STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012678	A. BUILDING: _____ B. WING _____	C 02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA FRANCISCAN	210 NORTH SPRINGFIELD AVENUE JOLIET, IL 60435

(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) COMPLETE DATE
S 000	Initial Comments Complaint Invstigation: 2571180/IL186267	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210b) 300.1210c) 300.1210d)2)3) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. 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	S9999		

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S9999	Continued From page 1	S9999		

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

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:

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

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.

These Regulations are not met as evidenced by:

Based on interview and record review the facility

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S9999	Continued From page 2	S9999		

failed to adequately assess, administer medications, and notify the physician for a resident who had not had a bowel movement in over 3 days on several occasions. This failure contributed to (R1) developing a fecal impaction, pain and inflammation in her colon. This applies to 1 of 3 residents (R1) reviewed for quality of care in the sample of 7.

The findings include:

R1's face sheet shows she was admitted to the facility on 6/29/22 with diagnoses including: Unspecified Dementia, Parkinsonism and Constipation.

R1's active Care Plan shows she has a cognitive impairment due to dementia, is incontinent of bowel and bladder, and is at risk for constipation due to impaired mobility. R1's constipation Care Plan initiated on 10/5/22 and revised on 1/5/25 shows that R1 will have one soft formed stool every 2-3 days. Interventions listed in the care plan include assess residents past bowel elimination pattern and document every shift, report negative findings to the physician, assess abdomen for distention, guarding, and bowel sounds at least every shift and administer laxatives/stool softeners and enemas as ordered by the physician.

R1's Electronic Treatment Administration Record (ETAR) Electronic Medication Administration Record (EMAR), and Physician Order Summary (POS) show an active order from 6/9/23 that states, "Monitor bowel movements (BM's) every shift if no BM in 3 days notify MD."

On 2/26/25 at 10:25 AM, R1's bowel elimination tracking for January 2025 was reviewed with V7

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S9999	Continued From page 3	S9999		

(Licensed Practical Nurse). R1 had documented BM's on 1/3/25 and not again until 1/8/25 (5 days in between), 1/13/25 and not again until 1/18/25 (5 days again in between) and next on 1/22/25 (4 days in between).

R1's EMAR shows she had PRN (as needed) medication orders for Milk of Magnesia (laxative) to be given daily as needed for constipation, and Miralax Powder (laxative) 17 grams every 12 hours as needed. The EMAR and paper copies of the Medication Administration Summary shows neither of these medications were administered in January 2025 to R1.

R1's January 2025 Nursing Progress notes and assessment have no documented abdominal assessment or phone calls to R1's physician to notify and obtain orders for lack of bowel movements longer than 3 days.

A change in condition note for R1 dated 1/24/25 shows that R1 was sent to a local community hospital for an unrelated medical issue.

R1's hospital records show R1 was assessed in the Emergency Room (ER) on 1/24/25 and admitted to the hospital for an unrelated medical issue. R1's hospital records show a Gastroenterologist consulted for R1 on 1/24/25 and his consultation report shows that a CT scan was performed of R1's abdomen due to abdominal pain and R1 was found to have a distended rectum and an "8-9 cm. (centimeter) area of fecal impaction and Stercoral Proctitis (inflammation of the colon)." Hospital records show R1 was started on stool softeners including rectal suppositories and oral laxative medications.

On 2/25/25 at 11:22 AM, V7 (LPN) stated if a

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S9999	Continued From page 4	S9999		

resident does not have a bowel movement in 3 days, they should assess the resident, administer any PRN medications, and call the doctor.

On 2/26/25 at 9:10 AM, V8 (LPN) stated 3 days is the maximum a resident should go without a bowel movement and is she has a resident who has not gone she would document and assess the resident, give PRN medication, and call the doctor. V8 stated the CNAs at the facility are the ones who generally document the bowel movements and if they do not report anyone not having one they have to check the computer and hard copies of BM tracking forms.

On 2/26/25 at 1:08 PM, V3 (R1's Physician) stated he does not recall being notified of the gap in R1's bowel movements. V3 stated he cannot do anything about or order medication if no one tells him about it. V3 additionally stated he would expect nurses to utilize PRN medications and do assessments if a resident has not had a bowel movement in 3 days. V3 described Stercoral Proctitis as an inflammation of the colon from a fecal impaction and said signs of an impaction would be pain, abdominal tenderness, or distention. V3 stated if the nursing staff had administered medications or called for orders it is possible R1's fecal impaction could have been avoided.

A policy for bowel elimination was requested from the facility on 2/26/25. The policy provided by V2 was titled Urinary Incontinence and did not address bowel movement monitoring.

(B)