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M 000	Initial Comments The State Agency (SA) conducted an on site Complaint Investigation (CI), MS CI #20934 and MS CI #21095, from 03/28/23-03/31/23. During the investigation, the SA determined that the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements at M. An extended survey was completed, and the following deficiencies were cited for CI MS #20934 and CI MS #21095: M500 at Level IV for Resident Rights. The facility's failure to prevent Resident (Res) #1's constipation resulted in neglect of Res #1. The facility's failure to render the care and services necessary to prevent constipation resulted in the ultimate death of Resident #1. The facility's failure to provide the care and services necessary to prevent constipation put all residents in the facility at risk for serious injury, serious harm, serious impairment, and possible death. The State Agency (SA) identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) that began on 03/02/23 when Res #1 began vomiting and complaining of stomach pain. Res #1 was admitted to the local hospital on 03/02/23 with vomiting and stomach pain and died on 03/03/23 as a result of aspiration from vomiting due to a bowel impaction. On 03/29/23 at 5:30 PM, the SA notified the facility Administrator and the Director of Nursing of the IJ and SQC and provided the facility with the IJ template. The IJ and SQC existed at:	M 000		

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M 000	Continued From page 1 Rule 45.17.2 Resident Rights - M500 Level IV The facility submitted an acceptable Removal Plan on 03/31/23, in which the facility alleged all corrective action to remove the IJ were completed on 03/30/23 and the IJ removed on 03/30/23. The SA validated the Removal Plan on 03/31/23, and determined the IJ was removed on 03/30/23, prior to exit. Therefore, the S/S of Rule 45.17.2 Resident Rights - M500 Level IV was lowered to Level II while the facility developed a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. The facility was licensed for 105 beds and the facility census was 88 on 03/28/23.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for	M 500		5/9/23

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M 500	Continued From page 2 services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule,	M 500		

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regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal;

6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law;

7. is free from mental and physical abuse;
8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint;
9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract;

10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs;

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M 500	Continued From page 4 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available	M 500		

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M 500	Continued From page 5 choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Based on record reviews, staff interviews, resident interviews, Resident Representative (RR) interview, job description reviews, and policy and procedure reviews, the facility failed to prevent neglect of a resident (Res) #1 from occurring by neglecting to document/record the treatment and services accessible to five (5) of five sampled residents reviewed for "bowel" functioning programs. Res. #1, #2, #3, #4 and #5. This failure had the potential to affect all residents in the facility. Resident #1 was admitted to the hospital with vomiting and stomach pain on 03/02/23 and later died from aspiration due to vomiting as a result of a bowel impaction on 03/03/23. Resident #1 had no documented bowel movements (BM's) for 11 days prior to the hospital admission on 03/02/23. Res #1 had no bowel programs/interventions documented on the Medication Administration Records (MAR) for January and February 2023, and Res #1 had no bowel programs/interventions nor any care and services rendered to Res #1 documented in the nursing notes for the month of February 2023. The facility's failure to prevent Res #1's constipation resulted in neglect of Res #1. The facility's failure to render the care and services necessary to prevent constipation resulted in the ultimate death of Resident #1. The facility's failure to provide the care and services necessary to prevent constipation put all residents in the facility at risk for serious injury, harm, impairment and possible death.	M 500	*Resident #1 was transferred to the hospital due to emesis and abdominal pain. **All residents have the potential to be affected by this same deficient practice. ***Bowel movement (BM) in-service was complete 3/29/23. Certified Nursing Assistants (CNA'S) will document bowel care via the kiosk on 3/16/23 to include whether the resident is continent, incontinent or colostomy as well as bowel characteristics of size and consistency with a prompt to notify nurse if stool is hard or watery. The medication nurse began monitoring CNA documentation 45 minutes prior to end of shift beginning on 4/4/23. The medication nurses are to check their hall 45 minutes prior to end of shift for CNA documentation completion. The staff development nurse will bring the No BM report daily to standup beginning 4/4/23, Monday through Friday. The weekend nurse supervisor began pulling the No BM report on 4/8/23 Saturday and Sunday. The No BM report(s) will be handed to the medication nurse on each hall for review and/or initiation of standing orders. ****Quality Assurance (QA) nurses will monitor BM reports beginning 4/5/23 weekly X four weeks. Then monthly x	

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M 500	Continued From page 6 The State Agency (SA) identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) that began on 03/02/23 when Res #1 began vomiting and complaining of stomach pain. Res #1 was admitted to the local hospital on 03/02/23 with vomiting and stomach pain and died on 03/03/23 as a result of aspiration from vomiting due to a bowel impaction. On 03/29/23 at 5:30 PM, the SA notified the facility Administrator (ADM) and the Director of Nursing (DON) of the IJ and SQC and provided the facility with the IJ template. The facility submitted an acceptable Removal Plan on 03/31/23, in which the facility alleged that the immediacy of the Jeopardy was removed on 03/30/23 the IJ was removed on 03/30/23. The SA validated the Removal Plan on 03/31/23, and determined the IJ was removed on 03/30/23, prior to exit. Therefore the scope and severity for CFR 483.12 (a) (1) Freedom from Abuse and Neglect (F600) was lowered from an "L" to an "F", while the facility developed a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include: Record review of the facility policy and procedure titled "Abuse Neglect and Exploitation/Misappropriation Policy" with a revision date of 3/19/2020 revealed "It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of	M 500	three months. Results will be brought to monthly QA meeting 5/3/23.	

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resident property.. Neglect means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress ...."

Record review the facility policy titled "Recognizing Signs and Symptoms of Abuse, Neglect, Exploitation/Misappropriation" with a revision date of 3/19/2020 revealed " ... Signs of Physical Neglect:.. Improper use/ administration of medication; Inadequate provision of care.."

Record review of the facility policy and procedure titled: "Bowel Program Policy" dated 07/01/2009 revealed, "Purpose: Monitoring of bowel movements are important to the general health and well being of the resident. Policy: A daily BM record will be monitored by the Charge Nurse on a daily basis. Should there be no BM of three consecutive days a Bowel Program will be initiated based on our Physicians standing orders. 1. Check abdomen for distention/pain. Auscultate bowel sounds. 2. Dulcolax suppository x (times) 1 dose. 3. If no BM in 24 hours give fleets enema x 1 dose. 4. If no BM after enema, notify MD/NP (Medical Doctor/Nurse Practitioner)."

Record review of the "Certified Nursing Assistant Job Description, undated, revealed "Objective: Assists nursing personnel in provision of basic care for residents and necessary unit tasks and functions in compliance with (Formal name of facility) policies and procedures, applicable health care standards and (Formal name of State Agency). Organization: The Certified Nurses Aide functions as a member of the health care team under the direction of the RN (Registered Nurse) or LPN (Licensed Practical Nurse) and reports to

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M 500	Continued From page 8 the Director of Nursing or ADON (Assistant Director of Nurses) in conformity with (Formal name of facility) and regulatory policy ... Responsibilities: Assists patients in the following areas: ...c. Toileting (bedpan, urinal, commode and/or toilet) ... 2. Assists with feeding of residents. 3. Measuring and recording intake and output. 10. Accurate documentation of all ADL's (Activities of Daily Living) by the end of each shift. Real time charting is required ...17. Immediately report any changes in resident's condition or incidents to the Nursing Supervisor ..." Interviews on 03/28/23 at 12:00 PM, with the DON and the facility ADM, the DON stated that the Activities of Daily Living (ADL) care sheets were kept in a binder at the nursing stations and that they were accessible to all staff. The Certified Nursing Assistants (CNAs) documented the ADL's for each resident at the end of each eight (8) hour shift. The "Care Tracker Documentation Record" ADL sheets were devised per the individual care plan of each resident. The ADL sheets were the venue in which the care plans are followed and instituted for each resident. The DON confirmed that there were two (2) care plan nurses working in the facility on 03/28/23. The DON stated that if something was not completed or a resident had issues the CNA's report that to the Licensed Practical Nurses (LPN) medication cart nurses or to the Registered Nurse (RN) or Charge Nurse for the 7-3 and 3-11 shifts. The DON revealed that for over a year the CNA's charted manually on paper charts and on 03/16/23 the facility installed computers (Kiosk) systems that now the CNA's digitally chart on each resident at the end of each 8 hour shift. If a resident does not have a bowel movement (BM) during that shift the CNA's report that to the Charge Nurse or to the medication cart nurses.	M 500		

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BM's can only be reported once per shift in the digital system. On the manual (paper) system the CNA's can record/documented the number of BM's during the shift, that the resident had. The ADM stated that one (1) Resident #1 (Res #1) had been sent out to the hospital and later passed away. But (Res #1) did not have an infection and did not have a known bowel issue, "I was informed by the nurses that she (Res #1) was not dependent upon staff for toileting.

Interview on 03/28/2023 at 3:30 PM, with the DON revealed that the facility did not have documentation to ensure that the Activities of Daily Living (ADL) care and Bowel Movement (BM's) had been implemented according to the residents care plans. The DON stated, "We are not going to be able to provide for you what you are looking for." The CNA's did not document the Bowel Movements (BM's) on the ADL sheets for the residents on each shift. The CNA's have been documenting manually on ADL sheets for approximately one (1) year due to no computer/kiosk' system available to CNA's. They had been told to manually document the BM's on the ADL sheets and if there had been no BM for that 8 hour shift they were instructed to tell the med cart nurse and the med cart nurse was to check the resident and decide the appropriate method for the resident's BM per the "Bowel" policy and procedure. The nurses were to document in the progress notes what they did and the results of the method for BM's. The DON stated that the nurses had not appropriately documented the BM's in the residents medical records. She stated that the ADL sheets had all been reviewed and an investigation completed by the two Quality Assurance (QA) nurses and there was no documentation of BM's on the ADL sheets and no documentation that the nurses had been

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notified of no BM's for the residents. The DON stated that they had no nursing notes and no documentation for Res #1 that she had BM's prior to her admission to the hospital on 03/02/23. The DON thought that the med cart nurses were supervising the CNA's more closely, but they had not. The DON stated that the "Bowel" policy and procedure had not been followed and the ADL sheets had not been documented appropriately for each resident and the licensed nurses had not documented in the progress notes appropriately or often enough for each resident . She stated the documented information needed for bowel movements on (Res #1) was not in the medical records.

Resident #1:

Interview with the DON on 03/29/23 at 9:00 AM, revealed that Res #1 had been admitted to the hospital from the facility on 03/02/23 due to vomiting "coffee ground" looking substances (emesis) and for stomach pain. The DON stated that Res #1 was diagnosed at the hospital on 03/02/23 with an impaction and on 03/03/23 Res #1 died of aspiration due to vomiting because of the bowel obstruction/bowel impaction. The DON stated that the facility had no documentation that Res #1 's BM's were appropriately monitored as per the facility policy and procedure and the nursing staff had not documented on the Medication Administration Record (MAR) or in the nursing notes that the BM's had been monitored. The facility had not followed the policy and procedure for bowel movement programs. DON stated that she felt responsible because she had "assumed" that the med cart nurses had been monitoring and supervising the CNA's. She should not have "assumed" she should have followed up and she should have "supervised" the

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nursing staff more closely. DON stated that the Quality Assurance (QA) nurses had conducted an investigation of the incident with Res #1 and they had found that there was no documentation of BM monitoring for Res #1. DON stated that the CNA's and licensed nurses had "neglected" to document and monitor the input and out put of Res #1 which led to her hospital transfer and ultimately led to her death from an impaction.

Record review of the facility's "Care Tracker Documentation Record" ADL care sheets for January-March 2023 were reviewed for Res #1 and they were not appropriately documented for Res #1's BM's on each eight (8) hour shift. The input and out put of Res #1 was not appropriately documented on each eight (8) hour shift by the CNA's, in accordance to the facility policies and procedures. The CNA's had documented that Res #1 had three (3) BM's during the dates of January 16, 2023-January 31, 2023. The record review revealed that Res #1 had one (1) BM during the 3:00 PM-11:00 PM shift on January 16, 2023; on January 20, 2023 there was one (1) BM documented on the 7:00 AM-3:00 PM shift; and on January 23, 2023 the CNA's documented one (1) BM during the 7:00 AM -3:00 PM shift. From January 24, 2023-January 31, 2023, Res #1 had no (zero) BM's documented on the ADL care sheets which confirms that Resident #1 went eight (8) days without having a BM. There was no documentation in the medical record of Res #1 to indicate that the CNA's had notified the licensed nurses that Res #1 had no BM's for eight (8) days. The record review revealed that the Progress Notes for January 2023 did not contain any documentation that spoke to Res #1's lack of BM's or that the licensed nurses had monitored the BM's of Res #1 or that Res #1 had received treatment and services for the lack of BM's during

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the month of January 2023. There were no progress notes documented/recorded for Res #3 during the month of February 2023. The ADL care sheet dated February 1, 2023-February 15, 2023 had documentation that Res #1 had no BM's from February 7, 2023-February 15, 2023. The ADL care sheet for Res #1 dated February 16, 2023-February 28, 2023 had documentation that Res #1 had two (2) BM's during this time period, 1 BM recorded during the 3:00 PM-11:00 PM shift on 2/16/23, and1 BM on 2/20/23 during the 7:00 AM-3:00 PM shift. Res #1 had no BM's recorded on the ADL care sheets from 2/21/23-2/28/23. The facility documentation that was provided for Res #1's BM's for 2/16/23-2/28/23 indicated that Res #1 had two (2) BM's recorded during a 13 day period. There was no progress notes in the medical record for Res #1 during the month of February 2023.

Record review of the Medication Administration Record (MAR) for the month of February 2023 revealed that Res #1 received no bowel functioning treatment and services.

The record review of the Nurse Practitioner's (NP) Progress Note date 3/3/2023 at 2:39 PM revealed: Acute Visit 03/02/2023 "Chef Complaint: Nausea, vomiting coffee-ground emesis, and abdominal distention." The patient also has associated abdominal distention with some tenderness to palpation worse on left upper and lower quadrants. Patient symptoms started today this morning nothing making it better or worse. We will send patient to (name of hospital) for further evaluation and treatment.

Record review of the medical records from the hospital dated 03/2/23-03/3/23 for Res #1 revealed: Patient was admitted with consult to

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gastroenterology and general surgery. Abdominal Computerized Tomography (CT) scan findings were consistent with small bowel obstruction, fecal impaction and stercoral colitis without bowel perforation. Large amounts of stool throughout the rectum. History and Physical Reports revealed positive left-sided abdominal tenderness. The patient was made NPO (nothing by mouth) and evaluated by general surgery. Was not felt necessary to place NG tube but instead was given some measures in an attempt to relieve fecal impaction. Discussion with family led to revelation patient wishes to be DO NOT RESUSCITATE/DO NOT INTUBATE. Unfortunately, shortly thereafter patient vomited as witnessed by nursing staff and as a result of aspiration had respiratory arrest and died. Cause of death Aspiration due to vomiting due to small bowel obstruction. Time of death 1200 on 3 March 2023.

Interview on 03/29/23 at 12:00 PM, with the facility ADM revealed that she never knew that the facility had not monitored the BM's of Res #1 and never was told of the bowel impaction of Res #1. ADM stated that she was unaware that the lack of documentation of bowel movements was neglect.

Interview on 03/29/23 at 2:15 PM, with the DON she stated that they knew on 03/03/23 when Res #1 died, that there was a problem with the monitoring of the BM's and that was why she had asked the Quality Assurance (QA) nurses to do an investigation. She stated that the written QA report was given to her and to the ADM by the QA nurses.

Interview on 03/29/23 at 2:50 PM, with the Assistant Director of Nursing (ADON) stated that

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no one had ever asked her to monitor the ADL sheets or the charting of nursing staff. She stated that she had been working the unit on 03/02/23 when the NP had called for her to assess Res #1, who was vomiting. ADON went to Res #1 and found her with "coffee ground" vomit on her clothing and on the floor. The ADON stated that Res #1 was complaining of stomach pain and her stomach was distended. She called 911 and stayed with Res #1 until the ambulance came to pick up Res #1. The ADON stated that she reported to the NP that Res #1 appeared to possibly have a GI bleed from the looks of the "coffee ground" vomit. ADON stated that she learned the next day that Res #1 had passed away at the hospital on 03/03/23 and that the hospital had reported that her death was due to an impaction/bowel obstruction. ADON stated that the nurses should document in the progress notes each shift on the residents and should document in the progress notes when they give certain medications such as PRN's (as needed medications). She stated that there were no documented nursing progress notes for the month of February 2023. ADON stated that no one had asked her to monitor charts. ADON stated that she had assumed that the DON was monitoring the ADL sheets and the nursing progress notes.

Interview on 03/29/23 at 3:00 PM, with the two (2) QA nurses RN#2 and LPN#1 revealed that they were asked by the DON to conduct an investigation of the incident involving Res #1 and they gave a written report to the DON and she gave it to the ADM. Then they had an emergency QA meeting with all the committee members to discuss the findings. They discovered that the CNA's had not documented on the ADL sheets the BM's of the residents and the nursing staff

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had not documented what actions they took to monitor the ADL's. The QA nurses stated that the BM's of Res #1 had not been recorded on the ADL sheets per their policy and procedure and the nurses had not documented in the progress notes for Res #1 during the month of February 2023. Resident #1 was sent out to the hospital on 03/02/23 for vomiting and then Resident #1 died on 03/03/23.

Interview on 03/29/23 at 4:10 PM, with the Administrator (ADM) she stated that she had no idea that Res #1 was impacted. "All I was told was that Res #1 was sent out to the hospital because she was vomiting." I was told later by QA nurses that Res #1 "only" had seven (7) days that the BM's weren't recorded/documented. "No one ever told me that was a problem, I'm not a nurse. I trusted what the nurses said." ADM stated that she had not read the hospital report for Res #1.

At 8:20 AM on 03/30/23 interviews and record reviews were completed along with the former Administrator (ADM #2) and the current ADM. They confirmed that the ADL sheets for Res #1 were not completed for BM's for at least the last 11 days in February 2023 and that there was no documented nursing notes/progress notes for the entire month of February 2023 regarding Res #1. They confirmed that the MAR's had no documented laxatives or stool softeners recorded for January-March 2023 for Res #1. They both confirmed the facility policy and procedure for bowel programs had not been followed. (ADM#2) stated that she learned a long time ago that if it was not written down in the medical records it did not happen.

In an interview on 03/30/23 at 10:25 AM, with the

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ADON she confirmed that after the death of Res #1 on 03/03/23 that the facility had a QA committee meeting to discuss the lack of documentation for the BM's of Res #1 and the lack of nursing progress notes. The facility also discussed the need to return to using the kiosk so the monitoring would be easier to track. The facility reinstated the CNA's kiosk system on 03/16/23. The ADON stated that she would be responsible for monitoring the ADL's through the week days and would do chart audits on the day shift 8:00AM-3:00PM Mon-Fri. and the weekend Charge Nurse would monitor the ADL sheets on the weekends. ADON stated that the facility was hiring a new Staff Development nurse and she would also monitor charts.

Interview on 03/30/23 at 1:00 PM, with the Resident Representative (RR) of Resident #1 revealed that she had been at the facility visiting Res #1 on 2/28/23 or 3/1/23 when Res #1 told her that her stomach was hurting and that she was in pain. RR stated that (Res #1) had dementia and had some cognitive difficulties but that she would talk and did at times complain of generalized pain, but on this day she was specific with where the pain was located in her stomach. RR stated that Res #1 told her that she had told the nurse and the RR stated that she did not know who the nurse was but the nurse was told by Res #1 that her stomach hurt. "I am positive that Res #1 reported not feeling well to the nurse, but I do not know who." RR did not witness the nurse evaluating Res #1. RR stated that the next day early in the morning at approximately 9:00 AM she was contacted by the facility that Res #1 was going to be transferred to the Emergency Room (ER) due to vomiting and stomach pain. RR met Res #1 at the hospital and stayed with her there. The hospital physician

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told RR that Res #1 had been vomiting due to a possible GI bleed and that they would run a test to see where the blood was coming from because she had vomit that looked like possible old blood was present somewhere. The hospital did the test and found that there was no GI bleed that Res #1 had a bowel impaction and that was why she was vomiting. The next day on 03/03/23 Res #1 passed away. RR stated that she had no Death Certificate as of yet but the hospital staff told her that the cause of death was due to an impaction. RR stated that she could not figure out how that could happen. RR stated that Res #1 was incontinent of bowel and bladder but at times she would ask to be assisted to the bathroom. RR stated that she had not obtained copies of the hospital records. RR stated that Res #1 had not received laxatives very much because she never knew of her having constipation issues.

Interview on 03/31/23 at 2:00 PM, with LPN#3 med cart nurse, revealed that she was the nurse for Res #1 everyday that Res #1 was living in the facility. LPN#3 confirmed that she worked days 7:00 AM-7:00 PM and she was never told that Res #1 was not having BM's. The CNA's did not report any negative findings to her for Res #1. LPN#3 also stated that she did not chart in Res #1's nursing notes because she was not aware of any findings that required documentation in the progress notes for Res #1. LPN#3 stated that Res #1 was incontinent of bowel and bladder and that she (LPN#3) was told that Res #1 took herself to the toilet and was independent with toileting. LPN#3 stated that she would have given Res #1 a stool softener and followed the physician's orders had she been told by the CNA's that Res #1 had not had a BM within three (3) days. LPN#3 stated that it was the facility

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policy that if a resident had not had a BM in three (3) days then the CNA would report it to the med cart nurse. "The CNA never reported to me that Res #1 had not had a BM. I was shocked to hear about what happened to Res #1." LPN#3 confirmed that she had never been told to monitor the CNA's ADL sheets. She confirmed that she now knows to monitor the ADL's and bowel movements (BM's) that the CNA's document in the kiosk. LPN#3 stated that the kiosk had been up and running since the middle of March. LPN#3 stated that she had been in-serviced on Abuse/Neglect many times and that she understood that neglect meant "not providing services to residents." LPN#3 stated that she believed that Res #1 did not receive the treatments and services that she deserved.

Interview on 03/31/23 at 2:00 PM, with the DON (RN#1) revealed that she had learned in the Attorney General's (AG's) in-service that neglect was defined as "when services are not provided to residents that may cause disfavorable out comes." The DON stated that Res #1's death met the definition of neglect.

Resident #2:

Observation of Res #2 on 03/29/23 at 12:30 PM, revealed that Res #2 was sitting in a wheelchair outside of her room. Res #2 was not interviewable.

Record review of Res #2's "Care Tracker Documentation Record" ADL sheet dated January 2023 revealed Res #2 had no BM's recorded for five (5) consecutive days for January 20, 2023-January 24, 2023. Res #2 had five (5) BM's recorded/documented on the ADL sheets for February 1, 2023-February 15, 2023. Res #2

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had no BM's documented on the ADL sheets for three (3) consecutive days from 2/5/23-2/7/23; and Res #2 had no BM's recorded on the ADL sheets for five (5) consecutive days of 2/10/23-2/14/23. Res #2 had no progress notes documented in the medical record for the month of February 2023. Res #2 had one (1) progress note recorded for January 29, 2023 and one (1) progress note recorded for March 3, 2023. No progress notes were recorded/documented for Res #2 pertaining to her ADL care and services for January 2023-March 2023.

Interview on 03/29/23 at 12:35 PM, with CNA#1 stated that she was the CNA for Res #2 on 03/29/23. CNA#1 stated that she would record the bowel movements of the residents she worked with on each of her eight (8) hour shifts. At the end of the eight (8) hour shift if the resident had not had a BM in eight (8) hours the CNA's were to report that to the med cart nurse.

Record review of Res #2 revealed a Face Sheet with an admission date of 03/30/2020 and diagnosis of Hemiplgia following cerebral infraction affecting right dominant side, among other diagnoses.

Record review revealed a MDS dated 02/14/2023 that contained a BIMS score of 3 which indicated that Res #2 was severely cognitively impaired.

Resident #3:

Observation on 03/29/23 at 12:20 PM revealed that Res #3, was lying in her bed. Res #3 was not interviewable.

Record review of the "Care Tracker Documentation Record" ADL sheets for January

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and February 2023 for Res #3 were not documented by the CNA's for every eight (8) hour shift seven (7) days per week as outlined in the CNA's Job Description.

Record review of Res #3 revealed that she had a Minimum Data Set (MDS) dated 02/17/2023 that contained a Brief Interview of Mental Status (BIMS) score of 0 (Blank) which indicated that Res #3 was severely cognitively impaired.

Record review of Res #3's Face Sheet revealed an admission date of 10/18/2022 and diagnoses including Constipation, Heart Failure; and Hemiplegia following cerebral infract affecting right dominant side.

Res #3 had no nursing progress notes written/recorded during the month of February 2023 addressing the constipation risk. There was one nursing progress note documented for the month of February dated 2/3/23 which did not address Res #3's ADL's or bowel program. Res #3 had one (1) documented progress note dated 3/1/23 written by the social worker. No progress notes were documented for March 2023 by nursing staff.

Interview on 03/29/23 at 1:00 PM with CNA #2 stated that she was assigned to work with Res #3 on 03/29/23 on the first (1st) shift. CNA#2 stated that she documented on the ADL sheets prior to 03/16/23 the BM's for residents on every shift. She stated that currently when she completed a shift she documented in the kiosk at the end of each eight (8) hour shift the ADL's and the BM's. If a resident does not have a BM on the eight (8) hour shift it is reported to the med cart nurse. The med cart nurse was responsible for checking the resident after the CNA reported to them.

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M 500	Continued From page 21 Resident #4: Interview and observation on 03/29/23 at 1:10 PM, with Res #4, revealed that she was awake and alert and was a good historian. She stated that she had been living in the facility for a little over a year and was a retired Registered Nurse. "I am able to do most things for myself , I just have bad knees and have a need to be assisted with my meds at times. I go to the bathroom by myself, I toilet my self, I bath my self and do most all things for myself." Res #4 stated that since she had been in the facility she had never been asked if she had had a bowel movement or what the consistency of her bowel movements were. Res #4 stated that she had never seen prune juice in the building and had never been offered a snack or juice of any type. No one had talked to her about her bowel movements. Res #4 stated that she thought that the reason why the staff had never asked her about her bowel movements was because she was cognitive and she was continent and had no bowel issues. Record review of the "Care Tracker Documentation Record" ADL sheets revealed Res #4's bowel functioning was not addressed by the staff for January 2023 - March 2023. Interview on 03/29/23 at 1:40 PM with CNA#3 revealed that they manually recorded the BM's on the ADL sheets for over a year because the kiosk were broken. She stated that if a resident did not have a BM during the 8 hour shift the CNA's reported it to the med nurse. Record review of Res #4's Minimum Data Set (MDS) dated 01/03/23 contained a Brief Interview of Mental Status (BIMS) score of 14 which	M 500		

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indicated that Res #4 was cognitively intact.

Record review of Res #4's Face Sheet revealed an admission date of 10/21/21 and diagnoses of Chronic Obstructive pulmonary disease; Gastro-escophageal reflux disease; among other diagnoses.

Record review revealed that Res #4 had one (1) progress note date 1/30/23 and one (1) progress note written on 2/28/23 neither of which addressed her ADL's or bowel functioning. Res #4 had no progress notes documented for March 2023.

Resident #5:

On 03/30/23 at 9:55 AM, during an interview and observation with Res #5 revealed she was lying in bed. She did answer questions asked of her. She stated that she wears briefs and has been incontinent of bowel and bladder. Res #5 stated that she has to have the assistance of staff for all her ADL's. Res #5 stated that the CNA's change her briefs for her on a regular basis. She stated that she had never been offered a stool softener or a laxative. She stated that a very few times she had been constipated and she had asked the nurse for "Metamucil." Res #5 was unable to recall when the event occurred for the medication for constipation. Res #5 stated that she had more times that she had diarrhea or loose stools rather than constipation. She stated that she had never been offered Prune Juice and had never asked for Prune Juice. Res #5 stated that she had to have total assistance for all her ADL's.

Record review of the Face Sheet for Res #5 revealed a re-admission date of 1/13/2017. Res

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M 500	Continued From page 23 #5 had diagnoses of Acute heart disease of native coronary artery; Acute systolic (congestive) heart failure; among other diagnoses. Record review of Res #5's MDS dated 03/20/2023 contained a BIMS score of 14 which indicated that she was cognitively intact. Record review of the "Care Tracker Documentation Record" January 16, 2023 - January 31 bowel function ADL sheet had Res #5 documented as having no bowel movements from January 18, 2023-January 20, 2023 (3 consecutive days with no bowel movement) and from January 22, 2023-January 24, 2023 (3 consecutive days with no bowel movement). There was no documentation in Res #5's medical record to indicate that the CNA's had notified the cart nurse of no BM's for Res #5. Record review of the February 2023 "Care Tracker Documentation Record" bowel function section of the ADL sheet revealed documentation that Res #5 had no bowel movements (BM's) for February 1-3, 2023. Res #5 had no bowel movements recorded on the ADL sheet for the days of February 13, 2023-February 15, 2023 (three (3) consecutive days). There was no documentation in the medical records of Res #5 that the CNA's had notified the licensed nurses (med cart nurse) about the bowel function of Res #5. There was no documentation provided by the facility to confirm that the nurses (cart nurses) had been monitoring the BM's of Res #5 during the months of January-March 2023. Summary: Record review of the ADL sheets for (5) of (5) sampled residents revealed that the BM's had not	M 500		

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M 500	Continued From page 24 been appropriately documented/recorded on the ADL sheets by the CNA's and there was no MAR documentation/recording of the BM's as per the facility policies and procedures. The nursing progress notes had not been documented for Resident #1 for the month of February 2023; and five (5) of five (5) residents nursing progress notes contained no information of ADL and/or BM functioning as outlined in the facility's policies and procedures for documenting BM functioning. The Care Plans for 5 of 5 Sampled Residents (Res #1; Res #2; Res #3; Res #4; and Res#5) had not been followed for bowel functioning /constipation risk, and ADL care. The medical record of Res #1 contained no monitoring of her BM's by the licensed nursing staff. As a result of neglecting to accurately and appropriately document/record the BM's of the residents led to Res #1 having un-treated serious constipation which led to a bowel impaction and hospital admission on 03/02/23 and ultimately led to the death of Res #1 at the hospital on 03/03/23. The DON and the QA nurses (RN#3 and LPN#2) confirmed through interviews that Res #1 had not been properly monitored for BM's for January 2023-February 2023 and that on 03/02/23 Res #1 suffered a bowel obstruction and was sent out to the hospital. Confirmed through record reviews and through interviews that Res #1's BM's were not monitored and the CNA's and licensed nurses had neglected to monitor Res #1 which ultimately resulted in her death at the hospital on 03/03/23. The facility provided an acceptable Removal Plan on 03/31/23. Review of the facility's Removal Plan revealed the facility took the following actions to remove the IJ: Removal Plan:	M 500		

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M 500	Continued From page 25 On 03/02/2023, Resident #1 began vomiting coffee ground emesis and was transferred to the hospital and expired at the hospital on 03/03/2023. The facility determined that Certified Nursing Assistants (CNA's) were documenting bowel movements inaccurately on the paper records. No one was assigned to check the CNA documentation. The facility's failure likely placed residents who reside in the facility at risk for serious adverse outcomes. The administration must take immediate action to monitor staff actions to prevent likelihood of serious harm, impairment or death. The State Survey Agency (SA) called Immediate Jeopardy (IJ) and provided the facility with IJ templates on 03/29/2023 for neglect, failure to maintain accurate documentation, failure to implement care plans, and failure to provide residents with necessary treatments. The SA provided an IJ template on 03/30/2023 for failure to administer the facility effectively. All 88 residents were assessed for being at risk of no bowel movement. The Bowel Program policy to include the standing orders was initiated for residents identified at risk by Registered Nurse (RN#1), RN#2, RN#3, RN#4, and RN#5 on 03/30/2023. Certified Nursing Assistants (CNA's) that have worked were in-serviced on the Bowel Care Task documentation via the kiosk, to include whether they are continent, incontinent or colostomy as well as bowel characteristics of size and consistency with a prompt to notify nurse if stool is hard or watery. This in-service was conducted by Quality Assurance (QA) RN#2. This in-service began on March 29, 2023. Medication nurses	M 500		

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that worked were in-serviced by Director of Nursing, RN#1, QA nurse RN#2 and Licensed Practical Nurse (LPN#1), in reference to checking the completion of documentation by the CNA's per shift. This in-service began on March 29, 2023. No staff will be allowed to work until the in-service training has been completed.

CNA's have documented bowel movements via the kiosk on 03/16/2023. 45 minutes prior to the end of each shift the medication nurse on each hall checked CNA documentation for completion, beginning 03/29/2023. Medication nurses who have residents at risk initiated standing orders for no bowel movement protocol. The standing orders are as follows: If a resident goes 3 days with no bowel movement (BM) initiate the standing orders. Obtain vital signs, check abdomen for distention/pain. Auscultate bowel sounds. Administer Dulcolax suppository x 1 dose. Reassess resident. If no BM in 24 hours give fleet enema x 1 dose. Reassess resident. If no BM 30 minutes after enema, notify Medical Doctor (MD)/Nurse Practitioner (NP).

All staff that worked were in-serviced on the duty to report signs and symptoms of abuse and neglect immediately to their supervisor, who will report to the DON and Administrator. They were also in-serviced that it is the duty of anyone to report suspected abuse or neglect. This in-service was conducted by RN#1, RN#2 and LPN#1. This in-service began on 03/29/2023 and no staff will be allowed to work until the in-service training has been completed. On Friday March 24, 2023 and Monday March 27, 2023 the Attorney General Office came to the facility and in-serviced all Administrative staff including the Administrator, DON, and facility staff on Abuse and Neglect.

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M 500	Continued From page 27 CNA's and License Practical Nurse's (LPN) and RN's that worked were in-serviced on the importance of reviewing and following resident care plans to prevent potentially serious outcomes. This in-service training was conducted by RN#1, RN#2, and LPN#1. This in-service was complete on 03//29/2023 for staff that worked and no staff will be allowed to work until the in-service training has been completed. All care plans related to residents at risk for constipation were reviewed by Minimum Data Set (MDS) assessment nurses on 03/30/2023. The standing orders were initiated for all residents identified at risk. All care plans have bowel interventions in place. An emergency QA meeting was held on March 03, 2023. In attendance were the Administrator, DON/Infection Preventionist (IP), Assistant Director of Nursing, QA RN#2 and QA LPN#1, MDS RN#3 and MDS LPN#2, the Social Service Director and the Nurse Practitioner. Changes in CNA charting from paper to kiosk was discussed. Staff in-service on constipation and standing orders were discussed and initiated by RN#2. It was decide to hire staff Development nurse. An Emergency QA meeting was held on 03/30/2023. In attendance was the Medical Director, Administrator, DON/IP, QA RN#2, QA LPN#1, MDS LPN #2 and Accounts Manager. Immediate Jeopardy deficiencies and immediate Action Plan was discussed. We allege the immediacy of the jeopardy was removed on 03/30/2023 and the IJ was removed on 03/31/2023.	M 500		

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M 500	Continued From page 28 VALIDATION: On 03/31/2023, the SA validated the facility had implemented the following measures to remove the Immediate Jeopardy (IJ). The Removal Plan was verified by staff interviews and record reviews of in-services and sign-in sheets. On 03/31/23 the SA confirmed through interviews with DON (RN#1), interviews with the x 2 QA nurses (RN#2 and LPN#1), interview with the ADON (RN#3), interview with the Wound Care Nurse (RN#4), and interview with MDS/Care Plan nurse (RN#5), and validated that the five (5) Registered Nurses assessed all 88 residents at risk of no bowel movements (BM's) and they initiated the Bowel Program policy and procedure for those residents that were identified. The SA validated through interviews and record review of the in-service sign in sheets that eight (8) CNA's working in the building on all three (3) shifts on 03/31/23 had attended in-service training beginning on 03/29/23 in reference of documentation of BM's in the kiosk. Interviews with six (6) RN's and five (5) LPN's confirmed that they had been in-serviced to supervise the CNA's documentation and to check the kiosk documentation after the CNA's had documented. On 03/31/23 the SA confirmed through interviews that the CNA's (CNA#1, #2, #3, #4, #5, #6, #7, and CNA#8) that they had begun digital documentation of the residents ADL's and BM's in the kiosk on 03/16/23. Validated through interviews with five (5) LPN's and one (6) RN's that they were instituting the "no bowel movement" protocol. All interviewed licensed nurses confirmed that they would contact the NP or the MD if the no bowel movement protocol did	M 500		

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not produce BM results.

The SA confirmed through interviews and record reviews with six (6) Registered Nurses (RN's), eight (8) CNA's, five (5) LPN's, and the facility Administrator that all facility staff had been in-serviced on Abuse and Neglect and all staff knew that any signs and symptoms of abuse would be reported immediately to their supervisors and to the DON and ADM. The ADM and the DON both confirmed and produced the sign in sheets for review for the Abuse and Neglect in-service that was conducted on Friday March 24, 2023 and on Monday March 27, 2023 presented by the AGO.

Confirmed through record review of in-services and through interview with RN#1, RN#2 and LPN#1 that they conducted in-service training of all staff that had worked on the importance of reviewing and following the care plans of all residents in order to prevent serious negative outcomes. Confirmed through interview with the two (2) MDS/Care Plan nurses (RN#5 and LPN#2) that all 88 resident care plans have bowel interventions in place.

The QA Nurse (RN#2) and (LPN#1) confirmed through interview that the facility conducted an Emergency QA committee meeting on 03/03/23 to discuss the bowel program and the documentation of BM's and that there would be changes in the documentation by the CNA's to the new kiosk system rather than the paper documentation. The x 2 QA nurses confirmed through interview that a new Staff Development nurse had been hired and she had begun on 03/29/23 with in-servicing of facility staff. The ADM confirmed through interview that the QA meeting on 03/03/23 had all members in

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M 500	Continued From page 30 attendance except the MD and the ADM confirmed that the DON is the certified (IP). The SA validated through interviews with the ADM that the facility QA committee had held a second QA committee meeting on 03/30/2023 to discuss the deficiencies from the IJ and to discuss the Action Plan for removing the immediacy of the IJ. The ADM confirmed through interview that the QA meeting on 03/30/23 had all required members present including the MD and the IP. Staff interviewed on 03/31/23 for Validations of the facility's Removal Plan were: eight (8) CNA's; six (6) RN's; five (5) LPN's; one (1) Activities Director; one (1) facility ADM; and one (1) DON.	M 500		