STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013361	A. BUILDING: _____ B. WING _____	C 12/14/2017

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LEXINGTON OF LAGRANGE	4735 WILLOW SPRINGS ROAD LA GRANGE, IL 60525

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S 000	Initial Comments Complaint Investigation 1797029/IL98550	S 000		
S9999	Final Observations Statement of Licensure Violations 300.1210b) 300.1220)b)3) Section 300.1210 General Requirements for Nursing and Personal Care 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. Restorative measures shall include, at a minimum, the following procedures: Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 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	**Attachment A** **Statement of Licensure Violations**	

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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.

These requirements were not met as evidenced by:

Based on interview and record review, the facility failed to develop a plan to reduce and prevent the risk of constipation for 1 of 3 residents (R1) reviewed for constipation. This failure resulted in R1 being transported to the local hospital and assessed with rectal distention and fecal impaction.

Findings include:

R1 was admitted 11-9-17 from the hospital for rehabilitation therapy, following left hip surgery due to fracture. R1 had diagnoses significant for Vascular Dementia and Dysphagia. V3's (NP -Nurse Practitioner) assessment 11-10-17 indicates R1 was alert and oriented to person only, with periods of confusion. R1's 11-16-17 MDS (Minimum Data Set) notes a BIMS (Brief Interview for Mental Status) score of "3," indicating severe cognitive deficits.

R1's "Continence" record dated 11-9-17 through 11-20-17 indicates only one bowel movement, which was on 11-9-17. R1's November MAR (Medication Administration Record) indicates the order for Docusate Sodium (stool softener laxative) 100 mg (mg) daily by mouth, as needed; however, no doses were ever given. Per Nursing notes and MAR, R1 did not complain or get medicated for abdominal pain or constipation

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during the course of her stay at the facility, 11-9-17 through 11-20-17. V5's (Nurse) "Nursing Admission Assessment" dated 11-9-17 indicates R1's abdomen as soft with bowel sounds present. V4's (Nurse) Nursing note dated 11-10-17 at 4:44pm indicates R1's abdomen as soft and non distended. V3 stated 12-12-17 she saw R1 11-10-17 and again on 11-17-17, and R1's abdomen was soft, non-distended, with present bowel sounds, and R1 had no complaints of abdominal pain. V3's notes from these visits indicate these findings. V6 (NP) stated 12-12-17 at 2:14pm that when she saw R1 on 11-13-17 and 11-14-17, R1's abdomen was soft. V6 noted the presence of normal bowel sounds on 11-13-17, but did not listen to R1's bowel sounds on 11-14-17. R1 did not complain of abdominal pain on either of these visits. V6's notes from these visits indicate these assessments. V9 (Rehab Physician) stated 12-12-17 she saw R1 on 11-10-17 and 11-17-17. Upon both of these visits, R1's abdomen was soft, non-distended, and bowel sounds were present. V9's notes from these visits indicate these findings. V9 did not receive any reports from Nursing that R1 was not moving her bowels. V8 (R1's Attending Physician) stated 12-13-17 at 2:26pm he saw R1 11-14-17 and again 11-17-17. Upon both of these visits, R1's abdomen was soft, non-distended, non-tender, with bowel sounds present. V8 did not receive any reports from Nursing that R1 was constipated or not having bowel movements.

V11 (CNA - Certified Nursing Assistant) stated 12-11-17 at 2:22pm she helped care for R1 on 11-20-17 the 7:00 am - 3:00 pm shift. In the early afternoon, R1 was not as alert as she normally was, and she moaned a little when repositioned. R1's abdomen was distended, and tender to touch. R1 hadn't urinated that day yet. V11 took

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R1's vital signs and reported these findings immediately to V4. V11 could not remember what these vital signs were, but thinks R1's BP was approximately 90's/50's. V12 (Occupational Therapist) stated 12-13-17 at 3:40pm when she went to see R1 for her therapy session 11-20-17 about 1:30pm R1 was in bed, moaning. R1 seemed to have both a physical and cognitive decline, was lethargic, and could not follow commands or participate in therapy. R1's abdomen was distended. V12 told V4, who was attending to another resident, but came immediately. V12's note from that day indicates these occurrences. V4 stated 12-11-17 at 3:15pm R1's vital signs and condition were stable when she came on duty in the morning of 11-20-17. R1 was up in her wheelchair at the Nurses' station that morning. At approximately 1:00pm - 1:30pm, V11 told V4 R1 had not urinated that day, and had not wanted to eat/drink. When told about R1's change in condition from V11 and V12, V4 immediately went to assess R1, then called V6 to come and see R1 for lethargy/changes in condition. R1's blood pressure was 102/55, pulse 100, and respiratory rate 18. V6 stated 12-12-17 she arrived to assess R1 on 11-20-17, she found R1 drowsy, but arousable, opening her eyes quickly to command, but then closing them. V7 was present, and insisted R1 be sent to the hospital. V6 called V13 (R1's Attending Physician's NP), who agreed to send R1 to the hospital for evaluation. V6 stated ordered V4 to send R1 to the hospital via regular ambulance, as she didn't feel this was a "911 situation," as 911 calls are for chest pain, stroke, severe traumatic injury, or unresponsiveness. R1 had no respiratory distress, and stable blood pressure. R1's heart rate was somewhat elevated, but not dangerously so. Neither V4 nor V6 stated they made a choice

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of ambulance transportation for insurance/money criteria. V4's Nursing note 11-20-17 at 2:37pm indicates the ambulance was called at 1:45pm, and arrived at 2:10pm to transport R1 to the hospital for evaluation. R1 was re-routed by the ambulance to a closer hospital by the ambulance due to a drop in her blood pressure to 90/52.

Hospital records indicate R1 arrived in the hospital ER (Emergency Room) at 2:49pm on 11-20-17 with a heart rate of 107, and a blood pressure of 104/70. R1's mouth appeared dry, and her abdomen was soft, with normal bowel sounds and diffuse abdominal tenderness with guarding. R1 was sleepy, but arousable to voice. R1 began vomiting after arrival in the ER. R1 was sent for a CT (Computerized Tomography) exam of the abdomen and pelvis 11-2017 which showed barium artifact in the right mid colon and rectum, significant distention of the rectum up to 9 cm (centimeters) with wall thickening and surrounding fat stranding as well as mildly prominent bowel loops with wall thickening more prominent in the transverse colon, a fluid filled left colon and an air-fluid level involving the sigmoid colon. These findings could represent a component of large bowel obstruction in the setting of fecal impaction of the rectum/associated stercolitis. Small amount of reactive free fluid identified in the right paracolic gutter and anterior pelvis. Superimposed infection not excluded. R1's WBC (White Blood Cell Count) was high at 26.1 (normal value 4.8-10.8), and serum lactic acid level was critical at 6.8 (normal value 0.5 - 1.0).

R1 was admitted to the Intensive Care Unit for of Severe Sepsis, Abdominal Distention, and Probable Large Bowel Obstruction. V14 (Surgeon) was consulted, and saw R1 on

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11-20-17 at 6:00pm. V14 assessed R1 as being in mild distress, opening her eyes to painful stimuli. R1's abdomen was soft, distended and somewhat full feeling, with non-focal tenderness, not peritonitic. R1 appeared dehydrated. R1 did not have any blood in her rectum, but had soft, pasty stool mixed with barium, which V14 disimpacted. V14 reviewed R1's abdominal CT results, and was told by V7 R1 drank barium on 11-8-17 for a swallow study. V14 presumed the barium remained in R1 since that time, since no barium had been given that day. V14 believed dehydration could be driving her colonic wall thickening. R1 did not have a small bowel obstruction or any definite signs of perforation. R1 tolerated the disimpaction "fairly well." V14 determined R1 was not in need of surgery at that time. V15's hospital "Discharge Summary" dated 11-22-17 indicates "Patient with severe illness. Made DNR (Do Not Resuscitate) by family. Patient expired peacefully." Hospital records obtained by Surveyor do not indicate the details surrounding R1's death. R1's death certificate signed by V16 (Medical Examiner) indicates R1 died 11-20-17 at 10:16pm at the hospital. The causes of death listed on this death certificate are Sepsis and Probable Large Bowel Obstruction. An autopsy was not performed.

V2 (Director of Nursing) stated 12-13-17 at 1:00pm Nurses and CNA's (Certified Nursing Assistants) are responsible to document each resident's bowel movements. It is the Nurse's responsibility to monitor these records to ensure residents are moving their bowels regularly, by information shared in verbal report, as well as review of the resident's "Continence" record. If the Nurse finds a resident hasn't moved his/her bowels, the Nurse should interview the resident (if cognitively intact and able to speak) regarding

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his/her normal bowel pattern, or interview the resident's family, when appropriate. Then, the Nurse should assess the resident's abdomen for distention, firmness, and the presence or absence of bowel sounds. The Nurse should then check the resident's MAR for any laxative/stool softer orders, and administer this medication. If no laxatives/stool softeners are listed on the resident's MAR, the Nurse should call the Physician or NP for orders.

V8 (R1's Attending Physician) stated 12-13-17 at 2:36pm he was not aware R1 had not been having bowel movements. V8 stated, "Constipation is a common problem with residents who are not regularly ambulating." If notified, V8 or any of the NP's would have given orders for laxatives or enemas, as needed.

R1's care plan includes the problem "Potential for constipation related to: Decreased mobility, use of the following - diuretic and psychotropic Medication," with interventions including "Monitor for signs of possible constipation, such as poor appetite, nausea, abdominal distention, decrease bowel movement frequency/output or change in bowel pattern," and "Monitor BM (bowel movement) output every shift and record," and "Refer to MD if no bowel movement for 3 days."

(A)