

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155551	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/16/2016
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NAME OF PROVIDER OR SUPPLIER  ROLLING MEADOWS HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 604 RENNAKER ST LA FONTAINE, IN 46940
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F 0000  Bldg. 00	<p>This visit was for the Investigation of Complaint IN00207287.</p> <p>Complaint IN00207287 - Substantiated. Federal/State deficiencies related to the allegations are cited at F157 and F309.</p> <p>Survey dates: August 15 and 16, 2016</p> <p>Facility number: 000447 Provider number: 155551 AIM number: 100289950</p> <p>Census bed type: SNF/NF: 88 Total: 88</p> <p>Census payor type: Medicare: 6 Medicaid: 51 Other: 31 Total: 88</p> <p>Sample: 4</p> <p>These deficiencies reflects State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed by 11474 on August 17, 2016.</p>	F 0000	<p>We at the facility are hereby respectfully requesting this agency to consider paper compliance for the following plan of correction as opposed to a post survey revisit. We are willing to submit any and all documentation as requested to assure our credible compliance with the deficient practices noted in the following CMS-2567. We are hereby providing our plan of correction. Submission of this Plan of Correction does not constitute an admission to or an agreement with facts alleged on the survey report. Submission of this Plan of Correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. The Plan of Correction is prepared and submitted because of requirements under State and Federal law. Please accept this Plan of Correction as our credible allegation of compliance.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/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.

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F 0157 SS=D Bldg. 00	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on interview and record review, the facility failed to ensure the physician was notified in a timely manner for a</p>	F 0157	<b>Facility Plan of Correction:</b> Resident B no longer resides at this facility. All residents residing in the facility that experience a	08/25/2016

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	<p>change in condition related to confusion for 1 of 4 Residents reviewed for physician notification. (Resident B)</p> <p>Findings include:</p> <p>During record review on 8/15/16 at 8:40 a.m., the clinical record indicated Resident B was admitted to the facility on 7/26/16. Diagnoses included, but were not limited to, congestive heart failure, chronic kidney disease, chronic obstructive pulmonary disease, depression and osteoarthritis.</p> <p>Review of an Admission/Readmission Evaluation dated 7/26/16 at 4:50 p.m., indicated Resident B was alert and oriented to person, place and time.</p> <p>A late entry progress note, dated 7/26/16 at 4:50 p.m. but unknown when it was actually done, indicated Resident B had a small amount of emesis that was light orange in color. Her bowel sounds were noted as "hypo-active throughout all quadrants. The last large BM [bowel movement] was on Thursday 7/21 by enema." Resident B complained of lower back pain.</p> <p>A late entry progress note, dated 7/27/16 at 9:30 p.m. but unknown when it was actually assessed, indicated "slightly</p>		<p>change in condition and/or bowel elimination issues have the potential to be affected by this alleged deficient practice. The facility policy and procedure for Physician-Family Responsible Party Notification and Bowel Elimination were reviewed and no changes were indicated. The facility nursing staff was re-inserviced on the facility policy and procedure for Physician-Family Responsible Party Notification and Bowel Elimination. The DON and/or designee will randomly audit five residents three times a week for four weeks, then every other week for four weeks, then monthly thereafter. The audit will be documented on the Notification of change QA tool(Attachment A) and the Bowel Elimination QA tool (Attachment B). Any concerns noted will receive immediate follow-up. Monitoring will continue until substantial compliance is achieved as determined by the Quality Assurance committee. The DON report of monitoring will be forwarded to the Administrator for monthly QA review and the plan of action will be adjusted accordingly. <b>Facility Provided information for IDR:</b> The facility respectfully requests the review of the following information and accompanying attachments (Attachment C). Resident B was admitted to this facility on 07/26/16 at 4:50pm from another</p>	

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	<p>hypoactive bowel sounds x 4 quads."</p> <p>On 7/28/16 at 2:10 p.m., the Nurse Practitioner was notified and decreased tramadol to 1 tablet every 4 hours.</p> <p>A progress note, dated 7/29/16 at 10:36 a.m., indicated an order for Milk of Magnesia (MOM) 400 mg/5mL had been received. The order indicated to give 30 mL my mouth every 24 hours as needed.</p> <p>On 7/29/16 at 10:36 a.m., 30 mL of MOM was given.</p> <p>A late entry, dated 7/29/16 at 12:21 p.m. but unknown when the assessment was actually completed, indicated a progress note of "Bowel sounds hypo-active throughout all quadrants...Resident continues to emesis, medication given...."</p> <p>On 7/29/16 at 1:00 p.m., Resident B complained of nausea and vomiting.</p> <p>On 7/29/16 at 2:53 p.m., Resident B continued to complain about nausea and vomiting. The physician was notified and a new order for promethazine (a medication used to treat nausea and vomiting) 25 mg every 6 hours as needed was received.</p> <p>Review of the July Medication</p>		<p>local long term care facility. At the time of admission both of the residents daughters were present. Upon arrival to the facility the resident's daughter made the resident's primary care nurse (RN) aware that the resident had not had a bowel movement since 07/21/16. The RN completed an admission head to toe assessment of the resident at the time of admission. Following the RN's assessment she contacted the physician on call and proceeded to notify the physician on call of the new admission, to clarify the resident's orders, and to notify the physician of the resident not having a bowel movement since 07/21/16. The physician on call provided clarification orders for the resident's prednisone and also provided new orders for Milk of Magnesia, Bisacodyl suppository, and a fleet enema as needed. The RN administered the ordered dose of Milk of Magnesia to the resident after receiving the order from the physician. The resident's daughter and granddaughter were present in the room when the RN administered the Milk of Magnesia to the resident. The Milk of Magnesia was effective with medium results of formed/normal stool. The Nurse Practitioner was contacted regarding the resident on 07/28/16 at 2:10pm regarding the resident's tramadol and chronic back pain, new orders were</p>		

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	<p>Administration Record (MAR), indicated Resident B was given promethazine on 7/29/16 at 9:51 p.m.</p> <p>On 7/29/16 at 10:29 p.m., the MAR indicated bisacodyl suppository (a stool irritant) 10 mg had been given.</p> <p>A progress note, dated 7/30/16 at 1:50 a.m., indicated Resident B had periods of "confusion." The note indicated emesis was noted earlier in the shift. No additional information was documented.</p> <p>A late entry, dated 7/30/16 at 6:52 a.m., indicated the physician was contacted related to continued emesis and hypoactive bowel sounds. A new order for an enema was received, as well as, an abdominal x-ray of the kidneys, ureters and bladder.</p> <p>A late entry, dated 7/30/16 at 7:36 a.m., indicated no results from the enema were received. The physician was notified and a new order to send to the local hospital was received.</p> <p>During a telephone interview on 8/16/16 at 9:48 a.m., LPN #1 indicated she was the admitting nurse. She indicated she gave Resident B an enema after she realized she had not had a bowel movement since 7/21/16. She indicated</p>		<p>received and both of the resident's daughters were updated. The physician was contacted on 07/29/16 to discuss the resident's specific dietary choices, food and fluid consumption, and sleeping patterns new orders received per the Registered Dietitian recommendation and resident individualized review. The resident and her daughter were made aware of the new orders received. When the RN resumed care of Resident B per schedule on 07/29/16 it was noted by the RN that the resident was beginning her sixth shift without the presence of a bowel movement. The nurse administered Milk of Magnesia per physician order at 10:36am. At approximately 12:00pm the resident had a scant amount of clear liquid emesis. The resident was consuming water at the time and the emesis appeared as if the resident has spit out a scant amount of water. At approximately 1:00pm the resident complained of nausea and vomiting the resident had an additional episode of emesis that was scant and appeared to be clear liquid. The physician was notified of the episodes of emesis and complaints of nausea and a new order was received for Promethazine as needed. Resident B displayed no further emesis or complaints of nausea and vomiting at that time,</p>	

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	<p>Resident B brought her medication from another facility. She also indicated she gave her a dose of tramadol for pain. Neither medication was documented as having been given on the MAR or in the progress notes.</p> <p>Review of the Admission Orders, dated 7/26/16, indicated no MOM or bisacodyl suppository was initially ordered.</p> <p>Review of the Bowel Movement report indicated Resident B had a medium size BM on 1st shift 7/27/16. She did not have any recorded for 7/28/16 or 7/29/16. On 7/30/16, Resident B had a medium size BM at 2:55 a.m. and a large BM at 10:52 a.m.</p> <p>During an interview on 8/15/16 at 1:35 p.m., the Director of Nursing (DON) indicated the computer had a physician's visit note that was no longer there. She indicated she had spoken to the physician and he deleted the note because Resident B left before the note was finished. Resident B was not seen by the physician or nurse practitioner during her stay.</p> <p>During an interview on 8/16/16 at 9:48 a.m., the Assistant Director of Nursing (ADON) indicated there was no information on the 24 hour report sheet that Resident B received either tramadol</p>		<p>The RN again resumed care of Resident B on 07/30/16. The RN discussed the resident's plan of care via telephone with the resident's daughter at approximately 6:40AM. The RN then placed a call to the Nurse Practitioner on call. The Nurse Practitioner was updated via phone regarding the resident's current condition. The Nurse Practitioner provided new orders to obtain a KUB and to proceed with administering an enema to the resident. The RN updated the residents daughter regarding the new order received from the Nurse Practitioner and the daughter was pleased and thankful. The RN promptly administered the enema. The RN returned to the residents' room shortly after the administration of the enema to administer the residents am medication. The nurse attempted to administer the resident's medication in pudding as requested by the resident. After the resident swallowed her medication she took a drink of water. After taking the drink of water the resident regurgitated the medications and pudding. The nurse immediately contacted the Nurse Practitioner to notify him that the resident had no results from the enema thus far and that the resident had displayed a small amount of emesis. The Nurse Practitioner provided a new order to send the resident to the local ER for an evaluation and</p>	

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	<p>or an enema on admission for 7/26/16. .</p> <p>Review of hospital records began on 8/16/16 at 9:30 a.m. Resident B was admitted to the hospital on 7/30/16. The chief complaint indicated she had not had a bowel movement since Tuesday (7/28/16). Her family indicated she had increased confusion over the past 2 or 3 days. She was noted to have several episodes of non-bloody, non-bilious vomiting. On 7/30/16, she had an elevated White Blood Cell (WBC) count of 28.0. The normal range was 4.0-10.0 K/uL.</p> <p>On 7/31/16, Resident B had an abdominal flat and upright x-ray. The impression indicated "...suspicious for small bowel obstruction and less likely bowel ileus."</p> <p>On 8/1/16, Resident B had a small bowel x-ray. The impression indicted "...likely representative of high grade small bowel obstruction...."</p> <p>On 8/2/16, an abdominal x-ray of the kidneys, ureters and bladder was completed. The impression indicated "...suspicious for obstruction."</p> <p>On 8/2/16, the WBC count was 30.6.</p>		<p>treatment. The resident's daughter was updated regarding the new order. The RN arranged transportation for the resident to the ER. As the transportation was arriving to transport the resident the resident had a large bowel movement that was soft/formed/normal. The resident was transported to the local ER. A nurse from the local ER contacted the facility and stated that the resident was being admitted to the hospital with a diagnosis of sepsis and renal failure. A CT scan of the resident's abdomen and pelvis completed at the hospital on 07/30/16 at 11:15am resulted in the following impression: findings most consistent with gastroenteritis and less likely bowel ileus. This is not to represent a bowel obstruction, given no focal transition was identified. Fluid density is also identified through out the small large and bowel with air fluid levels with fluid also seen in the rectum. Chronic and non-emergent findings as described above. The resident discharged from the facility to the hospital on 07/30/16. Nonetheless, Resident B resided in the facility for less than 87 hours. The physician and/or Nurse Practitioner was updated regarding the residents condition six times Resident B received Milk of Magnesia within two hours of admission after the order was</p>		

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	<p>A hospital discharge summary, dated 8/3/16, indicated a Gastrografin small bowel x-ray was obtained and did show findings suggestive of a severe ileus verses a grade small bowel obstruction. Resident B was not a candidate for surgical intervention and palliative care was provided. Resident B expired on 8/3/16.</p> <p>Review of a current facility policy, dated 8/20/13, titled "PHYSICIAN/FAMILY/RESPONSIBLE PARTY NOTIFICATION FOR CHANGE IN CONDITION" which was provided by the Director of Nursing on 8/16/16 at 11:44 a.m. indicated the following: "Purpose: To ensure that medical care problems are communicated to the attending physician and family/responsible party in a timely, efficient, and effective manner.</p> <p>"Policy: 1. Physician and family/responsible party notification is to included, but is not limited to: ...Emesis/Diarrhea...Change in level of consciousness...Unusual or worsening behaviors... 2. Physician and Family/Responsible...documented in the progress notes, it should contain</p>		<p>received on 06/26/16 (as seen on Resident B's order summary report) that effectively produced results after not having a bowel movement for five days prior to admission. Resident's family was at facility daily visiting with no complaints or concerns voiced. Resident B received additional laxatives per physician order and facility protocol after not producing a bowel movement for six shifts. The resident had two additional bowel movements a medium and a large that were soft/formed/normal prior to discharge on 07/30/16.</p>	

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F 0309 SS=D Bldg. 00	<p>information regarding the resident condition...."</p> <p>This Federal tag relates to Complaint IN00207287.</p> <p>3.1-5(a)(2)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on interview and record review, the facility failed to ensure a resident receive timely bowel evacuation assessment and medication to avoid constipation for 1 of 4 residents reviewed. (Resident B)</p> <p>Findings include:</p> <p>During record review on 8/15/16 at 8:40 a.m., the clinical record indicated Resident B was admitted to the facility on 7/26/16. Diagnoses included, but were not limited to, congestive heart failure, chronic kidney disease, chronic obstructive pulmonary disease,</p>	F 0309	<p><b>Facility Plan of Correction:</b> Resident B no longer resides at this facility. All residents residing in the facility that experience a change in condition and/or bowel elimination issues have the potential to be affected by this alleged deficient practice. The facility policy and procedure for Physician-Family Responsible Party Notification and Bowel Elimination were reviewed and no changes were indicated. The facility nursing staff was re-inserviced on the facility policy and procedure for Physician-Family Responsible Party Notification and Bowel Elimination. The DON and/or designee will randomly audit five</p>	08/25/2016

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	<p>depression and osteoarthritis.</p> <p>Review of an Admission/Readmission Evaluation, dated 7/26/16 at 4:50 p.m., indicated Resident B was alert and oriented to person, place and time.</p> <p>A progress note, dated 7/26/16 at 4:50 p.m., indicated Resident B had a small amount of emesis that was light orange in color. Her bowel sounds were noted as "hypo-active throughout all quadrants. The last large BM [bowel movement] was on Thursday 7/21 by enema." Resident B complained of lower back pain.</p> <p>A progress note, dated 7/27/16 at 9:30 p.m., indicated "slightly hypoactive bowel sounds x 4 quads." A medium stool was charted at 11:16 a.m.</p> <p>On 7/28/16 at 2:10 p.m., the Nurse Practitioner was notified and decreased tramadol ( an opiate known to cause constipation) to 1 tablet every 4 hours for pain.</p> <p>A progress note, dated 7/29/16 at 10:36 a.m., indicated an order for Milk of Magnesia (MOM) 400 mg/5mL had been received. The order indicated to give 30 mL my mouth every 24 hours as need.</p>		<p>residents three times a week for four weeks, then every other week for four weeks, then monthly thereafter. The audit will be documented on the Notification of change QA tool(Attachment A) and the Bowel Elimination QA tool (Attachment B). Any concerns noted will receive immediate follow-up. Monitoring will continue until substantial compliance is achieved as determined by the Quality Assurance committee. The DON report of monitoring will be forwarded to the Administrator for monthly QA review and the plan of action will be adjusted accordingly. <b>Facility Provided information for IDR:</b> The facility respectfully requests the review of the following information and accompanying attachments (Attachment C). Resident B was admitted to this facility on 07/26/16 at 4:50pm from another local long term care facility. At the time of admission both of the residents daughters were present. Upon arrival to the facility the resident's daughter made the resident's primary care nurse (RN) aware that the resident had not had a bowel movement since 07/21/16. The RN completed an admission head to toe assessment of the resident at the time of admission. Following the RN's assessment she contacted the physician on call and proceeded to notify the physician on call of the new admission, to</p>				

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	<p>On 7/29/16 at 10:36 a.m., 30 mL of MOM was given.</p> <p>On 7/29/16 at 12:21 p.m., a progress note indicated "Bowel sounds hypo-active throughout all quadrants...Resident continues to emesis, medication given...."</p> <p>On 7/29/16 at 1:00 p.m., Resident B complained of nausea and vomiting.</p> <p>On 7/29/16 at 2:53 p.m., Resident B continued to complain about nausea and vomiting. The physician was notified and a new order for promethazine (a medication used to treat nausea and vomiting) 25 mg every 6 hours as needed was received.</p> <p>Review of the July Medication Administration Record (MAR), indicated Resident B was given promethazine on 7/29/16 at 9:51 p.m.</p> <p>On 7/29/16 at 10:29 p.m., the MAR indicated bisacodyl suppository (a bowel irritant) 10 mg had been given.</p> <p>A progress note, dated 7/30/16 at 1:50 a.m., indicated Resident B had periods of "confusion." The note indicated emesis was noted earlier in the shift. No additional information was documented.</p>		<p>clarify the resident's orders, and to notify the physician of the resident not having a bowel movement since 07/21/16. The physician on call provided clarification orders for the resident's prednisone and also provided new orders for Milk of Magnesia, Bisacodyl suppository, and a fleet enema as needed. The RN administered the ordered dose of Milk of Magnesia to the resident after receiving the order from the physician. The resident's daughter and granddaughter were present in the room when the RN administered the Milk of Magnesia to the resident. The Milk of Magnesia was effective with medium results of formed/normal stool. The Nurse Practitioner was contacted regarding the resident on 07/28/16 at 2:10pm regarding the resident's tramadol and chronic back pain, new orders were received and both of the resident's daughters were updated. The physician was contacted on 07/29/16 to discuss the resident's specific dietary choices, food and fluid consumption, and sleeping patterns new orders received per the Registered Dietitian recommendation and resident individualized review. The resident and her daughter were made aware of the new orders received. When the RN resumed care of Resident B per schedule on 07/29/16 it was noted by the</p>				

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	<p>A late entry, dated on 7/30/16 at 6:52 a.m. but unknown when it was actually done, indicated the physician was contacted related to continued emesis and hypoactive bowel sounds. A new order for an enema was received, as well as, an abdominal x-ray of the kidneys, ureters and bladder.</p> <p>On 7/30/16 at 7:36 a.m., a late entry note indicated no results from the enema were received. The physician was notified and a new order to send to the local hospital was received.</p> <p>Resident B received tramadol (opiate for pain control) 50 mg, 1 or 2 tablets every 4 hours. She received 11 tramadol tablets from 7/26-7/28/16.</p> <p>During a telephone interview on 8/16/16 at 9:48 a.m., LPN #1 indicated she was the admitting nurse. She indicated she gave Resident B an enema after she realized she had not had a bowel movement since 7/21/16. She indicated Resident B brought her medication from another facility. She also indicated she gave her a dose of tramadol. Neither medication was documented as having been given on the MAR or in the progress notes.</p> <p>Review of the Admission Orders, dated</p>		<p>RN that the resident was beginning her sixth shift without the presence of a bowel movement. The nurse administered Milk of Magnesia per physician order at 10:36am. At approximately 12:00pm the resident had a scant amount of clear liquid emesis. The resident was consuming water at the time and the emesis appeared as if the resident has spit out a scant amount of water. At approximately 1:00pm the resident complained of nausea and vomiting the resident had an additional episode of emesis that was scant and appeared to be clear liquid. The physician was notified of the episodes of emesis and complaints of nausea and a new order was received for Promethazine as needed. Resident B displayed no further emesis or complaints of nausea and vomiting at that time, The RN again resumed care of Resident B on 07/30/16. The RN discussed the resident's plan of care via telephone with the resident's daughter at approximately 6:40AM. The RN then placed a call to the Nurse Practitioner on call. The Nurse Practitioner was updated via phone regarding the resident's current condition. The Nurse Practitioner provided new orders to obtain a KUB and to proceed with administering an enema to the resident. The RN updated the residents daughter regarding the</p>	

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	<p>7/26/16, indicated no MOM or bisacodyl suppository was initially ordered.</p> <p>Review of the Bowel Movement report, Resident B had a medium size BM on 1st shift 7/27/16. She did not have any recorded for 7/28/16 or 7/29/16. On 7/30/16, Resident B had a medium size BM at 2:55 a.m. and a large BM at 10:52 a.m.</p> <p>During an interview on 8/15/16 at 1:35 p.m., the Director of Nursing (DON) indicated the computer had a physician's visit note that was no longer there. She indicated she had spoken to the physician and he deleted the note because Resident B left before the note was finished. Resident B was not seen by the physician or nurse practitioner during her stay.</p> <p>During an interview on 8/16/16 at 9:48 a.m., the Assistant Director of Nursing (ADON) indicated there was no information on the 24 hour report sheet that Resident B received either tramadol or an enema on admission for 7/26/16. .</p> <p>Review of hospital records began on 8/16/16 at 9:30 a.m. Resident B was admitted to the hospital on 7/30/16. The chief complaint indicated she had not had a bowel movement since Tuesday (7/28/16). Her family indicated she had</p>		<p>new order received from the Nurse Practitioner and the daughter was pleased and thankful. The RN promptly administered the enema. The RN returned to the residents' room shortly after the administration of the enema to administer the residents am medication. The nurse attempted to administer the resident's medication in pudding as requested by the resident. After the resident swallowed her medication she took a drink of water. After taking the drink of water the resident regurgitated the medications and pudding. The nurse immediately contacted the Nurse Practitioner to notify him that the resident had no results from the enema thus far and that the resident had displayed a small amount of emesis. The Nurse Practitioner provided a new order to send the resident to the local ER for an evaluation and treatment. The resident's daughter was updated regarding the new order. The RN arranged transportation for the resident to the ER. As the transportation was arriving to transport the resident the resident had a large bowel movement that was soft/formed/normal. The resident was transported to the local ER. A nurse from the local ER contacted the facility and stated that the resident was being admitted to the hospital with a diagnosis of sepsis and renal failure. A CT scan of the</p>				

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	<p>increased confusion over the past 2 or 3 days. She was noted to have several episodes of non-bloody, non-bilious vomiting. On 7/30/16, she had an elevated White Blood Cell count of 28.0. The normal range was 4.0-10.0 K/uL.</p> <p>On 7/31/16, Resident B had an abdominal flat and upright x-ray. The impression indicated "...suspicious for small bowel obstruction and less likely bowel ileus."</p> <p>On 8/1/16, Resident B had a small bowel x-ray. The impression indicated "...likely representative of high grade small bowel obstruction...."</p> <p>On 8/2/16, an abdominal x-ray of the kidneys, ureters and bladder was completed. The impression indicated "...suspicious for obstruction."</p> <p>On 8/2/16, the WBC count was 30.6.</p> <p>A hospital discharge summary, dated 8/3/16, indicated a Gastrografin small bowel x-ray was obtained and did show findings suggestive of a severe ileus verses a grade small bowel obstruction. Resident B was not a candidate for surgical intervention and palliative care was provided. Resident B expired on 8/3/16.</p>		<p>resident's abdomen and pelvis completed at the hospital on 07/30/16 at 11:15am resulted in the following impression: findings most consistent with gastroenteritis and less likely bowel ileus. This is not to represent a bowel obstruction, given no focal transition was identified. Fluid density is also identified through out the small large and bowel with air fluid levels with fluid also seen in the rectum. Chronic and non-emergent findings as described above. The resident discharged from the facility to the hospital on 07/30/16. Nonetheless, Resident B resided in the facility for less than 87 hours. The physician and/or Nurse Practitioner was updated regarding the residents condition six times Resident B received Milk of Magnesia within two hours of admission after the order was received on 06/26/16 (as seen on Resident B's order summary report) that effectively produced results after not having a bowel movement for five days prior to admission. Resident's family was at facility daily visiting with no complaints or concerns voiced. Resident B received additional laxatives per physician order and facility protocol after not producing a bowel movement for six shifts. The resident had two additional bowel movements a medium and a large that were soft/formed/normal prior to</p>	

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	<p>Review of a current facility policy dated 2/2012, titled "BOWEL ELIMINATION PROTOCOL" which was provided by the Director of Nursing on 8/16/16 at 12:00 p.m. indicated the following: "Purpose: 1. To avoid constipation and fecal impaction in the resident.</p> <p>Objective: The resident will experience bowel evacuation every three days and will not experience fecal impaction or obstruction.</p> <p>General Protocol: ...4. The nurse that is notified of no bowel movement in 48 hours will give the first line of intervention for those residents who have not had a bowel movement for two days (six shifts), as ordered by physician. a. If no order, give four (4) ounces of prune juice.... b. Give laxative as ordered. c. If there is no laxative ordered, call physician and obtain order for laxative and enema. 5. If no results from the first intervention..., call physician and obtain order. 6. If there is still no results...physician will be notified for further orders."</p> <p>This Federal tag relates to Complaint</p>		discharge on 07/30/16.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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