

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

PRINTED: 05/01/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255182	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/31/2023
NAME OF PROVIDER OR SUPPLIER LAKEVIEW NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 16411 ROBINSON ROAD GULFPORT, MS 39503		
(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) COMPLETION DATE	
F 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 requirements for participation in Medicare and Medicaid. An extended survey was completed, and the following deficiencies were cited for CI MS #20934 and CI MS #21095: F600, F609, F656, F684, and F835 at an Immediate Jeopardy (IJ) level for Neglect, Reporting, Failure to revise, follow, and implement Care Plans, Quality of Care, and Administration. 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	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

04/19/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 the IJ template. The IJ and SQC existed at: 42 CFR 483.12 (a) (1) Freedom from Abuse and Neglect (F600) Scope and Severity (S/S) "L" 42 CFR §483.12(c)(1),(4) Reporting of Alleged Violations F609, S/S "J" 42 CFR 483.25 Quality of care- F684, S/S "L" IJ existed at: 42 CFR 483.21(b)(1)(2)(3) Comprehensive Care Plans- F656 S/S "L" On 03/30/23 at 1:30 PM, the SA provided the IJ template for F835 to the facility Administrator. IJ existed at: 42 CFR 483.70 Administration -F835, S/S "L" 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 03/31/23. The SA validated the Removal Plan on 03/31/23, and determined the IJ was removed on 03/31/23, prior to exit. Therefore, the S/S of 42 CFR 483.12 (a) (1) Freedom from Abuse and Neglect (F600); 42 CFR 483.21(b)(1)(2)(3) Comprehensive Care Plans; 42 CFR 483.25 Quality of care- F684; and 42 CFR 483.70 Administration -F835 was lowered from an "L" to an "F", and 42 CFR §483.12(c)(1)(4)Reporting of	F 000			

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FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: W47M11 Facility ID: 24LA If continuation sheet Page 3 of 113

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F 600	Continued From page 3 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. 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.	F 600	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 three months. Results will be brought to monthly QA meeting 5/3/23.		

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F 600	Continued From page 4 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 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.."	F 600			

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F 600	Continued From page 5 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 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	F 600			

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F 600	Continued From page 6 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. 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.	F 600			

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F 600	Continued From page 7 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 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	F 600			

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F 600	Continued From page 8 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 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	F 600			

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F 600	Continued From page 9 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 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	F 600			

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F 600	Continued From page 10 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, and 1 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 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	F 600			

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F 600	Continued From page 11 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 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	F 600			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255182	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/31/2023
NAME OF PROVIDER OR SUPPLIER LAKEVIEW NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 16411 ROBINSON ROAD GULFPORT, MS 39503		
(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) COMPLETION DATE	
F 600	Continued From page 12 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 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	F 600			

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

PRINTED: 05/01/2023
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F 600	Continued From page 13 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 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	F 600			

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

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F 600	Continued From page 14 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 told RR that Res #1 had been vomiting due to a possible GI bleed and that they would run a test	F 600			

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

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F 600	Continued From page 15 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 policy that if a resident had not had a BM in three	F 600			

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

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FORM APPROVED
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F 600	Continued From page 16 (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 unfavorable outcomes." 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	F 600			

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

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F 600	Continued From page 17 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 Hemiplegia 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	F 600			

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

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F 600	Continued From page 18 Documentation Record" ADL sheets for January 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.	F 600			

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

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F 600	Continued From page 19 The med cart nurse was responsible for checking the resident after the CNA reported to them. 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.	F 600			

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

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F 600	Continued From page 20 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 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-esophageal 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	F 600			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 600	Continued From page 21 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 #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.	F 600			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 600	Continued From page 22 Summary: Record review of the ADL sheets for (5) of (5) sampled residents revealed that the BM's had not 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	F 600			

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

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F 600	Continued From page 23 on 03/31/23. Review of the facility's Removal Plan revealed the facility took the following actions to remove the IJ: Removal Plan: 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			F 600			

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

PRINTED: 05/01/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255182	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/31/2023
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F 600	Continued From page 24 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 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	F 600			

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

PRINTED: 05/01/2023
FORM APPROVED
OMB NO. 0938-0391

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F 600	Continued From page 25 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. 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	F 600			

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

PRINTED: 05/01/2023
FORM APPROVED
OMB NO. 0938-0391

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F 600	Continued From page 26 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. 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.	F 600			

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

PRINTED: 05/01/2023
FORM APPROVED
OMB NO. 0938-0391

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F 600	Continued From page 27 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 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	F 600			

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

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F 600	Continued From page 28 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 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.	F 600			
F 609 SS=J	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property,	F 609			5/9/23

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

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FORM APPROVED
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F 609	Continued From page 29 are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and policy and procedure review the facility failed to report to the proper authorities the neglect of Resident (Res) #1 who was admitted to the hospital on 03/02/23 from the facility with a bowel impaction that ultimately caused Res #1 to die in the hospital on 03/03/23 for one (1) of five (5) sampled residents. Resident #1 The facility's failure to report negligence to render the care and services necessary to prevent constipation which resulted in the ultimate death of Resident #1 placed all residents in a situation that caused or was likely to cause serious harm, serious injury, serious impairment or death. The State Agency (SA) identified an Immediate	F 609	*Administrator (ADM) reported alleged violation of neglect to State Agency (SA) on 3/31/23 at 0500. **All residents are at risk for this deficient practice. ***All staff was in-serviced 3/29/23 on the duty to report signs and symptoms of abuse and neglect immediately to their supervisor who will report to the Director of Nursing (DON) and ADM. All staff have been required beginning 4/4/23 to watch Hand In Hand video module #5 on Abuse and Neglect and pass a written competency exam. Any staff with incorrect		

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

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F 609	Continued From page 30 Jeopardy (IJ) and Substandard Quality of Care (SQC) that began on 03/02/23 when the facility failed to report the neglect that resulted in Res #1 being 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 for F609. 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 03/31/23. 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) Reporting (F609) was lowered from an "J" to a "D" 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's policy and procedure titled "Reporting Alleged Violations" with a revision date of 12/26/2019 revealed, "Policy: The purpose of this policy is to ensure that all alleged violations involving ... neglect ...are reported immediately to the administrator of the facility and to other state officials in accordance with State Law through established procedures (including to the State survey and certification agency) ...Compliance Guidelines:..	F 609	answers will receive one on one in-service training with staff development nurse to ensure full understanding of abuse and neglect. ****Quality Assurance (QA) began daily monitoring on 3/29/23 to include nurses notes, incident reports, physician orders and no Bowel Movement (BM) report to determine the need for reporting. All findings will be brought to monthly QA meeting 5/3/23 for review and recommendations from interdisciplinary team, weekly X four weeks and monthly X 3 months.		

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

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F 609	Continued From page 31 2. If the alleged violation involves abuse or results in serious bodily injury it must be reported immediately but no later than 2 hours after the allegation is made ... Neglect: Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness ..." 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 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.." Interview on 03/28/23 at 12:00 PM, with the Director of Nursing (DON) and the facility Administrator (ADM) revealed the DON stated that she had not reported any incidents of Neglect/Abuse to the State Agencies (SA). The DON stated that the ADM was responsible for all Reporting to (SA). The ADM stated that Res #1 had been sent out to the hospital and later passed away. The ADM stated that she had not reported any Neglect/Abuse to the State Agency	F 609			

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

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F 609	Continued From page 32 (SA) in the past three months (Jan-March 2023). Interview on 03/28/2023 at 3:30 PM with the DON (RN#1) 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 facility's policies and procedures. The CNA's did not document the Bowel Movements (BM's) on the ADL sheets for the residents on each shift. The nurses did not supervise the CNA's documentation of BM's for Res #1. The facility staff did not provide the care and services for Res #1 to prevent a bowel impaction. DON stated the documented information needed for bowel movements on (Res #1) was not in the medical records. The DON confirmed that she had not reported the neglect of Res #1 to any SA. Interview with the DON (RN#1) on 03/29/23 at 9:00 AM, The DON stated that the facility ADM was responsible for reporting to the State Agencies (SA). DON stated that she did not report to the State Agencies (SA). 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 Res #1's death from an impaction. DON stated that she had read the hospital report for Res #1's admission and the ER had documented that Res #1's cause of death was aspiration due to vomiting as a result of a bowel impaction. Record review of Res #1's medical records from January 2023 - March 2023 confirmed that the facility had not provided the treatments and services to Res #1 to prevent constipation and/or a bowel impaction.	F 609			

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

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F 609	Continued From page 33 Record review of the facility's ADL care sheets for January -March 2023 were reviewed for Res #1 and was lacking documentation for Res #1's BM's and intake and output on each eight (8) hour shift. The ADL care sheet for January 2023 revealed the CNA's had documented that Res #1 had three (3) BM's during the dates of January 16, 2023-January 31, 2023. 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 the month of January 2023. The ADL care sheet dated February 1, 2023-February 15, 2023 documented/recorded 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 documented/recorded that Res #1 had two (2) BM's during this time period. 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. The Medication Administration Record (MAR) did not document that Res #1 received bowel functioning treatment and services for the month of February 2023. Record review of the NP progress note date 3/3/2023 at 2:39 PM revealed: Acute Visit	F 609			

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

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F 609	Continued From page 34 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 gastroenterology and general surgery. 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. She did have a small bowel movement. Patient found to have urinary tract infection and started on antibiotics. 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, the ADM confirmed that she had not reported the incident of Res #1's impaction because she was unaware that the facility had failed to monitor and document. ADM stated that she was unaware that the lack of documentation of bowel movements was neglect. The ADM stated that she never told any staff not to report the incident because she did not know neglect was an issue	F 609			

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

PRINTED: 05/01/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255182	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/31/2023
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F 609	Continued From page 35 for Res #1. Interview on 03/29/23 at 2:15 PM, with the DON 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 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 3:00 PM, with the 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. The QA nurses both confirmed that they did not report the findings of their investigation to the (SA). Interview at 9:30 AM on 03/31/23, the ADM confirmed that on 03/31/2023 at 5:00 AM she called the incident of alleged neglect in to the required State Agencies (SA). Summary: Record review of the ADL sheets for (5) of (5) sampled residents Res #1, Res #2, Res #3, and Res #4, revealed that the BM's had not been appropriately documented/recorded on the ADL sheets by the CNA's and there was no MAR documentation 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 BM functioning as outlined in the facility's policies and procedures for documenting BM functioning. The medical	F 609			

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

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F 609	Continued From page 36 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/measure 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 appropriately monitored for BM's by the CNA's, and the licensed nurses had neglected to monitor Res #1's BM's which ultimately resulted in Res #1's death at the hospital on 03/03/23. The facility had not reported the incident of neglect to the required SA's. The facility ADM reported the incident of neglect to the SA's on 03/31/23 at 5:00 AM as per the facility IJ Removal Plan. 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: 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	F 609			

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

PRINTED: 05/01/2023
FORM APPROVED
OMB NO. 0938-0391

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F 609	Continued From page 37 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 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	F 609			

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

PRINTED: 05/01/2023
FORM APPROVED
OMB NO. 0938-0391

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F 609	Continued From page 38 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. 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	F 609			

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

PRINTED: 05/01/2023
FORM APPROVED
OMB NO. 0938-0391

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F 609	Continued From page 39 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. VALIDATION: On 03/31/2023, the SA validated the facility had implemented the following measures to remove the Immediate Jeopardy (IJ). The Removal Plan	F 609			

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

PRINTED: 05/01/2023
FORM APPROVED
OMB NO. 0938-0391

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F 609	Continued From page 40 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 x2 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 not produce BM results. The SA confirmed through interviews and record reviews with six (6) Registered Nurses (RN's),	F 609			

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

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F 609	Continued From page 41 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 attendance except the MD and the ADM confirmed that the DON is the certified (IP).			F 609			

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

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F 609	Continued From page 42 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.	F 609			
F 656 SS=L	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. Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized	F 656		5/9/23	

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

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F 656	Continued From page 43 rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interviews, record reviews and policy and procedure reviews the facility did develop and/or implement the "bowel functioning" Care Plans for five (5) of five (5) residents reviewed. Resident (Res) #1, Res #2, Res #3, Res #4, and Res #5 had no implemented bowel functioning programs maintained in the medical records. This failure had the potential to affect all residents in the facility. The facility's failure to implement the "bowel functioning/constipation" care plan for Res #1 and to render the care and services necessary to prevent constipation resulted in her admission to	F 656	*On 03/29/2023 the Minimum Data Set (MDS) coordinator reviewed the comprehensive care plan for resident #1. The comprehensive care plan did not require any revisions. On 03/30/2023 all residents at risk for constipation care plans were audited by MDS assessment nurses for revision and updates. **All residents are at risk for this deficient practice. ***All current facility nurses and nursing contract personnel completed an		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 656	Continued From page 44 the hospital on 03/02/23 and her death on 03/03/23 from aspiration from vomiting due to small bowel obstruction. The facility's failure develop and implement care plans to provide the care and services necessary to prevent constipation placed all residents in the facility at risk for serious injury, harm, 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 for F656. 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 483.21 Develop/Implement Comprehensive Care Plans (F656) 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:	F 656	in-service training on 3/29/23 by RN #1, RN #2 and LPN #1 on the importance of reviewing and following resident care plans to prevent potentially serious outcomes. All new nursing personnel will receive the in-service during the orientation process. ****On 3/30/23 all at risk for constipation care plan monitoring began. Five care plans for residents at risk for constipation will be monitored weekly x four weeks and monthly x three months and will be brought to standup for interdisciplinary team review. Findings will be brought to Quality Assurance (QA) meeting on 5/3/23, then monthly x three months.		

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

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F 656	Continued From page 45 Record review of the facility policy and procedure titled: "Comprehensive Care Plans" undated revealed "Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessments ..." 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 the Director of Nursing or ADON (Assistant	F 656			

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

PRINTED: 05/01/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255182	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/31/2023
NAME OF PROVIDER OR SUPPLIER LAKEVIEW NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 16411 ROBINSON ROAD GULFPORT, MS 39503		
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F 656	Continued From page 46 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 Director of Nursing (DON (RN#1) revealed that the Certified Nursing Assistants (CNAs') documented the Activities of Daily Living (ADL's) for each resident at the end of each eight (8) hour shift. The 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 stated that the Care Plans for the residents have not been followed and the nursing staff had not documented the "bowel functions" of each individual resident in accordance with the Care Plans. The DON confirmed that there were two (2) care plan nurses working in the facility on 03/28/23. The DON stated that if a resident had bowel issues the CNAs' report that to the Licensed Practical Nurses (LPN) medication cart nurses or to the Registered Nurse (RN) or Charge Nurse. If a resident does not have a bowel movement (BM) during that shift the CNAs' report that to the Charge Nurse or to the medication cart nurses. The DON stated that the "bowel functioning" programs for the residents had been reviewed by the Care Plan nurses and the DON and they had not been followed or implemented.	F 656			

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

PRINTED: 05/01/2023
FORM APPROVED
OMB NO. 0938-0391

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F 656	Continued From page 47 Interview on 03/28/2023 at 3:30 PM with the DON revealed the documented information needed for bowel movements on Res #1 was not in the medical records. The DON confirmed that the Care Plans for the residents had not been implemented. Resident #1: Record review of the Care Plan for Res #1 dated 06/08/2022 revealed: "Constipation I have constipation risk r/t (in reference to) advanced age, impaired mobility, meds does not take laxative/stool softener regularly Risk for constipation/diarrhea. Goal: Will have soft formed stool 2-3 x week (2-3 times per week) to next review 3/21/23...Interventions: Administer meds as ordered Monitor & record frequency and amount of BM Note any problem with consistency or color of BM Encourage 100% fluid intake pm meal tray check bowel sounds prn (as needed) Administer PRN med a/o (as ordered) Monitor for effectiveness of prn offer Prune Juice prn Notify MD if needed. Record review of the facility's 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 CNAs', in accordance to the facility policies and procedures. The CNAs' 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	F 656			

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

PRINTED: 05/01/2023
FORM APPROVED
OMB NO. 0938-0391

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F 656	Continued From page 48 documented on the 7:00 AM-3:00 PM shift; and on January 23, 2023 the CNAs' 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 CNAs' 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 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, and 1 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. Interview with the DON on 03/29/23 at 9:00 AM, DON stated that the facility had no documentation that Res #1 's BM's were appropriately monitored	F 656			

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

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FORM APPROVED
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F 656	Continued From page 49 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 DON stated that the facility had not followed the care plan for Res #1 and the facility had not followed the policy and procedure for bowel movement programs. DON stated that the 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 as outlined in her care plan. 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 the Care Plan of Res #1 had not been implemented. Interview on 03/29/23 at 3:00 PM with the two (2) QA nurses RN#2 and LPN#1 confirmed that the Care Plan of Res #1 had not been followed for Res #1's "bowel program." At 8:20 AM on 03/30/23, interviews and record reviews completed along with the former Administrator (ADM #2) and the current ADM both confirmed that the Care Plan had not been followed for ADL care and Constipation risk and the facility policy and procedure for bowel functioning programs had not been followed.	F 656			

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

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F 656	Continued From page 50 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. Interview on 03/30/23 at 11:45 AM, with the two (2) care plan/MDS (Minimum Data Set) nurses RN #5 and LPN#2 both confirmed that the care plans for Res #1 had not been followed. Resident #2: Record review of Res #2's Care Plan dated 04/06/2020 revealed there was no Care Plan submitted by the facility that outlined the "bowel functioning" of Res #2. Record review of the Face Sheet revealed Resident #2 was admitted to the facility with an admission date of 03/30/2020. Diagnoses included Hemiplegia following cerebral infraction affecting right dominant side; Dysphagia; Speech and language deficits; Contracture of muscle, right hand; Dementia; Anxiety disorder; Anorexia. Record review revealed a Minimum Data Set (MDS) dated 02/14/2023 that contained a Brief Interview of Mental Status (BIMS) score of 3 which indicated that Res #2 was severely cognitively impaired. Record review of Res #2's ADL sheet dated January 16-31, 2023 that had many days of missing documentation under the "Bowel Function" section 1/16/23 none of the three (3) eight (8) hour shifts had recorded any BM's for Res #2. There were 12 BM's recorded for Res #2 during the three (3) eight (8) hour shifts for the days of 1/16/23-1/31/23. Res #2 had no BM's recorded for five (5) consecutive days for January	F 656			

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

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F 656	Continued From page 51 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 had no BM's recorded/documented on the ADL sheets for three (3) consecutive days from 2/5/23-2/7/23; 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/recorded 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. Resident #3: Record review of Res #3 revealed a Care Plan dated 10/24/2022 that read: At constipation risk r/t (in reference to) advanced age, impaired mobility, meds. Goal: Will have soft formed stool 2-3 x week (2-3 times per week) to next review 6/02/23...Interventions: Observe & record frequency and amount of BM, Note any problem with consistency or color of BM, Encourage 100% fluid intake on meal tray, check bowel sounds prn, Observe for effectiveness of prn, Offer Prune Juice prn, Notify MD if needed, Administer meds as ordered (See MAR). Record review of the medical record revealed 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. No	F 656			

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

PRINTED: 05/01/2023
FORM APPROVED
OMB NO. 0938-0391

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F 656	Continued From page 52 progress notes were documented for March 2023 by nursing staff. The ADL sheets for January and February 2023 for Res #3 were not documented by the CNAs' for every eight (8) hour shift seven (7) days per week. 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 the Face Sheet revealed Resident #3 was admitted to the facility on 10/18/2022 with diagnoses that included Hemiplegia following cerebral infract affecting right dominant side; Constipation, unspecified; Senile degeneration of the brain. Resident #4: Interview with Res #4 on 3/29/23 at 1:10 PM, revealed 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. Res #4 stated that she had never been offered a stool softener or a laxative. Res #4 stated that she had more issues with loose stools rather than with constipation. No one had talked to her about her bowel movements. Record review of Res #4's Care Plan dated 10/21/2021 revealed: Constipation has constipation risk r/t (in reference to) diverticulitis of the intestines, side effects of antipsychotic and antidepressant medications. Goal: Will have soft	F 656			

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

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FORM APPROVED
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(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) COMPLETION DATE	
F 656	Continued From page 53 formed stool 2-3 x week (2-3 times per week) to next review 4/02/23. Interventions: Administer meds as ordered, Record any problems with color or consistency of BM, Notify MD as needed, Encourage 100% fluid intake on meal tray, Check bowel sounds prn (as needed) , Encourage fluid intake, Offer Prune juice prn, Observe and record frequency and amount of BM, Observe for effectiveness of prn. Record review of Res #4's Minimum Data Set (MDS) dated 01/03/23 contained a BIMS score of 14 which indicated that Res #4 was cognitively intact. Record review of the Face Sheet revealed Res #4 was admitted to the facility on 10/21/21 with diagnoses that included Bipolar Disorder with mild depression; Chronic Obstructive pulmonary disease. Record review of the medical record revealed there was no documentation submitted by the facility to indicate that the Care Plan of Res #4 had been followed for constipation and/or the "bowel functioning" of Res #4. Resident #5: In an interview and observation on 03/30/23 at 9:55 AM, Res #5 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	F 656			

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

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FORM APPROVED
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NAME OF PROVIDER OR SUPPLIER LAKEVIEW NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 16411 ROBINSON ROAD GULFPORT, MS 39503		
(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) COMPLETION DATE	
F 656	Continued From page 54 been offered Prune Juice and had never asked for Prune Juice. Record review of Res #5's Care Plan dated 01/04/2028 revealed: Constipation: I am at risk for constipation related to diuretic use, impaired mobility, medication side effects, opiate use. Goal: Will have soft formed stool 2-3 x week (2-3 times per week) by 7/03/23. Interventions: Note any problem with consistency or color of BM, Encourage 100% fluid intake on meal tray, Check bowel sounds prn, Offer Prune juice prn (as needed) Administer my medication as per md orders, Observe & record frequency and amount of BM. Record review of the January 16, 2023 - January 31 bowel function ADL sheet had Res #5 documented/recorded as having no bowel movements from January 18, 2023-January 20, 2023 (three (3) consecutive days with no bowel movement). The ADL sheet had no BM's documented/recorded for Res #5 from January 22, 2023-January 24, 2023 (three (3) consecutive days with no bowel movement). Record review of the February 2023 bowel function ADL sheet documented that Res #5 had no bowel movements (BM's) for the first three (3) days of February (February 1-3, 2023). Res #5 had no bowel movements (BM's) documented/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 CNAs' had notified the licensed nurses (med cart nurse) about the bowel function of Res #5. There was no documentation in Res #5's medical record to indicate that the CNAs' had notified the cart nurse of no BM's for Res #5. There was no	F 656			

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

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FORM APPROVED
OMB NO. 0938-0391

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F 656	Continued From page 55 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. Record review revealed that the Care Plan for Res #5 had not been implemented for Constipation. Record review of the Face Sheet revealed Res #5 was admitted to the facility on 10/28/16 with diagnoses that included Acute heart disease of native coronary artery and Acute systolic (congestive) heart failure Record review of the MDS dated 03/20/2023 for Res #5 revealed BIMS score of 14 which indicated that she was cognitively intact. Summary: Record review of the ADL sheets for (5) of (5) sampled residents revealed that the BM's had not been appropriately documented/recorded on the ADL sheets by the CNAs' 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	F 656			

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

PRINTED: 05/01/2023
FORM APPROVED
OMB NO. 0938-0391

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F 656	Continued From page 56 neglecting to accurately and appropriately document/record the BM's of the residents led to Res #1 having un-treated serious constipation with 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 CNAs' 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: 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 (CNAs') were documenting bowel movements inaccurately on the paper records. No one was assigned to check the CNAs 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	F 656			

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

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FORM APPROVED
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NAME OF PROVIDER OR SUPPLIER LAKEVIEW NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 16411 ROBINSON ROAD GULFPORT, MS 39503		
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F 656	Continued From page 57 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 (CNAs') 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 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 CNAs' 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. CNAs' 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 CNAs documentation for completion, beginning 03/29/2023. Medication nurses who have residents at risk initiated standing orders for no bowel movement protocol.	F 656			

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

PRINTED: 05/01/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255182	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/31/2023
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F 656	Continued From page 58 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. CNAs' 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	F 656			

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

PRINTED: 05/01/2023
FORM APPROVED
OMB NO. 0938-0391

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F 656	Continued From page 59 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 CNAs 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. 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 x2 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	F 656			

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

PRINTED: 05/01/2023
FORM APPROVED
OMB NO. 0938-0391

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F 656	Continued From page 60 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) CNAs' 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 CNAs' documentation and to check the kiosk documentation after the CNAs' had documented. On 03/31/23 the SA confirmed through interviews that the CNAs' (CNAs#1, #2, #3, #4, #5, #6, #7, and CNAs#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 not produce BM results. The SA confirmed through interviews and record reviews with six (6) Registered Nurses (RN's), eight (8) CNAs', 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	F 656			

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

PRINTED: 05/01/2023
FORM APPROVED
OMB NO. 0938-0391

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F 656	Continued From page 61 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 CNAs' 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 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.	F 656			

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

PRINTED: 05/01/2023
FORM APPROVED
OMB NO. 0938-0391

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F 656	Continued From page 62	F 656			
F 684 SS=L	Staff interviewed on 03/31/23 for Validations of the facility's Removal Plan were: eight (8) CNAs'; six (6) RN's; five (5) LPN's; one (1) Activities Director; one (1) facility ADM; and one (1) DON. Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, record review, interviews, and policy and procedure reviews, the facility failed to implement the facility's protocol for monitoring bowel functioning for five (5) of five (5) residents reviewed, Resident #1, Resident #2, Resident #3, Resident #4, and Resident #5, which resulted in Resident #1 becoming ill with vomiting and stomach pain and transferred to the hospital on 03/02/23. On 03/03/23, Resident #1 died at the hospital as a result of a bowel impaction/obstruction. The facility's failure to render the care and services necessary to prevent constipation resulted in the 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 the likelihood of serious illness and death.	F 684	*Resident #1 was transferred to the hospital due to emesis and abdominal pain. **All residents have the potential to be at risk for this same deficient practice. ***Certified Nursing Assistants (CNA'S) document bowel care via the kiosk beginning 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 on each hall 45 minutes prior to each shift will check CNA documentation for completion beginning 3/29/23. The residents at risk for constipation have standing orders for no	5/9/23	

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

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FORM APPROVED
OMB NO. 0938-0391

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F 684	Continued From page 63 The State Agency (SA) identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) that began on 03/02/23 when Resident #1 began vomiting and complaining of stomach pain. Resident #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 templates for F 600; F 609; F 656; F 684; and on 03/30/23 at 1:30 PM the SA provided IJ temple for F 835 to the facility. 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. The scope and severity for CFR 483.25 (a) (1) Quality of Care (F 684) was lowered to an "F" while the facility monitors 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: "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	F 684	Bowel Movement (BM). The revised standing orders in-service for No BM began 3/29/23. ****The staff development nurse beginning 4/4/23 will pull the No BM report daily, Monday through Friday and bring to standup. The weekend supervisor beginning 4/8/23 will pull the No BM report on Saturday and Sunday. The No BM reports 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. Results will be brought to monthly QA meeting 5/3/23. Then monthly x three months.		

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

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OMB NO. 0938-0391

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F 684	Continued From page 64 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)." Review of the facility's policy and procedure titled: "Activities of Daily Living (ADLs)" dated 01/2008 Date Reviewed/Revised: 10/28/21 revealed: The facility will ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable. The staff will provide care on a timely basis to promote and prevent avoidable changes in care. 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 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 ADLs' (Activities of Daily Living) by the end of each shift.	F 684			

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

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F 684	Continued From page 65 Real time charting is required ...17. Immediately report any changes in resident's condition or incidents to the Nursing Supervisor ..." Interview on 03/28/23 at 12:00 PM with the Director of Nursing (DON) (RN#1) and the facility Administrator (ADM) revealed that the facility currently had a resident census of 88 residents and was licensed for 105 resident beds. The Certified Nursing Assistants (CNAs) documented the ADLs' for each resident at the end of each eight (8) hour shift. The DON stated that the nurses work 12 hour shifts and the CNAs work 8 hour shifts. The DON stated that the Activities of Daily Living (ADLs) care sheets were kept in a binder at the nursing stations and that they were accessible to all staff. The ADLs sheets were devised per the individual care plan of each resident. The ADLs sheets were the venue in which the care plans were followed and instituted for each resident. The DON stated that if something was not completed or a resident had issues, the CNAs 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 CNAs charted manually on paper charts and on 03/16/23 the facility installed computers (Kiosk) systems that the CNAs now use to 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 CNAs was supposed to report the lack of BM to the Charge Nurse or to the medication cart nurses. BMs can only be reported once per shift in the digital system. On the manually (paper) system the CNAs documented the number of resident BMs during the shift. The ADM stated that Resident (Res) #1 had been	F 684			

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

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F 684	Continued From page 66 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 (RN#1) revealed that the facility did not have documentation to ensure that Bowel Movement (BM's) the Activities of Daily Living (ADLs) care had been implemented according to the residents care plans. DON stated "We are not going to be able to provide for you what you are looking for". The CNAs did not document the Bowel Movements (BM's) on the ADLs sheets for the residents on each shift. The CNAs had been documenting manually on ADLs sheets for approximately one (1) year due to no computer/kiosk' system available to CNAs. They had been told to manually document the BMs on the ADLs sheets and if there had been no BM for that 8 hour shift they were instructed to tell the med cart nurse. The med cart nurse was supposed to check the resident and decide the appropriate method for the resident's BM per the "Bowel" policy and procedure. The nurses were supposed to document in the progress notes what they did and the results of the method for BMs. The DON stated that the nurses had not appropriately documented the BMs in the residents medical records. DON stated that the ADLs sheets had all been reviewed and an investigation completed by the facility's Quality Assurance (QA) nurses x 2, and there was no documentation of BMs on the ADLs sheets and no documentation that the nurses had been notified of residents' BMs. DON stated that they had no nursing notes and no documentation for Resident (Res) #1 stating that she had BMs prior	F 684			

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

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F 684	Continued From page 67 to her admission to the hospital on 03/02/23. DON said she thought that the med cart nurses were supervising the CNAs more closely, but they had not. DON stated that the "Bowel" policy and procedure had not been followed and the ADLs 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. DON stated the documented information needed for bowel movements on (Res #1) was not in the medical records. Resident #1: Interview with the DON (RN#1) on 03/29/23 at 9:00 AM revealed that (Res #1) had been transferred to the hospital from the facility on 03/02/23 due to vomiting "coffee ground" looking substances (emesis) and for stomach pain. DON stated that Res #1 was diagnosed at the hospital on 03/02/23 with an impaction. The DON stated that on 03/03/23, Res #1 died of aspiration due to vomiting because of the bowel obstruction/bowel impaction. DON stated that the facility had no documentation that Res #1's BMs 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 BMs had been monitored. DON stated that the facility had not followed the care plan for Res #1 and the facility had not followed the policy and procedure for bowel movement programs. The DON stated that she had "assumed" that the med cart nurses had been monitoring and supervising the CNAs. DON stated that she should not have "assumed", but she should have followed up and "supervised" the nursing staff more closely. The	F 684			

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

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F 684	Continued From page 68 DON stated that the QA nurses x 2 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. The DON stated that the Quality Assurance (QA) nurses x 2, did all investigations and the written reports were given to the DON and to the facility (ADM). The DON stated that the facility had CNAs began ADLs, including BMs, documentation in the kiosk on March 16, 2023. DON stated that the CNAs and licensed nurses had failed to document and monitor the input and output of Res #1 which led to her hospital transfer and led to her death from an impaction. Record review of the Care Plan for Res #1 dated 06/08/2022 read: "Constipation I have constipation risk r/t (in reference to) advanced age, impaired mobility, meds does not take laxative/stool softener regularly Risk for constipation/diarrhea. Will have soft formed stool 2-3 x week (2-3 times per week) to next review 3/21/23 Administer meds as ordered Monitor & record frequency and amount of BM Note any problem with consistency or color of BM Encourage 100% fluid intake pm meal tray check bowel sounds prn (as needed) Administer PRN med a/o (as ordered) Monitor for effectiveness of prn offer Prune Juice prn Notify MD if needed. Record review of the facility's "Care Tracker Documentation Record" ADLs care sheets for January 2023 through March 2023 for Res #1 revealed the sheets were not appropriately documented for Res #1's BMs on each eight (8) hour shift. The input and output of Res #1 was not documented in accordance to the facility policies and procedures for each eight (8) hour shift by the CNAs, . From January 24, 2023	F 684			

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

PRINTED: 05/01/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255182	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/31/2023
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F 684	Continued From page 69 through January 31, 2023, Res #1 had no (zero) BM's documented/recorded on the ADLs care sheets. There was no documentation in Res #1's medical record to indicate that the CNAs had notified the licensed nurses that Res #1 had no BMs for eight (8) days. The CNAs had documented/recorded that Res #1 had three (3) BMs during the dates of January 16, 2023 through 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 recorded/documented by the CNAs for Res #1 on the 7:00 AM-3:00 PM shift; and on January 23, 2023 the CNAs documented/recorded that Res #1 had one (1) BM during the 7:00 AM -3:00 PM shift. The record review revealed that the progress notes for January 2023 did not contain any documentation of Res #1's lack of BMs or that the licensed nurses had monitored the BMs of Res #1 or that Res #1 had received treatment and services for the lack of BMs during the month of January 2023. Record review revealed there were four (4) progress notes in January 2023, and there were no progress notes documented/recorded for Res #3 during the month of February 2023. The ADLs care sheet dated February 1, 2023 through February 15, 2023 documented/recorded that Res #1 had no (zero) BMs from February 7, 2023 through February 15, 2023. The ADLs care sheet for Res #1 dated February 16, 2023 through February 28, 2023 documented/recorded that Res #1 had two (2) BMs during this time period one (1) BM recorded/documented during the 3:00 PM-11:00 PM shift on 2/16/23, and one (1) BM on 2/20/23 during the 7:00 AM-3:00 PM shift. Res #1 had no (zero) BMs documented/recorded on	F 684			

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

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F 684	Continued From page 70 the ADLs care sheets from February 21, 2023 through February 28, 2023. The facility documentation that was provided for Res #1's BMs for February 21, 2023 through February 28, 2023, 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. The Medication Administration Record (MAR) did not document that Res #1 received bowel functioning treatment and services for the month of February 2023. The record review of the Nurse Practitioner's (NP) progress note, dated 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 gastroenterology and general surgery. Patient was made NPO 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. She did have a small bowel movement. Patient found to have urinary tract infection and started on antibiotics. 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	F 684			

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

PRINTED: 05/01/2023
FORM APPROVED
OMB NO. 0938-0391

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F 684	Continued From page 71 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 noon with the facility Administrator (ADM) revealed that she had been the facility ADM for 1 year. The ADM stated that she had not received any reports from the QA nurses that the facility was responsible for the impaction of Res #1. The ADM stated that she had been told by the Nurse Practitioner (NP) that the hospital was to blame for Resident #1's death because they did not place an NG tube that was needed. ADM stated that she never knew that the facility had not monitored the BMs of Res #1 and was never was told of the bowel impaction of Res #1. The ADM stated that she was not a "nurse" and that she had been licensed as an ADM for approximately one (1) year. The ADM confirmed she was the one that instituted the new "kiosk" system on 03/16/23. ADM confirmed that she had not reported the incident of Res #1's impaction because she was unaware that the facility had failed to monitor and document. Interview on 03/29/23 at 2:15 PM with the DON (RN#1) revealed the facility knew on 03/03/23, when Res #1 died, that there was a problem with the monitoring of the BMs 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-RN#3) revealed that she had been working at the facility since November 2022. She stated that no one	F 684			

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

PRINTED: 05/01/2023
FORM APPROVED
OMB NO. 0938-0391

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F 684	Continued From page 72 had ever asked her to monitor the ADLs 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. The ADON assessed and found Res #1 with "coffee ground" vomit on her clothing and on the floor. ADON stated that Res #1 was complaining of stomach pain and her stomach was distended. (ADON-RN#3) called 911 and stayed with the resident until the ambulance arrived to transfer 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. The 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). The ADON stated that there were no documented nursing progress notes for the month of February 2023. The ADON stated that she did not know why the nurses had not documented progress notes for a month. The ADON stated that no one had asked her to monitor charts, and she had assumed that the DON was monitoring the ADLs 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(RN#1) to conduct an investigation of the incident involving (Res #1) and they gave a written report to the DON and also to the ADM, then they had an emergency QA meeting with all the committee members present	F 684			

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

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F 684	Continued From page 73 to discuss the findings. They discovered that the CNAs had not documented on the ADLs sheets the BMs of the residents and the nursing staff had not documented what actions they took to monitor the ADLs. The QA nurses stated that the BMs of Res #1 had not been recorded on the ADLs 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. 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 BMs weren't recorded/documented. No one ever told me that was a problem. I trusted what the nurses said". The ADM stated that she had not read the hospital report for Res #1 and that the family of Res #1 was contacted and they did not raise any questions. The ADM stated that the AG's office came to the facility and in-serviced all staff on Abuse/Neglect. The ADM stated that she had called the Attorney General(AG) to come and in-service the staff because it was time for their annual Abuse/Neglect in-service. At 8:20 AM on 03/30/23 Interviews and record reviews completed along with the former Administrator (ADM #2) and the current ADM. They confirmed that the ADLs 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	F 684			

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

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F 684	Continued From page 74 confirmed that the Care Plan had not been followed for ADLs care and Constipation risk, and the facility policy and procedure for bowel programs had not been followed. Interview on 03/30/23 at 10:25 AM, with the ADON-RN#3, revealed 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 BMs 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-RN#3 stated that she would be responsible for monitoring the ADLs' through the week days and would do chart audits on the day shift 8:00 AM-3:00 PM Monday through Friday, and the weekend Charge Nurse would monitor the ADLs sheets on the weekends. The ADON stated that the facility did not have a Staff Development Nurse but was hiring one and she would also monitor charts. Interviewed on 03/30/23 at 11:45 AM with Care Plan/MDS nurses, RN #5 and LPN#2, revealed they both confirmed that the care plans for Res #1 had not been followed and that the facility had a QA meeting immediately after Res #1 died on 03/03/23, and they learned at the QA meeting that Res #1 had died as a result of an impaction. They discussed at the QA meeting on 03/03/23 that the ADLs sheets had not been documented for bowel movements for Res #1 and that the nurses had not written nursing progress notes for Res #1 for over one (1) month. The Care Plan/MDS Nurses confirmed that the facility hired a new staff development nurse on 03/29/23 and she began in-services with all staff on 03/29/23.	F 684			

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

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F 684	Continued From page 75 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. RR stated that (Res #1) had dementia and had some cognitive difficulties. "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 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 but 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. 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 BMs. The CNAs did not	F 684			

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

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FORM APPROVED
OMB NO. 0938-0391

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F 684	Continued From page 76 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 she documented on the MAR when she gave Res #1 meds. 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 CNAs that Res #1 had not had a BM within three (3) days. LPN #3 stated that it was the facility 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 ADLs sheets. She confirmed that she now knows to monitor the ADLs' and bowel movements (BMs) that the CNAs document in the kiosk. LPN #3 stated that the facility had been using the kiosk since the middle of March. The nursing progress notes had not been documented for Resident #1 for the month of February 2023; and The medical record of Res #1 contained no monitoring of her BMs by the licensed nursing staff. As a result of neglecting to accurately and appropriately document/record the BMs of the resident led to Res #1 having untreated constipation with 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.	F 684			

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

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F 684	Continued From page 77 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 Plan dated 04/06/2020 revealed: I am incontinent of bowel and bladder, I have a history of UTI' and E-coli. This is r/t (in reference to) my limited mobility with transfers and toileting and my decreased cognition. Please monitor me for s/s (signs and symptoms) of UTI. Provide me incontinence pads Assess me for symptoms of urinary tract infection. Provide me with good pericare after each incontinent episode Observe me for acute behavioral changes that may indicate UTI Evaluate my fluid intake and hydration status Notify my MD as needed. There was no Care Plan submitted by the facility that outlined the "bowel functioning" of Res #2. Record review of Res #2 revealed a face sheet with an admission date of 03/30/2020 and diagnoses of Hemiplegia following cerebral infraction affecting right dominant side; Dysphagia; Speech and language deficits; Contracture of muscle, right hand; dementia; Anxiety disorder; Anorexia; among other diagnoses. Record review revealed a Minimum Data Set (MDS) dated 02/14/2023 that contained a Brief Interview of Mental Status (BIMS) score of 3 which indicated that Res #2 was severely cognitively impaired. Record review of Res #2's ADLs sheet, dated January 16, 2023 through January 31, 2023, revealed documentation under the "Bowel	F 684			

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

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NAME OF PROVIDER OR SUPPLIER LAKEVIEW NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 16411 ROBINSON ROAD GULFPORT, MS 39503		
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F 684	Continued From page 78 Function" section as follows Res #2 had no BM's recorded for five (5) consecutive days for January 20, 2023 through January 24, 2023. Res #2 had no BM's recorded/documented on the ADLs sheets for three (3) consecutive days from 2/5/23-2/7/23; and Res #2 had no BM's recorded on the ADLs sheets for five (5) consecutive days of 2/10/23-2/14/23. Res #2 had no progress notes documented/recorded 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 ADLs care and services for January 2023-March 2023. Interview on 03/29/23 at 12:35 PM with CNA#1 revealed that she was the CNA for Res #2 on 03/29/23. CNA#1 stated that Res #2 was wearing briefs and was incontinent of bowel and bladder. 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 CNAs were to report that to the med cart nurse. Resident #3: Observation on 03/29/23 at 12:20 PM revealed that Res #3, was small and frail and was lying in fetal position on her right side. Res #3 was not interviewable. 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	F 684			

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

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F 684	Continued From page 79 Res #3 was severely cognitively impaired. Res #3 had a face sheet that contained an admission date of 10/18/2022 and diagnoses of Heart Failure; Hemiplegia following cerebral infarct affecting right dominant side; Vascular Dementia; Hypertension; Depression; Constipation, unspecified; Senile degeneration of the brain; among other diagnoses. 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 ADLs' 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. The ADLs sheets for January and February 2023 for Res #3 were not documented by the CNAs for every eight (8) hour shift seven (7) days per week. Record review of Res #3 revealed a Care Plan dated 10/24/2022 that read: At constipation risk r/t (in reference to) advanced age, impaired mobility, meds. Will have soft formed stool 2-3 x week (2-3 times per week) to next review 6/02/23. Observe & record frequency and amount of BM, Note any problem with consistency or color of BM, Encourage 100% fluid intake on meal tray, check bowel sounds prn, Observe for effectiveness of prn, Offer Prune Juice prn, Notify MD if needed, Administer meds as ordered (See MAR). Interview on 03/29/23 at 1:00 PM with CNA #2 she stated that she had been working at the facility as a CNA since January 24, 2023. She	F 684			

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

PRINTED: 05/01/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255182	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/31/2023
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F 684	Continued From page 80 stated that when she completed a shift she documented in the kiosk at the end of each eight (8) hour shift the ADLs and the BMs. CNA #2 stated that she was assigned to work with Res #3 on 03/29/23 on the first (1st) shift. 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. CNA#2 stated that she documented on the ADLs sheets prior to 03/16/23. CNA#2 stated that they documented on the ADLs sheets the BMs for residents on every shift. CNA #2 did not remember Res #1. 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. Res #4 stated that the facility staff had been talking about the lady that "died from an impaction" for weeks. Res #4 stated the DON nor the ADM ever walk around and look, and they never go in and out of the residents rooms. Res #4 stated "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 myself, I bath myself and do most all things for myself. I am aware that a person died from a bowel obstruction." 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 juice of any type. Res #4 stated that she had never been offered a stool	F 684			

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

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F 684	Continued From page 81 softener or a laxative. Res #4 stated that she had more issues with loose stools rather than with constipation. 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. Interview on 03/29/23 at 1:40 PM with CNA #3 revealed that she had worked the third shift 11:00 PM -7:00 AM since 2018 prior to today and yesterday. She stated that the third shift checked the residents every 2 hours and changed those that needed changing. She stated that if a resident did not have a BM during the 8 hour shift the CNAs reported it to the med nurse. CNA #3 stated that they report the BMs on the ADLs sheets in the kiosk since 03/16/23 and before that they wrote the BMs on the ADLs sheets every 8 hour shift. CNA #3 stated that they manually recorded the BMs on the ADLs sheets for over a year because the kiosk were broken. Record review of Res #4's Care Plan dated 10/21/2021 revealed: Constipation has constipation risk r/t (in reference to) diverticulitis of the intestines, side effects of antipsychotic and antidepressant medications. Will have soft formed stool 2-3 x week (2-3 times per week) to next review 4/02/23. Administer meds as ordered, Record any problems with color or consistency of BM, Notify MD as needed, Encourage 100% fluid intake on meal tray, Check bowel sounds prn (as needed) , Encourage fluid intake, Offer Prune juice prn, Observe and record frequency and amount of BM, Observe for effectiveness of prn. Record review of Res #4's Minimum Data Set	F 684			

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

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FORM APPROVED
OMB NO. 0938-0391

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F 684	Continued From page 82 (MDS) dated 01/03/23 contained a Brief Interview of Mental Status (BIMS) score of 14 which indicated that Res #4 was cognitively intact. Res #4 had a facesheet that revealed an admission date of 10/21/21 and diagnoses of Bipolar Disorder with mild depression; Chronic Obstructive pulmonary disease; Insomnia; Gastro-esophageal 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 ADLs or bowel functioning. Res #4 had no progress notes documented for March 2023. Res #4's bowel functioning was not addressed by the staff for January 2023 through March 2023. Resident #5: 03/30/23 at 9:55 AM Interview and Observation with Res #5 revealed she was lying in bed. Res #5 had a flat affect and she presented as sad and slightly depressed. She did answer questions asked of her. She was lying supine in her bed wearing a night gown. She stated that she wears briefs and has been incontinent of bowel and bladder. She stated that she had been living in the facility for approximately five (5) years. Res #5 stated that she has to have the assistance of staff for all her ADLs. Res #5 stated that the CNAs 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	F 684			

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

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FORM APPROVED
OMB NO. 0938-0391

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F 684	Continued From page 83 #5 stated that she had to have total assistance for all her ADLs'. Record review for Res #5 revealed that she had a face sheet that documented her original admission date as 10/28/16 and a re-admission date of 1/13/2017. Res #5 had diagnoses of Acute heart disease of native coronary artery; Acute systolic (congestive) heart failure; Gout; Weakness; History of falling; Major depression disorder; Contracture of left hand; among other diagnoses. Res #5 had a Minimum Data Set (MDS) dated 03/20/2023 that contained a Brief Interview of Mental Status (BIMS) score of 14 which indicated that she was cognitively intact. Record review of the February 2023 bowel function ADLs sheet recorded/documented that Res #5 had no bowel movements (BM's) for the first three (3) days of February (February 1-3, 2023). Res #5 had no bowel movements (BM's) documented/recorded on the ADLs 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 CNAs had notified the licensed nurses (med cart nurse) about the bowel function of Res #5. The January 16, 2023 - January 31 bowel function ADLs sheet had Res #5 documented/recorded as having no bowel movements from January 18, 2023-January 20, 2023 (three (3) consecutive days with no bowel movement). The ADLs sheet had no BM's documented/recorded for Res #5 from January 22, 2023-January 24, 2023 (three (3) consecutive days with no bowel movement). There was no documentation in Res #5's medical record to indicate that the CNAs had notified the cart nurse	F 684			

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

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FORM APPROVED
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F 684	Continued From page 84 of no BM's for 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 2023 through March 2023. Record review of Res #5's Care Plan dated 01/04/2028 revealed: Constipation I am at risk for constipation related to diuretic use, impaired mobility, medication side effects, opiate use. Will have soft formed stool 2-3 x week (2-3 times per week) by 7/03/23. Note any problem with consistency or color of BM, Encourage 100% fluid intake on meal tray, Check bowel sounds prn, Offer Prune juice prn (as needed) Administer my medication as per MD orders, Observe & record frequency and amount of BM. Record review of the ADLs sheets for (5) of (5) sampled residents revealed that the BM's had not been documented/recorded per facility policy on the ADLs sheets by the CNAs and there was no MAR documentation/recording of the BMs as per the facility policies and procedures. Five (5) of five (5) residents nursing progress notes contained no information of ADLs and/or BM functioning as outlined in the facility's policies and procedures for documenting BM functioning. 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: On 03/02/2023, Resident #1 began vomiting	F 684			

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

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FORM APPROVED
OMB NO. 0938-0391

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F 684	Continued From page 85 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 (CNAs) 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 temple 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 (CNAs) 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 that worked were in-serviced by Director of	F 684			

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

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F 684	Continued From page 86 Nursing, RN#1, QA nurse RN#2 and Licensed Practical Nurse (LPN#1), in reference to checking the completion of documentation by the CNAs 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. CNAs 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.	F 684			

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

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F 684	Continued From page 87 CNAs 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.	F 684			

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

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F 684	Continued From page 88 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) CNAs 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) RNs and five (5) LPNs confirmed that they had been in-serviced to supervise the CNAs documentation and to check the kiosk documentation after the CNAs had documented. On 03/31/23 the SA confirmed through interviews that the CNAs (CNA#1, #2, #3, #4, #5, #6, #7, and CNA#8) that they had begun digital documentation of the residents ADLs' 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	F 684			

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

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F 684	Continued From page 89 movement" protocol. All interviewed licensed nurses confirmed that they would contact the NP or the MD if the no bowel movement protocol did not produce BM results. The SA confirmed through interviews and record reviews with six (6) Registered Nurses (RNs), eight (8) CNAs, five (5) LPNs, 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 CNAs to the new kiosk system rather than the paper documentation. The x 2 QA nurses confirmed through interview that a new Staff Development	F 684			

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

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F 684	Continued From page 90 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 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) CNAs; six (6) RN's; five (5) LPN's; one (1) Activities Director; one (1) facility ADM; and one (1) DON.	F 684			
F 835 SS=L	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, observations, job description reviews, interviews, and policy and procedure reviews, the facility administration failed to identify the staff's failure to monitor residents bowel movements and provide treatment and services to prevent avoidable changes in residents medical conditions as	F 835	*Administrator (ADM) reported alleged violation of neglect to State Agency (SA) on 3/31/23 at 0500. Corporate Administrator (CADM) in-serviced the ADM on 3/31/2023 on sentinel events and what questions to ask staff regarding health and well being of residents.	5/9/23	

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

PRINTED: 05/01/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255182	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/31/2023
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F 835	Continued From page 91 evidenced by the lack of documentation or the inaccurate documentation of five (5) of five (5) sampled residents bowel movement regimens. Resident (Res) #1, #2, #3, #4 and #5. This failure had the potential to affect all residents. The facility's failure to provide administrative oversight and supervision to prevent Res #1's 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, and in a situation likely to cause serious injury, serious impairment, serious harm or 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 on 03/30/23 at 1:30 PM the SA provided IJ template for F835 to the facility. 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 and 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 483.70 (a) (1) Administration (F835) was lowered from an "L" to a "F", while the facility developed a plan of correction to monitor the	F 835	**All residents have the potential to be affected by this same deficient practice. ***Administrator is checking daily reports beginning 4/4/23 in software system to monitor No Bowel Movement (BM) report, instances of pain, as needed medications, wound report and incident reports. ****ADM and CADM will meet weekly beginning 4/4/23 for three months to discuss report findings and how ADM responded to the findings. CADM will attend Quality Assurance (QA) meetings beginning 5/3/23 for three months.		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 835	Continued From page 92 effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include: Record review of the facility's policy and procedure titled "Reporting Alleged Violations" with a revision date of 12/26/2019 revealed, "Policy: The purpose of this policy is to ensure that all alleged violations involving ... neglect ...are reported immediately to the administrator of the facility and to other state officials in accordance with State Law through established procedures (including to the State survey and certification agency) ...Compliance Guidelines:.. 2. If the alleged violation involves abuse or results in serious bodily injury it must be reported immediately but no later than 2 hours after the allegation is made ... Neglect: Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness ..." 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 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	F 835			

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

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F 835	Continued From page 93 "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 a written statement dated March 31,2023 and signed by the Administrator revealed "I, _____(Proper name of Administrator) have not been issued a job description as Administrator at (Proper name of facility)." Record review of the "Job Description" for the Director of Nursing, undated and unsigned revealed the facility job description titled "Director of Nursing" undated and unsigned revealed "Job Summary: Administer all areas in the Nursing Department. This includes patient care, personnel management, and material management. Ensure that license requirements are met. Responsible for: 1. Staff education and performance 2. Staff supervision 3. Setting the standard for patient care. 4. Compliance with	F 835			

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

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F 835	Continued From page 94 state and federal regulations to include ... Care Plans, and patient records ...". Interviews on 03/28/23 at 12:00 PM, with the Director of Nursing (DON) and the facility Administrator (ADM) revealed that the facility currently had a resident census of 88 residents and was licensed for 105 resident beds. The DON stated that the "Care Tracker Documentation Record" 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 ADL sheets were developed 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 CNAs 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 stated that the nurses work 12 hour shifts and the CNAs work 8 hour shifts. The DON revealed that for over a year the CNAs charted manually on paper charts. If a resident does not have a bowel movement (BM) during that shift the CNAs report that to the Charge Nurse or to the medication cart nurses. On the ADL sheets, the CNAs could record the number of BM's during the shift, that the resident had. DON stated that she had not reported any incidents of Neglect/Abuse to the State and that the ADM was responsible for all reporting to the State. The ADM stated that Resident #1 (Res) had been sent out to the	F 835			

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

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F 835	Continued From page 95 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. ADM stated that she had not reported any Neglect/Abuse to the State Agency (SA) in the past three months (Jan-March 2023). In an interview on 03/28/2023 at 3:30 PM with the DON, she stated 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 CNAs did not document the Bowel Movements (BM's) on the ADL sheets for the residents on each shift. The CNAs have been documenting manually on ADL sheets for approximately one (1) year due to no computer/kiosk' system available to CNAs. 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. She stated that the nurses had not appropriately documented the BM's in the residents medical records. The DON stated that the ADL sheets had all been reviewed and an investigation completed by the Quality Assurance (QA) nurses and there was no documentation of BM's on the ADL sheets and no documentation that the nurses had been notified of no BM's for the residents. DON stated that they had no nursing notes and no	F 835			

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

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F 835	Continued From page 96 documentation for Res #1 that she had BM's prior to her admission to the hospital on 03/02/23. DON thought that the med cart nurses were supervising the CNAs more closely, but they had not. 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. During an interview at 9:30 AM on 03/31/23, the ADM stated that the cooperate office did not have a job description for her as Administrator and she was unable to provide the responsibilities of the ADM. ADM documented on facility letterhead a statement that she was unable to provide a job description for the facility Administrator (ADM). Resident #1: Record review of the Nurse Practitioner's (NP) progress note date 3/3/2023 at 2:39 PM revealed: Acute Visit 03/02/2023 "Chief 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	F 835			

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

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F 835	Continued From page 97 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. In an 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. 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. 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. DON stated that the facility had not followed the care plan for Res #1 and the facility had not followed the policy and procedure for bowel movement programs. The	F 835			

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

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F 835	Continued From page 98 DON stated that she felt responsible because she had "assumed" that the med cart nurses had been monitoring and supervising the CNAs. DON stated that she should not have "assumed" she should have followed up and she should have "supervised" the nursing staff more closely. DON stated that the Cans 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. The DON confirmed that the CNAs' and the licensed nurses had not been adequately supervised and their documentation monitored for implementing the plan of care for each resident. 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 CNAs, in accordance to the facility policies and procedures. From January 24, 2023-January 31, 2023 Res #1 had no (zero) BM's documented 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 CNAs had notified the licensed nurses that Res #1 had no BM's for eight (8) days. The CNAs 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 recorded on the 7:00 AM-3:00 PM shift; and on January 23, 2023 the CNAs documented (1) BM during the 7:00 AM -3:00 PM shift. The record review	F 835			

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

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F 835	Continued From page 99 revealed that the progress notes for January 2023 did not contain any documentation that spoke to Res #1's lack of BM's, 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 the month of January 2023. The ADL care sheet dated February 1, 2023-February 15, 2023 documented/recorded that Res #1 had no (zero) BM's from February 7, 2023-February 15, 2023. The ADL care sheet for Res #1 dated February 16, 2023-February 28, 2023 documented/recorded that Res #1 had two (2) BM's during this time period (one (1) BM recorded/documented during the 3:00 PM-11:00 PM shift on 2/16/23, and one (1) BM on 2/20/23 during the 7:00 AM-3:00 PM shift). Res #1 had no (zero) BM's documented/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) did not document that Res #1 received bowel functioning treatment and services for the month of February 2023. In an interview on 03/29/23 at 12:00 PM, with the facility Administrator (ADM) revealed that she had been licensed and the facility ADM for 1 year. She stated 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. The ADM stated that she was not a "nurse" and that she was still learning the ropes. ADM confirmed that she had not reported the incident of Res #1's	F 835			

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

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F 835	Continued From page 100 impaction because she was unaware that the facility had failed to monitor and document the BM's. ADM stated that she was unaware that the lack of documentation of bowel movements was neglect. In an 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-RN#3) revealed that she had been working at the facility since November 2022. She stated that no one had ever asked her to monitor the ADL sheets or the charting of nursing staff. 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 PRNs (as needed medications). ADON stated that there were no documented nursing progress notes for the month of February 2023 and that this was not a standard of practice. The ADON stated that she did not know why the nurses had not documented progress notes for a month. She stated that no one had asked her to monitor charts. The 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	F 835			

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

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F 835	Continued From page 101 investigation of the incident involving (Res #1) and they gave a written report to the DON and she gave it to the ADM. They discovered that the CNAs had not documented on the "Care Tracker Documentation Record" ADL sheets the BM's of the residents and the nursing staff 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. In an 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 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. ADM stated that the family of Res #1 was contacted and they did not raise any questions. ADM stated that this past Monday and last Friday the Attorney General's office came to the facility and in-serviced all staff on Abuse/Neglect. ADM stated that she had called the Attorney General(AG) to come and in-service the staff because it was time for their annual Abuse/Neglect in-service. ADM stated that she did not ask them to come do the in-service as a result of any incidents at the facility. At 8:20 AM on 03/30/23, interviews and record reviews were completed along with the former	F 835			

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

PRINTED: 05/01/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255182	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/31/2023
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F 835	Continued From page 102 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 that the Care Plan had not been followed for ADL care and Constipation risk and 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. Resident #2: Record review of Res #2's "Care Tracker Documentation Record" ADL sheet dated January 16-31, 2023 revealed many days of missing documentation under the "Bowel Function" section. 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 had no BM's recorded/documented on the ADL sheets for three (3) consecutive days from 2/5/23-2/7/2, and no BM's recorded on the ADL sheets for five (5) consecutive days of 2/10/23-2/14/23. No progress notes were documented for Res #2 pertaining to her ADL care and services for January 2023-March 2023. Record review of Res #2 revealed a Face Sheet with an admission date of 03/30/2020 and diagnoses of Hemiplegia following cerebral	F 835			

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

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F 835	Continued From page 103 infraction affecting right dominant side, Dysphagia, and dementia, among other diagnoses. Record review revealed a Minimum Data Set (MDS) dated 02/14/2023 that contained a Brief Interview for Mental Status (BIMS) score of 3 which indicated that Res #2 was severely cognitively impaired. Resident #3: Record review of the "Care Tracker Documentation Record" ADL sheets for January and February 2023 for Res #3 were not documented by the CNAs' for every eight (8) hour shift seven (7) days per week as outlined in the CNAs' Job Description. Record review revealed Res #3 had no nursing progress notes written/recorded during the month of February 2023 addressing the constipation risk. Record review of Res #3 revealed that she had a MDS dated 02/17/2023 that contained a 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 of Heart Failure; Hemiplegia following cerebral infract affecting right dominant side; Constipation, unspecified; Senile degeneration of the brain; among other diagnoses. Resident #4: Interview and Observation on 03/29/23 at 1:10	F 835			

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

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FORM APPROVED
OMB NO. 0938-0391

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F 835	Continued From page 104 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. 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. No one had talked to her about her bowel movements. Record review of Res #4's "Care Tracker Documentation Record" revealed bowel functioning was not addressed by the staff for January 2023 - March 2023. Record review of Res #4's MDS dated 01/03/23 contained a BIMS score of 14 which indicated that Res #4 was cognitively intact. Record review revealed Res #4 had a Face Sheet with an admission date of 10/21/21 and diagnoses of Chronic Obstructive pulmonary disease; and Gastro-esophageal reflux disease; among other diagnoses. Resident #5: In an interview and observation on 03/30/23 at 9:55 AM, with Res #5 revealed 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 CNAs' change her briefs for her on a regular basis. Record review of the January 16, 2023 - January 31 "Care Tracker Documentation Record" bowel function ADL sheet had Res #5 documented/recorded as having no bowel	F 835			

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

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F 835	Continued From page 105 movements from January 18, 2023-January 20, 2023 (three (3) consecutive days with no bowel movement). The ADL sheet had no BM's documented for Res #5 from January 22, 2023-January 24, 2023 (three (3) consecutive days with no bowel movement). There was no documentation in Res #5's medical record to indicate that the CNAs' had notified the med cart nurse of no BM's for Res #5. Record review of the February 2023 "Care Tracker Documentation Record" bowel function ADL sheet recorded/documented that Res #5 had no bowel movements (BM's) for the first three (3) days of February (February 1-3, 2023). Res #5 had no bowel movements (BM's) documented/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 CNAs' 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 med cart nurses had been monitoring the BM's of Res #5 during the months of January-March 2023. Record review for Res #5 revealed that she had a Face Sheet revealed a re-admission date of 1/13/2017. Res #5 had diagnoses of Acute heart disease of native coronary artery; Acute systolic (congestive) heart failure; History of falling; among other diagnoses. Record review revealed Res #5's MDS dated 03/20/2023 contained a BIMS score of 14 which indicated that she was cognitively intact. Summary:	F 835			

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

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F 835	Continued From page 106 Record review of the ADL sheets for (5) of (5) sampled residents revealed that the BM's had not been appropriately documented/recorded on the ADL sheets by the CNAs' 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 with 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 CNAs' 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	F 835			

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

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F 835	Continued From page 107 actions to remove the IJ: Removal Plan: 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 (CNAs') were documenting bowel movements inaccurately on the paper records. No one was assigned to check the CNAs 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 (CNAs') 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	F 835			

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

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F 835	Continued From page 108 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 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 CNAs' 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. CNAs' 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 CNAs 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	F 835			

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

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F 835	Continued From page 109 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. CNAs' 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 CNAs 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.	F 835			

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

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F 835	Continued From page 110 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. 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) CNAs' 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 CNAs' documentation and to check the kiosk documentation after the CNAs' had documented.	F 835			

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

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F 835	Continued From page 111 On 03/31/23 the SA confirmed through interviews that the CNAs' (CNAs#1, #2, #3, #4, #5, #6, #7, and CNAs#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 not produce BM results. The SA confirmed through interviews and record reviews with six (6) Registered Nurses (RN's), eight (8) CNAs', 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	F 835			

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

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F 835	Continued From page 112 to discuss the bowel program and the documentation of BM's and that there would be changes in the documentation by the CNAs' 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 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) CNAs'; six (6) RN's; five (5) LPN's; one (1) Activities Director; one (1) facility ADM; and one (1) DON.	F 835			