STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G338	A. BUILDING _____ B. WING _____	C 01/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOSTERBURG TERRACE	4617 WONDERLAND DRIVE ALTON, IL 62002

(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
W 000	INITIAL COMMENTS INCIDENT INVESTIGATION SURVEY INCIDENT OF 12/22/15 ===>>IL 82354	W 000		
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on interview and record review, the facility has failed to thoroughly investigate and take action to prevent reoccurrence during and after their investigation for 1 of 1 individual in the sample (R1) who expired on 12/22/15 after being taken to the hospital by staff with headache and excessive sweating and diagnosed at the Emergency Room (ER) with a small bowel obstruction. The facility failed to ensure that: 1) Staff demonstrate competencies in the facility's policy for Nurse on Call with a revised date of 12/05/14 when they failed to document each entry of attempts to contact the nurse and relay all relevant information on 12/21/15; 2) Staff demonstrate competencies in the facility's policy for Residential Options Non-Life Threatening Medical Emergencies to insure that individuals in need of Emergency Room services are transferred via 911 or ambulance services; and 3) The facility's current Bowel Movement protocol is adequate in monitoring individuals with diagnosis of constipation. Findings include:	W 154		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 154	Continued From page 1	W 154		

The Physician's Orders Medications and Treatments sheet dated 12/01-12/31/15 identifies that R1 is a 61 year old male with diagnoses which includes severe intellectual disability, Congenital Heart Disease, Coronary Disease, Impulse Control Disorder and Constipation.

1) The facility's On Call Nurse Log for December 2015 which is completed by direct support persons (DSPs) identifies that R1 had diarrhea on 12/20/15. The nurse was contacted and orders were received for Imodium and to monitor and push fluids. On 12/21/15 the nurse (E3)) was contacted because of R1 having a headache and instructions were received to give Tylenol. Later at 8:00 P.M. staff contacted the on call nurse (E3) to inform her that R1 was complaining of a stomach ache and of a head ache. On the side of this entry a notation states, "called repeatedly 5 times". Instructions were received to send R1 to the ER (Emergency Room).

The Emergency Room Report dated 12/22/15 states that R1 arrived at the ER at 9:08 P. M. This report states. " Resident... brought to the ED (Emergency Department by private auto with report of diaphoresis, high BP and c/o (complaints of) LUQ (left upper quadrant) pain without vomiting... No history of fever, chills, vomiting. Refused dinner this evening which is atypical for this patient. Sx (symptom) onset about 19:30 (7:30 P.M.)... 9:25 P.M. c/o LUQ pain with lump and diaphoresis (excessive sweating) since this morning.

A report entitled, "Study Result for the CT Abdomen Pelvis without contrast" was completed

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W 154	Continued From page 2	W 154		

while R1 was at the hospital (dated 12/22/15 at 1:36 AM). This report states,

"Findings... There is severely distended stomach and fluid filled small bowel with decompression of the distal small bowel as well as the color and rectum... Impression: High-grade partial mechanical small bowel obstruction with right lower quadrant transition point, suspected to represent distal ileum..."

The facility's on-call nursing notes for 12/21/15 states, "

"5:00 R1 client has headache, VS (vital signs) stable from this morning. b/p (blood pressure)146/80 and 140/84. OK to give Tylenol as directed on MAR (medication administration record)...
8:54 R1 staff reports clients b/p is elevated 157/101, temp normal 97.3 Pulse is 117 and client has been sitting no exertion...respirations are 18. Staff report client is sweating profusely. No SOB (shortness of breath) or LOC (loss of consciousness), client s alert sitting in chair. Send to ER for evaluation..."

E4 (DSP) was interviewed on 12/29/15 at 2:30 P.M. and confirmed that she was working on 12/21/15. E4 stated, "On 12/21 I think R1 came home about 2:00 P.M.. He took a nap and refused dinner. He complained of a headache and Tylenol was orders. Later R1's vitals were taken and his blood pressure was high. R1 also was found laying on the bathroom counter which is not typical behavior for him."

E5 (DSP) was interviewed on 12/29/15 at 2:40 P.M. and confirmed that she was working on

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W 154	Continued From page 3	W 154		

12/21/15. E5 stated, "On 12/21/15 R1 wasn't feeling well. The flu bug was going through the facility, so we assumed that he had the touch of the flu. I gave him a bath and when he came back up to the front area he complained of his head and stomach hurting. We also noticed that he starting sweating. I'm not sure who called the nurse and they told me that she (E3) told them to call 911 or take him to the emergency".

E6 (DSP - Direct Support Person) was interviewed on 12/29/15 at 2:10 P.M. and confirmed that she was working on 12/21/15. E6 stated, "The flu bug had been going through the building. We had several individuals vomiting, diarrhea with symptoms lasting 24-48 hours. On the 20th, R1 did not eat his supper. He was pointing to his stomach and indicating it was hurting. On the 21st, he didn't have any diarrhea or vomiting but he wouldn't eat. He layed down and would get up. At about 5 P.M. R1, got up and began pointing to his head. His vitals were abnormal and I called the nurse. She ordered Tylenol for his headache. Afterwards he just laid around. At about 8:00 P.M.. R1 came out and was sitting with staff. He was sweating and we took his vitals. His pressure was high. We started calling the nurse (E3) and she didn't answer. I called her 5 times. I started panicking when I couldn't get ahold of her (E3). I called E2 (Residential Services Manager) and I later found out that E3 was on the phone with another facility. When E3 (LPN) called she told us to send him to ER. We used the company van to take R1 to the ER".

E6's written statement dated 12/22/15 (included within the facility's investigations) states that during the time on 12/21 that R1 was sweating,

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W 154	Continued From page 4	W 154		

he showed staff a spot on his side and said it hurt..." There is no further mention of this spot/lump until mentioned within the ER report for 12/21/15.

The facility's policy for Nurse on Call with a revised date of 12/05/14 states, Procedure:
1. DSPs are required to make an immediate phone report tot he Primary Nurse on Nurse on Call (if after hours) in the following situations involving a client:
g. Physical complaints (i.e.: chest pain, nausea, etc.)
6. DSPs should allow 15 minutes for the Nurse to return a message. If no response is received within 15 minutes, staff she place a second call and allow 15 minutes for a response.
7. . If no response after the second attempt to call the Director of Nursing (DON). If a message is left with the DON and no response is received within 15 minutes, staff will place a second call and allow 15 minutes for a response.
8. If no response after the second attempt to contact the DON, staff will call/page the RSM on call for further assistance....
10. All attempts to contact a nurse on call will be documented on the Nurse on Call Log..."

E3 was interviewed on 01/12/16 at 12:45 P.M. via telephone and confirmed that she was the nurse on call on 12/21/15. E3 stated, Staff had called me initially and told me that R1 was complaining of a headache and that his vitals were within normal limits. Tylenol was ordered. They called me a second time and told me that his vitals were abnormal, his respirations were ok but that he was sweating profusely with no known cause. I instructed them to send him to the Emergency

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Room for evaluation". When E3 was asked if she recalled staff mentioning a lump on R1's side she stated that she did not recall.

E7 (Director of Nursing) was interviewed on 01/12/16 at 12:59 P.M. and stated that staff are to document each time that they attempt to contact the nurse. E7 stated, If E3 did not answer, the policy states that they are to call me. E6 confirmed during this interview that she never received a call from the facility when staff were unable to contact E3 on 12/21/15.

2) The facility's Residential Options Non-Life Threatening Medical Emergencies policy with a review date of 01/2012 states that it is the purpose of this policy to provide residents with appropriate first aid services for non-life threatening medical situations. The Procedures section, #6 states, "If transfer to the Emergency Room is necessary, staff will contact 911 or the ambulance service to provide the transfer".

E6 (DSP - Direct Support Person) was interviewed on 12/29/15 at 2:10 P.M. and stated, "... that when E3 (LPN) called (on 12/21/15) she told us to send him (R1) to ER. We used the company van to take R1 to the ER".

During the interview with E3 on 01/12/16, E3 was asked why staff transported R1 in the facility van and she stated that she was unaware that staff had not called an ambulance to transfer R1 to the Emergency Room.

7) Further review of the facility's investigation does not identify the current BM monitoring

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system that the facility is using and/or the discrepancies that are noted with staff's documentation on R1's BM monitoring sheets for the month of December 2015.

The Medication Administration Record for 12/1 - 12/21/15 identifies that staff are to ask R1 if he has had a bowel movement at 9:00 P.M.. Review of the initiated entries, staff documented that R1 had a bowel movement every day from the 1st thru the 21st.

R1's BM (Bowel Movement) Charting for the month of December 2015 identifies that bowel movements are document by staff and indicate the size/amount of the bowel movement. Contrary to the MAR, this chart states that R1 did not have a bowel movement on 12/02, 12/10, 12/13, 12/15, 12/18 nor 12/21/15.

The bottom of the sheet states: Amount (approximate) and if the bowel movement was: L- large (more than 3 cups), M- medium (about 2 cups) and/or S-small (less than 1 cup). This form does not provide an area for staff to document the color of the BM. nor the consistency of each BM (hard, soft formed, loose unformed, or fluid/watery).

R1's Emergency Room Report dated 12/22/16 states that at 3:37 A.M... "Prior to placement of NG (nasogastric tube) pt (patient) developed large bloody, coffee ground emesis with LOC (loss of consciousness) and agonal respiratory effort. Pt without palpable pulse. Bag mouth mask respirations hindered by continued emesis of dark liquid and vegetable matter initiated as well as CPR (cardio pulmonary resuscitation) and Code Blue. Pt intubated... during which time

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W 154	Continued From page 7 upper airway suctioned with return of copious emesis... resuscitation efforts unsuccessful and pt pronounced dead at 0322 (3:22 A.M.)". The Hospital Report of Death dated 12/22/15 identifies, Impression: Bowel Obstruction. The facility's Investigative Case Summary dated 12/28/15 identifies that witness statements were secured from all staff present on 12/21/15. Documentation within this report indicates that staff contacted the nurse on call but does not address that the nurse did not initially respond or that staff did not document each call placed as per facility policy. This investigation also identifies that R1 was transported to the Emergency Room,, but does not indicate that staff drove him in the van as opposed to calling for an ambulance to transport him to the Emergency Room as per facility policy. After the facility received the hospital records in January 2016, there is no documentation that this information was reviewed by their special constituted committee and/or that any adjustments were made to their bowel monitoring system, especially for individuals with diagnosis of Constipation.	W 154		
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on interview and record review, the facility has failed to ensure that individuals receive nursing services in accordance with their needs for 1 of 1 individual in the sample (R1) who expired on 12/22/15 after being taken to the	W 331		

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hospital by staff with headache and excessive sweating and diagnosed at the Emergency Room (ER) with a small bowel obstruction. The facility's nursing staff failed to ensure that Direct Support Persons (DSPs):

1) Demonstrate competencies in the facility's policy for Nurse on Call with a revised date of 12/05/14 when they failed to document each entry of attempts to contact the nurse and to relay all relevant information to the nurse on 12/21/15;

2) Demonstrate competencies in the facility's policy for Residential Options Non-Life Threatening Medical Emergencies to insure that individuals in need of Emergency Room services are transferred via 911 or ambulance services and not the facility van; and

3) That the facility's current Bowel Movement protocol is adequate in monitoring individuals with diagnosis of constipation.

Findings include:

The Physician's Orders Medications and Treatments sheet dated 12/01-12/31/15 identifies that R1 is a 61 year old male with diagnoses which includes severe intellectual disability, Congenital Heart Disease, Coronary Disease, Impulse Control Disorder and Constipation.

R1's Emergency Room Report dated 12/22/16 states that at 3:37 A.M... "Prior to placement of NG (nasogastric tube) pt (patient) developed large bloody, coffee ground emesis with LOC (loss of consciousness) and agonal respiratory effort. Pt without palpable pulse. Bag mouth mask respirations hindered by continued emesis

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of dark liquid and vegetable matter initiated as well as CPR (cardio pulmonary resuscitation) and Code Blue. Pt intubated... during which time upper airway suctioned with return of copious emesis... resuscitation efforts unsuccessful and pt pronounced dead at 0322 (3:22 A.M.)". The Hospital Report of Death dated 12/22/15 identifies, Impression: Bowel Obstruction.

1) The facility's On Call Nurse Log for December 2015 which is completed by direct support persons (DSPs) identifies that R1 had diarrhea on 12/20/15. The nurse was contacted and orders were received for Imodium and to monitor and push fluids. On 12/21/15 the nurse (E3)) was contacted because of R1 having a headache and instructions were received to give Tylenol. Later at 8:00 P.M. staff contacted the on call nurse (E3) to inform her that R1 was complaining of a stomach ache and of a head ache. On the side of this entry a notation states, "called repeatedly 5 times". Instructions were received to send R1 to the ER (Emergency Room).

The Emergency Room Report dated 12/22/15 states that R1 arrived at the ER at 9:08 P. M. This report states. " Resident... brought to the ED (Emergency Department by private auto with report of diaphoresis, high BP and c/o (complaints of) LUQ (left upper quadrant) pain without vomiting... No history of fever, chills, vomiting. Refused dinner this evening which is atypical for this patient. Sx (symptom) onset about 19:30 (7:30 P.M.)... 9:25 P.M. c/o LUQ pain with lump and diaphoresis (excessive sweating) since this morning.

A report entitled, "Study Result for the CT

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W 331	Continued From page 10	W 331		

Abdomen Pelvis without contrast" was completed while R1 was at the hospital (dated 12/22/15 at 1:36 AM). This report states,

"Findings... There is severely distended stomach and fluid filled small bowel with decompression of the distal small bowel as well as the color and rectum... Impression: High-grade partial mechanical small bowel obstruction with right lower quadrant transition point, suspected to represent distal ileum..."

The facility's on-call nursing notes for 12/21/15 states, "

"5:00 R1 client has headache, VS (vital signs) stable from this morning. b/p (blood pressure)146/80 and 140/84. OK to give Tylenol as directed on MAR (medication administration record)...
8:54 R1 staff reports clients b/p is elevated 157/101, temp normal 97.3 Pulse is 117 and client has been sitting no exertion...respirations are 18. Staff report client is sweating profusely. No SOB (shortness of breath) or LOC (loss of consciousness), client s alert sitting in chair. Send to ER for evaluation..."

E4 (DSP) was interviewed on 12/29/15 at 2:30 P.M. and confirmed that she was working on 12/21/15. E4 stated, "On 12/21 I think R1 came home about 2:00 P.M.. He took a nap and refused dinner. He complained of a headache and Tylenol was orders. Later R1's vitals were taken and his blood pressure was high. R1 also was found laying on the bathroom counter which is not typical behavior for him."

E5 (DSP) was interviewed on 12/29/15 at 2:40

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W 331	Continued From page 11	W 331		

P.M. and confirmed that she was working on 12/21/15. E5 stated, "On 12/21/15 R1 wasn't feeling well. The flu bug was going through the facility, so we assumed that he had the touch of the flu. I gave him a bath and when he came back up to the front area he complained of his head and stomach hurting. We also noticed that he starting sweating. I'm not sure who called the nurse and they told me that she (E3) told them to call 911 or take him to the emergency".

E6 (DSP - Direct Support Person) was interviewed on 12/29/15 at 2:10 P.M. and confirmed that she was working on 12/21/15. E6 stated, "The flu bug had been going through the building. We had several individuals vomiting, diarrhea with symptoms lasting 24-48 hours. On the 20th, R1 did not eat his supper. He was pointing to his stomach and indicating it was hurting. On the 21st, he didn't have any diarrhea or vomiting but he wouldn't eat. He layed down and would get up. At about 5 P.M. R1, got up and began pointing to his head. His vitals were abnormal and I called the nurse. She ordered Tylenol for his headache. Afterwards he just laid around. At about 8:00 P.M.. R1 came out and was sitting with staff. He was sweating and we took his vitals. His pressure was high. We started calling the nurse (E3) and she didn't answer. I called her 5 times. I started panicking when I couldn't get ahold of her (E3). I called E2 (Residential Services Manager) and I later found out that E3 was on the phone with another facility. When E3 (LPN) called she told us to send him to ER. We used the company van to take R1 to the ER".

E6's written statement dated 12/22/15 (included within the facility's investigations) states that

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W 331	Continued From page 12	W 331		

during the time on 12/21 that R1 was sweating, he showed staff a spot on his side and said it hurt..." There is no further mention of this spot/lump until mentioned within the ER report for 12/21/15.

The facility's policy for Nurse on Call with a revised date of 12/05/14 states, Procedure:
1. DSPs are required to make an immediate phone report tot he Primary Nurse on Nurse on Call (if after hours) in the following situations involving a client:
g. Physical complaints (i.e.: chest pain, nausea, etc.)
6. DSPs should allow 15 minutes for the Nurse to return a message. If no response is received within 15 minutes, staff she place a second call and allow 15 minutes for a response.
7. . If no response after the second attempt to call the Director of Nursing (DON). If a message is left with the DON and no response is received within 15 minutes, staff will place a second call and allow 15 minutes for a response.
8. If no response after the second attempt to contact the DON, staff will call/page the RSM on call for further assistance....
10. All attempts to contact a nurse on call will be documented on the Nurse on Call Log..."

E3 was interviewed on 01/12/16 at 12:45 P.M. via telephone and confirmed that she was the nurse on call on 12/21/15. E3 stated, Staff had called me initially and told me that R1 was complaining of a headache and that his vitals were within normal limits. Tylenol was ordered. They called me a second time and told me that his vitals were abnormal, his respirations were ok but that he was sweating profusely with no known cause. I

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G338	A. BUILDING _____ B. WING _____	C 01/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOSTERBURG TERRACE	4617 WONDERLAND DRIVE ALTON, IL 62002

(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
W 331	Continued From page 13	W 331		

instructed them to send him to the Emergency Room for evaluation". When E3 was asked if she recalled staff mentioning a lump on R1's side she stated that she did not recall.

E7 (Director of Nursing) was interviewed on 01/12/16 at 12:59 P.M. and stated that staff are to document each time that they attempt to contact the nurse. E7 stated, If E3 did not answer, the policy states that they are to call me. E6 confirmed during this interview that she never received a call from the facility when staff were unable to contact E3 on 12/21/15.

2) The facility's Residential Options Non-Life Threatening Medical Emergencies policy with a review date of 01/2012 states that it is the purpose of this policy to provide residents with appropriate first aid services for non-life threatening medical situations. The Procedures section, #6 states, "If transfer to the Emergency Room is necessary, staff will contact 911 or the ambulance service to provide the transfer".

E6 (DSP - Direct Support Person) was interviewed on 12/29/15 at 2:10 P.M. and stated, "... that when E3 (LPN) called (on 12/21/15) she told us to send him (R1) to ER. We used the company van to take R1 to the ER".

During the interview with E3 on 01/12/16, E3 was asked why staff transported R1 in the facility van and she stated that she was unaware that staff had not called an ambulance to transfer R1 to the Emergency Room.

3) Further review of the facility's investigation

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does not identify the current BM monitoring system that the facility is using and/or the discrepancies that are noted with staff's documentation on R1's BM monitoring sheets for the month of December 2015.

The Medication Administration Record for 12/1 - 12/21/15 identifies that staff are to ask R1 if he has had a bowel movement at 9:00 P.M.. Review of the initiated entries, staff documented that R1 had a bowel movement every day from the 1st thru the 21st.

R1's BM (Bowel Movement) Charting for the month of December 2015 identifies that bowel movements are document by staff and indicate the size/amount of the bowel movement. Contrary to the MAR, this chart states that R1 did not have a bowel movement on 12/02, 12/10, 12/13, 12/15, 12/18 nor 12/21/15.

The bottom of the sheet states: Amount (approximate) and if the bowel movement was: L- large (more than 3 cups), M- medium (about 2 cups) and/or S-small (less than 1 cup). This form does not provide an area for staff to document the color of the BM. nor the consistency of each BM (hard, soft formed, loose unformed, or fluid/watery).