STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008171	A. BUILDING: _____ B. WING _____	C 03/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATAVIA REHABILITATION & HEALTH CARE C	520 FABYAN PARKWAY BATAVIA, IL 60510

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S 000	Initial Comments Investigation of complaint number 1971684/IL110198.	S 000		
S9999	Final Observations Statement of Licensure Violations 300.1010(h) 300.1210(a) 300.1210(b) 300.1210(c) 300.1210(d)(1)(2)(3) 300.1210(4)(A) 300.1220(b)(2) 300.1220(b)(3) 300.3240(a) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1	S9999		

comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.

2) All treatments and procedures shall be administered as ordered by the physician.

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S9999	Continued From page 2 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. 4) Personal care shall be provided on a 24-hour, seven-day-a-week basis. This shall include, but not be limited to, the following: A) Each resident shall have proper daily personal attention, including skin, nails, hair, and oral hygiene, in addition to treatment ordered by the physician. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall	S9999		

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	IL6008171	A. BUILDING: _____ B. WING _____	C 03/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 3	S9999		

be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These requirements are not met as evidenced by:

Based on interview and record review, the facility failed to recognize, identify, evaluate and monitor detailed bowel habits to prevent constipation and fecal impaction. The facility also failed to follow physician's order to treat constipation.

This failure resulted in R1's admission to the hospital with diagnoses of obstipation (severe or complete constipation) and fecal impaction.

This applies to one of three residents (R1) reviewed for bowel elimination.

The findings include:

R1 has diagnoses that include but are not limited to depression, anxiety, hypothyroidism, diabetes mellitus, status post hip replacement, hypertension, hyperlipidemia, insomnia, left knee DJD (degenerative joint disease), compression fracture of left lumbar vertebra, and lumbar spinal stenosis. R1 was a 78 year old admitted to the facility on 12/13/2018 from the hospital.

The POS (Physician Order Sheet) for the month

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S9999	Continued From page 4	S9999		

of December 2018 showed that R1 was on Suboxone (a medication that is a partial opiate that blocks pain receptors). It is used for chronic pain management. One side effect of this medication is constipation. R1 was on Suboxone 8 mg (milligram) every night when admitted. The dose was increased to 10 mg every night on 2/15/2019. R1 was also placed on Colace (stool softener) as prophylaxis for prevention of constipation on 12/14/2018.

The initial physician history and physical examination dated 12/13/2018 was entered by V7 (R1's Attending Physician) showed that R1 has cognitive impairment, anxiety, and requires medication management. Further visits by V7 dated 1/8/2019 shows R1 had episodes of restlessness and anxiety. R1 also complained of generalized pain, headaches and neck pain. V7's visit on 2/26/2019 showed R1 had altered mental status change, urine was cloudy, has been sleepier, and that "(R1) does get constipated because of opioids." V7's plan of care were urinalysis and Colace for constipation (R1 was already on Colace since admission of 12/13/2018). There was also an order for ultrasound of kidney done 2/27/2019 due to "pain and not urinating." The result of the ultrasound of kidney shows that R1's has significant post void residual with the bladder. Furthermore, R1's "left kidney is not visible secondary to overlying bowel gas."

The MAR (Medication Administration Record) for the month of February 2019 shows R1 was given (MOM) Milk of Magnesia 30 ml (milliliters) on 2/2/2019 at 4:15 P.M.; 2/8/2019 at 8:00 A.M.; 2/21/2019 at 3:00 P.M.; 2/23/2019 at 9:00 A.M.; and 2/25/2019 at 6:00 P.M. R1 was given MOM because R1 "complained of constipation." Further

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008171	A. BUILDING: _____ B. WING _____	C 03/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 5	S9999		

review of the MAR shows the result of administering the MOM documented "observation." It does not show details of bowel habits, if R1 had relief from the MOM, or evacuated stools completely.

The bowel monitoring for the month of February 2019 shows R1 had bowel movement marked as "medium" stool for 7 times for 28 days; "small" stool for 17 days; and no stool for 5 days. R1's clinical record including the bowel and bladder monitoring and nurse's notes showed no documentation of detailed bowel habits to determine and prevent impending obstipation/fecal impaction. There were no comprehensive assessment(s) to identify and manage R1's constipation. The bowel monitoring suggested a none to minimal bowel elimination pattern. However, no assessment was done to identify, recognize, and provide alternate interventions to prevent obstipation and fecal impaction.

The clinical chart also showed there was no care plan for R1's bowel management considering R1 was a risk for constipation due to chronic use of opioids.

On 3/14/2019 at 11:30 A.M., V2 (Director of Nursing) stated R1 had no care plan for constipation/bowel management.

On 3/13/2019 at 11:10 A.M., V5 (Certified Nurse Assistant) stated that she provided care to R1 most of the day/pm shift while R1 was at the facility. V5 also added that R1 was able to verbalize R1's needs. V5 also added R1 needed assistance to go to bathroom for bladder and bowel elimination. V5 stated that she assisted R1 to bathroom. However, R1 complained R1 had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S9999	Continued From page 6	S9999		

difficulty evacuating R1's stools and R1 felt R1 was not emptying the bowel fully. V5 added that she assisted R1 for bowel elimination, but R1 failed to evacuate R1's stools. V5 also stated V8 (R1's family member) had stated to her R1 has constipation problem due to the opioid medication. V5 said she informed the nurse and the nurse gave MOM but V5 was not aware of the result of the MOM and that R1 continued with difficulty passing stools.

On 3/13/2019 at 10:30 A.M., V3 (Licensed Practical Nurse) stated care planning regarding R1's care was held with V8 on 2/27/2019. V3 stated V8 had complained regarding R1's constipation. V3 also stated she updated V7 and an order for Miralax 17 grams to be given daily was obtained on 2/27/2019. V3 also stated Miralax was given on 2/27/2019 in the evening. However, R1 remained constipated and V8 requested for a fleet enema to be given to R1. V3 also stated that when she came in the following day on 2/28/2019 (day shift), R1 had not received the fleet enema that was ordered on 2/27/2019 evening time. V3 also added the facility had no stock of fleet enema and that V4 (Assistant Director of Nursing) was about to buy from a local drug store. However, around lunch time of 2/28/2019, V8 came to facility and administered fleet enema without staff's knowledge. V3 also stated that V8 was very involved with R1's care and V8 also is a nurse by profession. V3 also added R1 complained of constipation and MOM was provided occasionally. V3 also stated she did not perform a rectal examination on R1 to check if R1 was impacted.

On 3/13/2019 at 11:00 A.M., V4 (Assistant Director of Nursing) stated she was about to buy fleet enema for R1 at a local drug store that day

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S9999	Continued From page 7	S9999		

of 2/28/2019. V4 also added around lunch time V8 came to facility with fleet enema and administered the fleet enema to R1. V4 also added that there was no fleet enema stock at the facility at that time. V4 also added she did not perform a rectal examination on R1 to check if R1 was impacted.

On 3/13/2019 at 12:15 P.M., V6 (Licensed Practical Nurse) stated V8 informed her on 2/27/2019 before 9:00 P.M., for R1 to have fleet enema to evacuate R1's stools. V6 also added that V8 informed her that Miralax medication was not enough to relieve R1 of constipation. V6 added that she called V7 and was able to obtain an order for fleet enema that evening. V7 added she did not administered the fleet enema to R1. V6 also added she did not performed rectal examination because it was beyond her nursing practice as an LPN.

On 3/13/2019 at 2:00 P.M., V2 (Director of Nursing) stated V6 can perform rectal examination. However, if V6 was not comfortable doing the rectal examination,V6 should have sought assistance from other nurse(s) to perform rectal examination and determine if R1 was impacted.

The nurse's notes dated 2/28/2019 shows R1 was sent to hospital for evaluation and treatment regarding constipation. The nurse's notes also shows that R1 was admitted to the hospital for constipation.

The hospital record dated 2/28/2019 shows R1's admitting diagnosis to the hospital was "obstipation." The abdominal x-ray dated 2/28/2019 done at the hospital shows R1 has "Prominent amount of fecal material in the rectum

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S9999	Continued From page 8	S9999		

and colon consistent with obstipation." The "Assessment /Plan" for R1 at the hospital shows that due to "obstipation/fecal impaction", and with failed enemas, stool softeners, and chronic use of Suboxone, R1 was given Golytely to cleanse bowel by causing diarrhea, disimpacted every 4 hours, and a gastroenterologist consultation.

The hospital discharge summary dated 3/7/2019 shows that R1 final diagnosis was "obstipation; severe colonic stool burden." R1's secondary diagnosis was urinary retention which was "likely secondary to opiate issue, immobility, and stool retention."

On 3/14/2019 at 10:30 A.M., V7 (Attending Physician) stated R1 was admitted to the hospital on 2/28/2019 with diagnoses of obstipation and fecal impaction. V7 stated R1's fecal impaction was preventable if only there was a close monitoring of detailed bowel habits. V7 also stated she should have been informed of R1's minimal evacuation of stool based on the bowel monitoring for the month of February 2019. V7 also added this fecal impaction could have been prevented if alternate interventions were implemented and if she would been informed of the minimal stool elimination. V7 also added that her expectation was the facility should have done a comprehensive assessment including rectal examination to determine and recognize impending impaction and that applicable treatment could have been provided timely. V7 also added the fleet enema she ordered on 2/27/2019 should have been administered as soon as she had ordered. V7 also stated the fleet enema would not help due to R1's severe obstipation, however, it might have helped relieve some discomfort.

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S9999	Continued From page 9 (B)	S9999		