F 000 INITIAL COMMENTS

Amended: August 29, 2013

F 309 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.

This REQUIREMENT is not met as evidenced by:
Intakes: TN00032288

Based on policy review and medical record review, it was determined the facility failed to ensure functional bowel well being for 2 of 8 (Residents #3 and #8) sampled residents.

The findings included:

1. Review of the facility's "CLINICAL PATHWAYS" policy documented, "...Constipation: After 2 days of constipation, check for impaction first; give milk of magnesia 30 [cubic centimeter] cc po [by mouth] peg [percutaneous endoscopy gastrostomy] daily prn [as needed] if no renal failure; or give dulcolax 5 mg tablet, 1 tablet po/peg/suppository per rectum daily prn; if milk of magnesia or dulcolax not effective after 4 hours, give fleet's enema. Notify provider if not effective within 24 hours."

2. Medical record review for Resident #3...
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documented an admission date of 6/12/12 with diagnoses of Hypertension, Urinary Tract Infection and Malnutrition. Review of the bowel and bladder (B&B) report for July 2013 revealed no documentation that Resident #3 had a bowel movement (BM) on 7/1/13, 7/2/13 and 7/3/13 for a total of 3 consecutive days with no BM. The facility was unable to provide documentation that interventions were implemented when the resident had no BM after 2 days.

3. Medical record review for Resident #8 documented an admission date of 8/29/12 and a readmission date of 5/26/13 with diagnoses of Bipolar Disorder, Diabetes Mellitus and Hypertension. Review of the B&B report for July 2013 revealed no documentation that Resident #8 had a BM on 7/11/13, 7/12/13, 7/13/13, 7/14/13 and 7/15/13 for a total of 5 consecutive days with no BM. The facility was unable to provide documentation that interventions were implemented when the resident had no BM after 2 days.

F 309 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING SS = D

Each resident is to receive and 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.

MidSouth Health and Rehabilitation Center will 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. MidSouth Health and Rehabilitation Center will monitor the bowel warnings and follow the clinical pathways as ordered by the Medical Director.

Resident number three was noted to have had a bowel movement prior to being discharged on 8/1/13. Bowel movement noted on July 7, 8, 9, 10, 11, 14, 18, 19, 21, 23, 24, 27, 28, 30, 31.

Employees were in-serviced on the constipation protocol on 8/29/13
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3. Medical record review for Resident #8 documented an admission date of 8/29/12 and a readmission date of 5/25/13 with diagnoses of Bipolar Disorder, Diabetes Mellitus and Hypertension. Review of the B&B report for July 2013 revealed no documentation that Resident #8 had a BM on 7/11/13, 7/12/13, 7/13/13, 7/14/13 and 7/15/13 for a total of 5 consecutive days with no BM. The facility was unable to provide documentation that interventions were implemented when the resident had no BM after 2 days.

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The bowel warnings will be observed each day by the Unit Managers, Assistant Director of Nursing, and the Director of Nursing. Each resident on the warning list will have the necessary constipation medication administered as ordered by the physician. The medication will be signed off on the MAR and its effectiveness documented on the back of the MAR. The process will be ongoing. The Unit manager, ADON and DON will monitor the MAR and the documentation to make sure compliance is obtained and all residents are kept free of constipation. The MAR will be brought to Quality morning meeting daily and discussed with the IDT team. This quality assurance monitoring began on 8/26/13 and will be ongoing.