<br>large bloody, coffee g<br>(loss of consciousnes<br>effort. Pt without palp | headache and excessive<br>sed at the Emergency Room<br>vel obstruction. The facility's<br>ensure that Direct Support<br>betencies in the facility's<br>all with a revised date of<br>ailed to document each entry<br>the nurse and to relay all<br>to the nurse on 12/21/15;<br>betencies in the facility's<br>Options Non-Life<br>Emergencies to insure that<br>Emergency Room services<br>1 or ambulance services<br>1 or ambulance services<br>n; and<br>urrent Bowel Movement<br>n monitoring individuals with<br>tion.<br>rs Medications and<br>ed 12/01-12/31/15 identifies<br>Id male with diagnoses<br>e intellectual disability,<br>ease, Coronary Disease, | W                   | 331 |   |      |   |

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|                          |  | ID HUMAN SERVICES<br>MEDICAID SERVICES   |                     |   |  | FORM      | ): 02/16/2016<br>APPROVED<br>0. 0938-0391 |
|--------------------------|--|--|---------------------|---|--|-----------|---|
| STATEMENT                | DF DEFICIENCIES<br>CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | . ,                 | LE CONSTRUCTION                         | -  | (X3) DATE | SURVEY<br>LETED                           |
|                          |  | 14G338   | B. WING             |   |  |           | _<br>22/2016                              |
| NAME OF P                | ROVIDER OR SUPPLIER  |  |                     | STREET ADDRESS, CITY, S                 |  |           |   |
| FOSTERE                  | SURG TERRACE   |  |                     | 4617 WONDERLAND DRIV<br>ALTON, IL 62002 | /E   |           |   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | (EACH CORRE<br>CROSS-REFERE             | S PLAN OF CORRECTION<br>ECTIVE ACTION SHOULD BI<br>ENCED TO THE APPROPRIA<br>DEFICIENCY) |           | (X5)<br>COMPLETION<br>DATE                |
| W 331                    | of dark liquid and veg<br>well as CPR (cardio p<br>Code Blue. Pt intubat<br>upper airway suctions<br>emesis resuscitation<br>pt pronounced dead a<br>Hospital Report of De<br>identifies, Impression<br>1) The facility's On Ca<br>2015 which is comple<br>persons (DSPs) ident<br>12/20/15. The nurse w<br>were received for Imo<br>push fluids. On 12/21.<br>contacted because of<br>instructions were rece<br>at 8:00 P.M. staff con<br>to inform her that R1<br>stomach ache and of<br>this entry a notation s<br>times". Instructions w<br>the ER (Emergency Roor<br>states that R1 arrived<br>This report states. " R<br>(Emergency Departm<br>report of diaphoresis,<br>(complaints of) LUQ<br>without vomiting No<br>vomiting. Refused din<br>atypical for this patier | etable matter initiated as<br>pulmonary resuscitation) and<br>ed during which time<br>ed with return of copious<br>in efforts unsuccessful and<br>at 0322 (3:22 A.M.)". The<br>path dated 12/22/15<br>: Bowel Obstruction.<br>all Nurse Log for December<br>ted by direct support<br>ifies that R1 had diarrhea on<br>was contacted and orders<br>odium and to monitor and<br>/15 the nurse (E3)) was<br>R1 having a headache and<br>eived to give Tylenol. Later<br>tacted the on call nurse (E3)<br>was complaining of a<br>a head ache. On the side of<br>tates, "called repeatedly 5<br>ere received to send R1 to<br>Room).<br>In Report dated 12/22/15<br>at the ER at 9:08 P. M.<br>tesident brought to the ED<br>ent by private auto with<br>high BP and c/o<br>(left upper quadrant) pain<br>o history of fever, chills,<br>uner this evening which is<br>st. Sx (symptom) onset<br>A.) 9:25 P.M. c/o LUQ<br>aphoresis (excessive<br>norning. | W 33                | 1                                       |  |           |   |

Facility ID: IL6013973

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|                          | -   | ID HUMAN SERVICES<br>MEDICAID SERVICES   |                     |                                       |  | FORM              | ): 02/16/2016<br>APPROVED<br>). 0938-0391 |
|--------------------------|---|--|---------------------|---------------------------------------|--|-------------------|---|
| STATEMENT (              | OF DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | . ,                 | PLE CONSTRUCTION G                    | _  | (X3) DATE<br>COMP | SURVEY<br>LETED                           |
|                          |   | 14G338   | B. WING             |                                       |  |                   | C<br>22/2016                              |
| NAME OF PI               | ROVIDER OR SUPPLIER   |  |                     | STREET ADDRESS, CITY, S               | STATE, ZIP CODE  |                   |   |
| FOSTERB                  | URG TERRACE   |  |                     | 4617 WONDERLAND DR<br>ALTON, IL 62002 | IVE  |                   |   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | (EACH CORR                            | R'S PLAN OF CORRECTION<br>ECTIVE ACTION SHOULD BI<br>ENCED TO THE APPROPRIA<br>DEFICIENCY) |                   | (X5)<br>COMPLETION<br>DATE                |
| W 331                    | while R1 was at the h<br>1:36 AM). This report<br>"Findings There is s<br>and fluid filled small b<br>the distal small bowel<br>rectum Impression:<br>mechanical small bowel<br>rectum Impression:<br>"5:00 R1 client has he<br>stable from this mornin<br>pressure)146/80 and<br>as directed on MAR (n<br>record)<br>8:54 R1 staff reports of<br>157/101, temp norma<br>client has been sitting<br>are 18. Staff report cli<br>No SOB (shortness of<br>consciousness), clien<br>Send to ER for evalua<br>E4 (DSP) was intervie<br>P.M. and confirmed th<br>12/21/15. E4 stated, "<br>home about 2:00 P.M<br>refused dinner. He co<br>and Tylenol was order<br>taken and his blood p<br>was found laying on th<br>is not typical behavior | but contrast" was completed<br>ospital (dated 12/22/15 at<br>states,<br>severely distended stomach<br>owel with decompression of<br>as well as the color and<br>High-grade partial<br>vel obstruction with right<br>tion point, suspected to<br>"<br>ursing notes for 12/21/15<br>eadache, VS (vital signs)<br>ng. b/p (blood<br>140/84. OK to give Tylenol<br>medication administration<br>clients b/p is elevated<br>1 97.3 Pulse is 117 and<br>no exertionrespirations<br>ent is sweating profusely.<br>f breath) or LOC (loss of<br>t s alert sitting in chair.<br>ation"<br>ewed on 12/29/15 at 2:30<br>hat she was working on<br>'On 12/21 I think R1 came<br>He took a nap and<br>omplained of a headache<br>rs. Later R1's vitals were<br>ressure was high. R1 also<br>he bathroom counter which<br>'for him." | W 33                | 31                                    |  |                   |   |
|                          | E5 (DSP) was intervie   | ewed on 12/29/15 at 2:40   |                     |                                       |  |                   |   |

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| DEPARTMENT OF HEALTH<br>CENTERS FOR MEDICARE   |  |                    |                       |                               |   | FORM              | ): 02/16/2016<br>1 APPROVED<br>0. 0938-0391 |  |
|--|--|--------------------|-----------------------|-------------------------------|---|-------------------|---|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | . ,                |                       | CONSTRUCTION                  |   | (X3) DATE<br>COMP | SURVEY<br>LETED                             |  |
|  | 14G338   | B. WING            |                       |                               |   | (<br>01//         | )<br>22/2016                                |  |
| NAME OF PROVIDER OR SUPPLIER   | •  | 1                  | S                     | TREET ADDRESS, CITY, STA      | TE, ZIP CODE  |                   |   |  |
| FOSTERBURG TERRACE   |  |                    | 4617 WONDERLAND DRIVE |                               |   |                   |   |  |
|  |  |                    | Α                     | LTON, IL 62002                |   |                   |   |  |
| PREFIX (EACH DEFICIE   | Y STATEMENT OF DEFICIENCIES<br>ENCY MUST BE PRECEDED BY FULL<br>DR LSC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |                       | (EACH CORREC<br>CROSS-REFEREN | PLAN OF CORRECTION<br>TIVE ACTION SHOULD BE<br>CED TO THE APPROPRIA<br>EFICIENCY) |                   | (X5)<br>COMPLETION<br>DATE                  |  |
| <ul> <li>12/21/15. E5 state feeling well. The ffacility, so we assut the flu. I gave him back up to the from head and stomach he starting sweatin nurse and they tole call 911 or take him E6 (DSP - Direct S interviewed on 12/ confirmed that she stated, "The flu bu building. We had diarrhea with sympthe 20th, R1 did no pointing to his stor hurting. On the 21 or vomiting but he and would get up. and began pointing abnormal and I ca Tylenol for his head around. At about 5 was sitting with stated calling the answer. I called h when I couldn't ge (Residential Service out that E3 was or When E3 (LPN) ca ER. We used the or ER".</li> </ul> | age 11<br>d that she was working on<br>ed, "On 12/21/15 R1 wasn't<br>lu bug was going through the<br>umed that he had the touch of<br>a bath and when he came<br>at area he complained of his<br>a hurting. We also noticed that<br>ng. I'm not sure who called the<br>d me that she (E3) told them to<br>n to the emergency".<br>Support Person) was<br>29/15 at 2:10 P.M. and<br>e was working on 12/21/15. E6<br>g had been going through the<br>several individuals vomiting,<br>otoms lasting 24-48 hours. On<br>ot eat his supper. He was<br>nach and indicating it was<br>1st, he didn't have any diarrhea<br>wouldn't eat. He layed down<br>At about 5 P.M. R1, got up<br>g to his head. His vitals were<br>lled the nurse. She ordered<br>dache. Afterwards he just laid<br>8:00 P.M R1 came out and<br>aff. He was sweating and we<br>a pressure was high. We<br>nurse (E3) and she didn't<br>er 5 times. I started panicking<br>t ahold of her (E3). I called E2<br>ces Manager) and I later found<br>on the phone with another facility.<br>alled she told us to send him to<br>company van to take R1 to the<br>pontent dated 12/22/15 (included<br>investigations) states that | W                  | 331                   |                               |   |                   |   |  |

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|   |  | D HUMAN SERVICES<br>MEDICAID SERVICES  |  |      |   |                             | FORM                          | ): 02/16/2016<br>// APPROVED<br>). 0938-0391 |
|---|--|--|--|------|---|-----------------------------|-------------------------------|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION A. BUILDING |      |   |                             | (X3) DATE SURVEY<br>COMPLETED |  |
|   |  | 14G338   | B. WING                                |      |   | C<br>01/22/2016             |                               |  |
| NAME OF PI  | ROVIDER OR SUPPLIER  |  |  | S    | TREET ADDRESS, CITY, STATE, ZIP CO  |                             |                               |  |
|   |  |  |  | 4    | 617 WONDERLAND DRIVE  |                             |                               |  |
| FOSTERB   | URG TERRACE  |  | ALTON, IL 62002                        |      |   |                             |                               |  |
| (X4) ID<br>PREFIX<br>TAG                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION) |  |  | IX   | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO TH<br>DEFICIENCY | ON SHOULD B<br>HE APPROPRIA |                               | (X5)<br>COMPLETION<br>DATE                   |
| TAG<br>W 331  | (EACH DEFICIENCY MUST BE PRECEDED BY FULL  |  | W                                      | 3331 |   |                             | ATE                           | DATE   |
|   | normal limits. Tyleno<br>me a second time and<br>abnormal, his respirat  | at his vitals were within<br>I was ordered. They called<br>I told me that his vitals were<br>ions were ok but that he<br>Iy with no known cause. I |  |      |   |                             |                               |  |

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|   |  | ID HUMAN SERVICES  |  |                 |                               |  | FORM | 02/16/2016<br>APPROVED |  |
|---|--|--|--|-----------------|-------------------------------|--|------|------------------------|--|
| CENTERS FOR MEDICARE & I<br>STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION A. BUILDING   |                 |                               | OMB NO. 0938-0391<br>(X3) DATE SURVEY<br>COMPLETED         |      |                        |  |
|   |  | 14G338   | B. WING                                  |                 |                               | C<br>01/22/2016  |      |                        |  |
| NAME OF P   | ROVIDER OR SUPPLIER  | •  | •  |                 | STREET ADDRESS, CITY, STA     | TE, ZIP CODE   | •    |                        |  |
| FOSTERE   | URG TERRACE  |  | 4617 WONDERLAND DRIVE<br>ALTON, IL 62002 |                 |                               |  |      |                        |  |
|   | SUMMARY ST   | ATEMENT OF DEFICIENCIES  | ID                                       |                 |                               | PLAN OF CORRECTION   |      | (X5)                   |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC)   | Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | PREF                                     | IX              | (EACH CORREC<br>CROSS-REFEREN | TIVE ACTION SHOULD B<br>CED TO THE APPROPRIA<br>EFICIENCY) |      | COMPLETION<br>DATE     |  |
| W 331   | W 331 Continued From page 13<br>instructed them to send him to the Emergency<br>Room for evaluation". When E3 was asked if she<br>recalled staff mentioning a lump on R1's side she<br>stated that she did not recall. |  | w  | 33 <sup>,</sup> | 1                             |  |      |                        |  |
|   |  |  |  |                 |                               |  |      |                        |  |
|   | 01/12/16 at 12:59 P.N<br>document each time t<br>the nurse. E7 stated,<br>policy states that they<br>confirmed during this   | interview that she never<br>ne facility when staff were  |  |                 |                               |  |      |                        |  |
|   | Threatening Medical<br>review date of 01/201<br>purpose of this policy<br>appropriate first aid se<br>threatening medical s<br>section, #6 states, "If   | to provide residents with<br>ervices for non-life<br>ituations. The Procedures<br>transfer to the Emergency<br>staff will contact 911 or the |  |                 |                               |  |      |                        |  |
|   | " that when E3 (LPN  | 15 at 2:10 P.M. and stated,<br>N) called (on 12/21/15) she<br>R1) to ER. We used the   |  |                 |                               |  |      |                        |  |
|   | asked why staff trans<br>and she stated that sl  | vith E3 on 01/12/16, E3 was<br>ported R1 in the facility van<br>he was unaware that staff<br>pulance to transfer R1 to the                   |  |                 |                               |  |      |                        |  |
|   | 3) Further review of th  | ne facility's investigation  |  |                 |                               |  |      |                        |  |

|   |   | D HUMAN SERVICES<br>MEDICAID SERVICES                 |  |                             |  | FORM   | : 02/16/2016<br>APPROVED   |
|---|---|---|--|-----------------------------|--|--|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING |                             |  | OMB NO. 0938-0391<br>(X3) DATE SURVEY<br>COMPLETED |                            |
|   |   | 14G338  | B. WING                                |                             |  | C<br>01/22/2016                                    |                            |
| NAME OF PI  | ROVIDER OR SUPPLIER   |   |  | TATE, ZIP CODE              | •  |  |                            |
| FOOTEDD   |   |   |  | 4617 WONDERLAND DRIV        | /E   |  |                            |
| FUSTERB   | URG TERRACE   |   |  | ALTON, IL 62002             |  |  |                            |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC)  | Y MUST BE PRECEDED BY FULL                            | ID<br>PREFIX<br>TAG                    | (EACH CORRE<br>CROSS-REFERE | S PLAN OF CORRECTION<br>CTIVE ACTION SHOULD BE<br>NCED TO THE APPROPRIA<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE |
|   | does not identify the current BM monitoring<br>system that the facility is using and/or the<br>discrepancies that are noted with staff's<br>documentation on R1's BM monitoring sheets for<br>the month of December 2015.<br>The Medication Administration Record for 12/1 -<br>12/21/15 identifies that staff are to ask R1 if he<br>has had a bowel movement at 9:00 P.M Review<br>of the initiated entries, staff documented that R1<br>had a bowel movement every day from the 1st<br>thru the 21st.<br>R1's BM (Bowel Movement) Charting for the<br>month of December 2015 identifies that bowel<br>movements are document by staff and indicate<br>the size/amount of the bowel movement.<br>Contrary to the MAR, this chart states that R1 did<br>not have a bowel movement on 12/02, 12/10,<br>12/13, 12/15, 12/18 nor 12/21/15.<br>The bottom of the sheet states: Amount<br>(approximate) and if the bowel movement was: L-<br>large (more than 3 cups), M- medium (about 2<br>cups) and/or S-small (less than 1 cup). This form<br>does not provide an area for staff to document<br>the color of the BM. nor the consistency of each<br>BM (hard, soft formed, loose unformed, or |   |  | CROSS-REFERE                | NCED TO THE APPROPRIA  |  | DATE                       |
|   | fluid/watery).  |   |  |                             |  |  |                            |

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