The following reflects the findings of the Department of Public Health during a Complaint Investigation visit:

CLASS AA CITATION -- PATIENT CARE
92-2270-0012307-F
Complaint(s): CA00259236

Representing the Department of Public Health:
Surveyor ID # 27787, HFEN

The inspection was limited to the specific facility event investigated and does not represent the findings of a full inspection of the facility.

F309
CFR 483.25
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.

The facility failed to assess, monitor, and react promptly to Resident 1’s change in bowel movement (stools) habits, to prevent constipation before it progressed to fecal impaction [a solid, immobile bulk of stool that can develop in the rectum or colon (large intestine) as a result of chronic constipation and prolonged retention of stool. While this stool may be too large to pass, loose, watery stools may be able to get by, leading to diarrhea or leakage of fecal material], by failing to, including but not limited to:

The signing of this plan of correction is not an admission or agreement by this facility of the truth of the facts alleged in this statement of deficiencies and plan of correction. In fact, this plan of correction is submitted exclusively to comply with state and federal law. This plan of correction serves as our written credible allegation of compliance.

F-309

Corrective Action

Resident 1 no longer resides in the facility.

Identification of other residents and corrective actions

Based on record review of residents with constipation no other residents were affected by this practice.
1. Utilize Resident 1's past diagnoses and treatment of rectal bleeding, constipation, colon surgery, when conducting the initial assessment and plan of care.

2. Assess Resident 1's bowel habits, including monitoring the characteristics of the stools for frequency, color, amount, and consistency (soft, formed, hard, watery) of the stools, as indicated in the plan of care.

3. Implement Resident 1’s care plan interventions to prevent constipation, including inadequate fluid intake, immobility, and pain medications that could lead to suppression of defecation (bowel movements), constipation, and fecal impaction.

4. Consistently assess and monitor for side effects of consistent use of narcotic pain medications that included constipation.

5. Consistently monitor Resident 1’s intake and output (I&O) of fluids to ensure adequate hydration and prevent constipation.

As a result, Resident 1 was admitted to the general acute care hospital (GACH) on October 22, 2009, in severe pain with acute peritonitis (new onset of an inflammation of the tissue that lines the inner wall of the abdomen), from a severe bowel impaction. She was at the emergency room (ER) with an altered level of consciousness, moaning in pain, and had a
### SUMMARY STATEMENT OF DEFICIENCIES

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<td>designee will review the records for residents with a diagnosis of constipation weekly for 3 months to ensure adequate monitoring is complete. The Director of Staff development or designee will provide additional in-service education monthly for 3 months for licensed nurses and CNA/RNA staff regarding bowel management and monitoring for signs and symptoms of constipation including pain.</td>
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### Event ID:IVLG11

**2/8/2017**

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**distended (larger than normal) abdomen.** Resident 1 required endotracheal intubation (tube inserted down the throat to provide artificial breathing) at the ER. Her survival rate was deemed to be zero. Resident 1 was diagnosed with a perforated viscus (an abnormal opening in a hollow internal organ in the abdomen), and sepsis (serious blood infection). Resident 1 died in the hospital on October 24, 2009, two days after her emergency room admission.

The Certificate of Death dated November 16, 2009, indicated the immediate cause of death as (A) Acute Peritonitis for a time period of days; (B) Colon Obstruction And Perforation, with a time period of days; and (C) Severe Fecal Impaction, with an unknown time period. (Fecal impaction of the bowel can cause a perforation of the bowel, sepsis, and if not remedied death).

The autopsy report's opinion, dated November 12, 2009, stated "Autopsy confirms the clinical diagnosis of perforated viscus. In this case, there was severe fecal impaction in the sigmoid colon, with perforation." The autopsy report stated "Immediate cause" (A) acute peritonitis, Due to, or as a consequence of, (B) colon obstruction and perforation, Due to, or as a consequence of (C) severe fecal impaction."

On February 16, 2011, the Department received a complaint alleging staff failed to monitor Resident 1's bowel habits and

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**Monitoring performance and integration into quality assurance system**

Any unexpected findings of the Medical Records ADL audit and the Director of Nursing record review will be presented to the facility's Quality Assurance Committee monthly for 3 months and quarterly thereafter for review and further action as needed.
recognize Resident 1's change in condition, including notification of the family and the physician for prompt medical intervention when there was a change in condition. The complaint indicated Resident 1 was diagnosed with a perforated (abnormal opening) viscus (internal organ) and sepsis (life-threatening condition that arises when the body's response to infection injures its own tissues and organs), and when Resident 1 had been admitted to the facility, staff had been informed of the resident's history of a previous perforated viscus.

On March 3, 2011, at 2:45 p.m., an unannounced complaint investigation was conducted at the skilled nursing facility.

A review of Resident 1's GACH (G-E) History and Physical dated May 31, 2009, indicated the present chief complaint was acute psychosis (new onset of mental disease involving loss of contact with reality), rectal bleeding, hypotension (low blood pressure); she also had a new onset of atrial fibrillation (irregular heart beat). Resident 1 was initially admitted at Mental Health with constipation, and was given laxatives. The resident had some diarrhea and profuse (large amount) bowel movement. Past medical history indicated Resident 1 had previous bilateral (both) hip replacement (no dates indicated). She had acquired methicillin resistant staphylococcus aureus (MRSA - bacteria that does not respond well to certain antibiotic
medications) infection after having hip surgery. Her past history diagnoses included hypertension (high blood pressure), degenerative joint disease (breakdown of joints and underlying bone), anemia (low red blood cell count), dementia (decline in mental status), and tachycardia (fast heart beat).

A review of the G-E Pathology Report dated June 5, 2009, indicated a colonoscopy (scope view) of the large intestine that was diagnosed with necrotic debris (dead tissue) consistent with ischemic colitis (inflammatory condition of the large intestine or colon that develops when there isn’t enough blood flow to the area).

A review of Resident 1’s medical record indicated an original admission date to the skilled nursing facility (SNF) from the G-E on June 17, 2009. The SNF Physician’s Orders dated June 17, 2009, indicated Haldol one half milligram (mg) (0.5) one tablet by mouth (PO) four times a day (QID) for psychosis manifested by striking out at staff. Monitor behavior every shift and tally by hashmarks. Another order indicated Haldol one mg PO every four hours as necessary (PRN) for adjunct (additional) treatment.

A review of Resident 1’s Dehydration Risk Assessment dated June 17, 2009, indicated she was at risk for constipation.

Resident 1’s Plan of Care for altered behavior pattern related to psychosis manifested by...
stopping out at staff and others dated June 17, 2009, indicated a goal to lessen episodes of stopping out at staff and others to once every week or less. Evaluate every three months. The interventions included to administer Haldol as ordered, observe and report signs of adverse effects that included constipation, loss of appetite, and urinary retention.

Resident 1 was discharged to a GACH (G-P) on June 25, 2009, due to a long history of a poor-healing infection of the right hip incision site, severe hip pain, and cellulitis (potentially serious bacterial skin infection). She was diagnosed with a femoral neck fracture (the narrow top end of the large leg bone that connects at the body). She had a right hip replacement and was readmitted back to the SNF on July 2, 2009.

Resident 1's Minimum Data Set (MDS) assessment (a screening assessment and care tool), dated July 7, 2009, indicated Resident 1 required extensive assistance (2 or more persons) physical assist for bed mobility and transfers. She required one person physical assist for walking, dressing, eating, personal hygiene and bathing. She had an unsteady gait (walk). Resident 1 was occasionally incontinent with bowel continence, and continent with bladder. Her bowel elimination pattern was regular, indicating at least one movement every three days, according to the assessment. The MDS indicated Resident 1 had a wound infection (hip), and she had
### Summary Statement of Deficiencies

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The assessment RAP Summary Focus Review (RAP) dated July 5, 2009, for nutritional status indicated causal and risk factors was therapeutic diet, risk for urinary tract infection (UTI) and dehydration; proceed to care plan. The RAP dated July 8, 2009, for incontinence, indicated Resident 1 had a risk for urinary tract infection, and proceed to care planning. The "Referrals/Follow-up was to increase fluids as tolerated. There was no RAP for the potential for constipation indicated.

Resident 1's Care Plan initiated on July 13, 2009, indicated a potential for constipation related to reduced mobility, use of narcotic pain medications, and incontinent of bowel. The short-term goals indicated Resident 1 will be free from signs and symptoms of constipation as evidenced by no abdominal pain, no abdominal distention, no nausea/vomiting, regular bowel movements without complications daily for 90 days; and the resident will be adequately emptied without complications as evidenced by regular bowel movements and no abdominal distention, daily for 90 days. The approaches included evaluate for bowel sounds and abdominal distention, monitor elimination patterns, increase physical activity and fluid intake to promote optimal bowel function, maintain adequate nutrition and hydration, encourage optimal activity to stimulate resident's bowel movements.
Resident 1’s Care Plan initiated on July 13, 2009, indicated alteration in nutrition secondary to mechanically altered therapeutic diet [soft no added salt (NAS) diet]. The approaches included to provide diet/nutrition support as ordered and dietary consultation as indicated. There was no documented evidence the Registered Dietician (RD) had included dietary interventions to include fruits and vegetables, or other foods with natural laxatives and rich in fiber to better manage Resident 1’s constipation, as indicated in the care plan, and the facility’s policies and procedures for constipation.

Resident 1’s Care Plan initiated on July 13, 2009, indicated a potential for fluid volume deficit related to the use of hypertension (high blood pressure) medications and periods of decreased oral intake. The plan indicated the resident had the potential for fluid volume deficit (too little) related to anticoagulant therapy (prevents the thickening of blood). The goal was for the resident to be adequately hydrated as evidenced by moist oral mucosa (mouth tissue), good skin turgor ( suppleness), no change in level of care, vital signs (blood pressure, heart rate, breathing, temperature) within normal limits daily for 90 days. The approaches included to monitor hydration status, provide feedings as ordered, monitor intake and record as indicated, monitor urinary output and record as ordered and indicated.
A review of Resident 1's medical record revealed she was discharged to the G-P on September 21, 2009, due to her right hip (fracture) surgical site had drainage and was opening. She was treated and readmitted to the SNF on September 29, 2009, with diagnoses added of status post wound debridement.

The Physician's Orders dated September 29, 2009, included:

1. Ferrous sulfate (iron) 325 mg PO three times a day (TID) for anemia (low red blood cell count). [Side effects include constipation and dark tarry stools]
2. Ativan 0.5 mg PO twice a day (BID) for anxiety. [Side effects include constipation]
3. Morphine sulfate (narcotic pain medication) 4 mg intramuscularly (IM-injection) every four hours as needed (PRN) for "severe" pain. [Side effects include constipation]
4. Norco (narcotic brand name combination medication used to treat moderate to severe pain) 10/325 mg one tablet PO every four hours PRN for "moderate" pain. (Resident information indicated to take with food or milk, instruct resident to eat high-fiber diet, maintain adequate fluid intake, and use stool softener or bulk laxative to prevent constipation). [Side effects include constipation]
5. Milk of magnesia (MOM) 30 cubic centimeters (cc) PO daily PRN for constipation (laxative).
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6. Colect 100 mg PO daily for stool softener.
7. Protonix 40 mg PO daily before (ac) breakfast for GERD (gastroesophageal reflux disease – stomach contents back up into food pipe).
8. Mechanical soft (easy to chew and swallow, generally chopped, soft foods) no added salt diet.

The Minimum Data Set (MDS) significant change in status assessment initiated September 29, 2009, completed October 12, 2009, indicated Resident 1 was moderately impaired for cognitive skills for daily decision-making, mood persistence had indicators present that were easily altered, and no behavioral symptoms. Resident 1 now required extensive (2 or more persons) physical assist and was totally dependent on full staff performance for bed mobility and transfers; she was totally dependent on full staff performance (with one person physical assist) for locomotion on and off the unit and toilet use; and was not able to walk (not performed); she had no functional limitation in range of motion. The MDS indicated Resident 1 was incontinent of both bowel and bladder and used pads/briefs. Pain symptoms indicated a frequency of pain less than daily, and an intensity of moderate pain. The pain site indicated hip pain and incisional pain.

Under section K for oral/nutritional status, the resident's height was 60 inches and 118 pounds. Nutritional problems indicated the resident leaves 25 percent (%) or more of
food uneaten at most meals. Nutritional approaches were mechanically altered therapeutic diet.

Resident 1’s Plan of Care dated September 29, 2009, indicated altered bowel pattern - risk for constipation due to use of narcotic pain management. The goal was to have “soft formed stools” at “least” three times a week. The interventions included encourage maximum food/fluid intake to tolerance, encourage and assist out of bed (OOB) as tolerated, monitor bowel movements (BM) daily and record, Colace as ordered, MOM as ordered, and report if ineffective.

Resident 1’s Plan of Care dated September 29, 2009, indicated altered comfort due to generalized pain. The interventions included to administer Norco as ordered for moderate pain; and administer morphine sulfate (MSO4) as ordered for severe pain, and report if ineffective.

The Nutritional Assessment dated September 30, 2009, indicated Resident 1 was on a regular portion, mechanical soft, no added salt therapeutic diet. She required 1609 cc of free water (fluids) per day. The diet provided greater than 2000 cc of fluids per day (if completely consumed). The summary of level of care indicated the resident was at a high risk of excessive weight loss (laboratory data/diagnosis was consistent with potential or presence of malnutrition, or food intake was
There was no documentation on the Nutritional Assessment to indicate the Registered Dietician had considered nutritional/dietary approaches for the medication side effects of constipation; or that the Director of Dietary Services assessed for possible non-pharmaceutical interventions for constipation, in accordance with the facility's policies and procedures for "Constipation" and as indicated in the resident's care plan.

Resident 1's Pain Risk Assessment dated September 30, 2009, had a total score of 20, indicating she was a "very high" risk for pain. The Pain Assessment dated September 30, 2009, indicated Resident 1 had "frequent" pain to the right hip/leg. The resident was unable to describe the pain, therefore staff were to assess for moaning, groaning, and restlessness. The Pain Rating Scale used was a non-verbal scale that indicated moderate pain with moaning and restlessness. The Plan/Recommendations were to monitor pain as indicated, administer pain medications as ordered, manage the resident's pain within acceptable level, notify the physician for any changes in condition as indicated, monitor effectiveness of pain medications, and document as indicated. The section for "Intensity of Pain" for pain at worst and tolerable level of pain, was blank.

A review of the Pain Assessment Flowsheet
dated from October 1, 2009, to October 21, 2009, indicated Resident 1 received Norco pain medication at least 34 times. The location of pain was at the right leg with a pain level rating between 7/10 or 8/10 (on a pain rating scale of 0 to 10, with 0 as no pain and 10 as the worst possible pain). It was consistently documented in October 2009, that Resident 1's pain rating after medication was 1/10.

A review of Resident 1's medical record on March 3, 2011, with the Director of Nursing (DON), revealed there was no documented evidence that the resident's fluid intake was consistently monitored by means of an Intake and Output (I&O) record. The DON could not provide documentation that the resident received an adequate amount of fluids of 1609 cc free water, as recommended by the Registered Dietitian (RD) and in the resident's care plan.

A review of the Medication Record dated October 2009, indicated Resident 1 received her "routine" medications as ordered by the physician. There was no documentation that the MOM was administered in October 2009 to prevent constipation.

A review of Resident 1's medical record on March 3, 2011, with the DON, that included the licensed Nurses Notes, indicated the resident was not consistently assessed for bowel habits, and monitored for the characteristics of the bowel movements including the frequency,
color, amount, and consistency (hard, soft, formed, liquid) of the stool, in accordance with the facility's policy and procedure and the resident's care plan. The Certified Nursing Assistant ADL Sheet for October 2009, indicated on October 8, 2009, the 3 p.m. to 11 p.m. shift, October 13, 2009, the 3 p.m. to 11 p.m. shift, October 17, 2009, the 7 a.m. to 3 p.m. and 3 p.m. to 11 p.m. shifts, and October 20, 2009, the 3 p.m. to 11 p.m. shift, the frequency and amount of BM was not recorded accurately. There was no color of the stool documented, nor was the consistency documented to enable nursing to make a thorough assessment of Resident 1's bowel habits, as indicated in the policy and procedure for "Constipation" and in her care plan (to ensure Resident 1 had soft formed stools).

A review of Resident 1's undated History and Physical, (reviewed to be September 29, 2009 readmission) indicated Resident 1 did not have the capacity to understand and make decisions. The Physical Examination section for exam of the abdomen (Section F), was blank.

A review of the Nutritional Assessment progress notes dated October 12, 2009, indicated the diet ordered was mechanical soft NAS diet, and to cater to food preferences. The resident was able to express needs to Dietary Services Supervisor (DSS); continue to monitor weight and intake amount.

A review of the Certified Nursing Assistant ADL
Sheet dated October 2009, indicated Resident 1 required being fed, and had an average amount of 53% consumption for breakfast, 58% for lunch, and 74% for dinner. On October 11 and 12, 2009, the resident refused breakfast. There was no documentation to indicate the resident was assessed as to why she refused her breakfast.

A review of the License Nurse Record dated October 22, 2009, indicated at 7:30 a.m., Resident 1 was awake, was served breakfast, ate and tolerated 40% of food served; the resident remained confused and disoriented with episodes of screaming and yelling, no signs of pain noted. The resident was provided with incontinent care by her certified nursing assistant (CNA). At 11 a.m., the resident continued to have episodes of "yelling and screaming." The charge nurse "ascertained" for behavior; no "obvious" signs of pain noted.

On October 22, 2009, at 2:25 p.m., during rounds, the License Nurse Record documentation indicated Resident 1 was noted to have diminished response. The vital signs taken were as follows: temperature of 98 degrees Fahrenheit, pulse of 114 beats per minute (normal range is 60 to 100), blood pressure of 82/59 (normal reference is 120/80), and oxygen saturation of 86% (normal reference range of 95% to 100%). The resident's skin was cold and clammy. Ten liters of oxygen were administered via mask, and the
### Summary Statement of Deficiencies

- **Resident's Oxygen Saturation:** Went up to 96%; lung sounds were clear to auscultation (listening with a stethoscope), no coughing noted.
- **Bowel Sounds:** Present to all four quadrants (bowel sounds have to be listened to for 5 minutes per section of the quadrant for a thorough assessment. There were no characteristics of the bowel sounds documented, such as hyperactive). No distention noted. The resident had a "small BM early this morning during care."

There were no identifying characteristics documented for Resident 1's BM (such as the color and/or if formed, hard, soft, runny, or watery), as indicated in the facility's policy and procedure, and in the care plan intervention to ensure soft formed BM. There was no documented evidence the licensed nurse assessed the reason for the resident's screaming and yelling to rule out pain. There was no documented assessment for mood/behavior management for Resident 1's screaming/yelling, or that nonpharmacological interventions were attempted for the screaming/yelling, either for pain or for behavior reasons. There was no documentation the abdominal region was thoroughly assessed by inspection or palpation (use of the hands to touch).

A review of Resident 1's medical record with the Director of Nursing (DON) on March 3, 2011, at 2:45 p.m., indicated:

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1. The CNA flow sheet for October 2009 indicated Resident 1 was in bed "B" on all three shifts, all but three occasions on the 3 p.m. to 11 p.m. shift, which did not increase physical activity to promote optimal bowel function as indicated in the resident's care plan.

2. The resident's intake was not monitored to ensure she was offered and consumed her daily fluid requirements as assessed by the RD. According to the flow sheets, Resident 1 never consumed 100% of her meals. She consumed an average of approximately 60% of her meals, which was far less than the assessed 1609 cc of free water daily (1609/60 = approximately 650 cc of fluids).

During the review and interview the DON was unable to answer why the resident was not given medication to prevent constipation, and why Resident 1's intake and output was not monitored to enable nursing to thoroughly evaluate her status. She stated the incident occurred prior to her hire at the facility.

On March 4, 2011, at 10 a.m., during an interview with Staff Member 1 (SM 1), she stated most of the nurses were no longer working in the facility, therefore, interviews could not be conducted.

On March 4, 2011, at 10:30 a.m., during an interview with the Director of Staff Development (DSD), she stated there were no employee or in-service files for 2009; the DSD only had...
employee files from 2010 to the present.

The facility's undated policy and procedure titled, "Constipation" indicated the purpose was to maintain proper bowel function and minimize episodes of constipation. Residents are to be monitored daily for bowel movements by CNAs, who are to document observations in the nursing assistant notes. When a resident does not have a bowel movement within 48 to 72 hours, a licensed nurse is to be notified. The licensed nurse is to contact the physician and obtain orders. Physician's orders shall be carried out. If physician's orders prove ineffective, a licensed nurse shall assess the resident through observation of bowel sounds (presence/absence, quality), abdominal distention, nausea, vomiting and/or lack of appetite, abdominal discomfort/pain. The physician shall be notified for additional orders, which are to be administered. Nursing shall provide nutritional intervention as necessary. Director of Dietary Services shall assess for possible non-pharmaceutical intervention as necessary. Registered Dietitian is to provide assessment as necessary.

A review of the GACH ER consultation reports indicated Resident 1 was admitted on October 22, 2009, in severe pain. She had an altered level of consciousness, was moaning in pain, and had a distended and taught abdomen, with no bowel sounds present. Resident 1 required endotracheal intubation, and X-rays showed she had a large amount of stool in her colon.
Her survival rate was deemed to be zero, and she was a very high risk for any surgical intervention. Resident 1 died in the hospital on October 24, 2009, two days after her ER admission. Her “Expiration Diagnosis” included perforated viscous, respiratory failure, and septic shock.

The facility failed to monitor, assess, and react promptly to Resident 1’s change in bowel movement (stools) habits, to prevent constipation before it progressed to fecal impaction [a solid, immobile bulk of human feces that can develop in the rectum or colon (large intestine) as a result of chronic constipation and prolonged retention of feces], by failing to, including but not limited to:

1. Utilize Resident 1’s past diagnoses and treatment of rectal bleeding, constipation, and colon surgery, when conducting the initial assessment and plan of care.

2. Assess Resident 1’s bowel habits, including monitoring the characteristics of the stools for frequency, color, amount, and consistency (soft, formed, hard, watery) of the stools, as indicated in the plan of care.

3. Implement Resident 1’s care plan interventions to prevent constipation, including inadequate fluid intake, immobility, and pain medications that could lead to suppression of defecation (bowel movements), constipation, and fecal impaction.

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<td>4. Consistently assess and monitor for side effects of consistent use of narcotic pain medications that had side effects of constipation.</td>
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<td>5. Consistently monitor Resident 1's intake and output (I&amp;O) of fluids to ensure adequate hydration to prevent constipation.</td>
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<td>As a result, Resident 1 was admitted to the GACH on October 22, 2009, in severe pain with acute peritonitis from a severe bowel impaction. She was at the ER with an altered level of consciousness, moaning in pain, and had a distended abdomen. Resident 1 required endotracheal intubation at the ER. Her survival rate was deemed to be zero. Resident 1 was diagnosed with a perforated viscus and sepsis. Resident 1 died in the hospital on October 24, 2009, two days after her emergency room admission.</td>
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<td>The above violation presented a substantial probability of death or serious physical harm and was a direct proximate cause of Resident 1's death.</td>
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