STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195324	A. Building B. Wing	03/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fair City Health and Rehab	2000 Main Street Franklinton, LA 70438

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44590 Based on interviews and record review, the facility failed to develop and implement a comprehensive person-centered care plan for 1 (#3) of 9 (#1, #2, #3, #4, #5, R#3, R#5, #10, and R#11) sampled residents reviewed. This was evidenced by the facility failing to ensure: 1. Resident #3's comprehensive person-centered care plan was accurately individualized and updated to reflect his bowel and skin status; 2. Resident #3's care plan was implemented to meet his nursing needs through on-going monitoring of bowel movements to prevent constipation, the administration of PRN bowel medications per physician orders and notification of change in status to the resident's physician. Cross Reference: F684, F835 Findings: A review of Resident #3's clinical record revealed he was admitted on [DATE] with diagnoses including, in part, the following: Quadriplegia, Unspecified Injury at the Level of the Cervical Spinal Cord, Constipation, Non-infective Gastroenteritis and Colitis, Neurogenic Bowel, Chronic Urinary Tract Infection, Neurogenic Bladder, Chronic Foley Catheter, Multiple Pressure Ulcers, Depression, Suicidal ideations, and Contractures. A review of Resident #3's most recent quarterly MDS with an ARD of 01/13/2022 revealed a BIMS of 15, indicating the resident was cognitively intact. Further review indicated he required total assistance from a minimum of two staff members for all areas of care; bed mobility, transfers, dressing, toileting, and personal hygiene. A review of Resident #3's Care Plan included in part, the following: Problem: Bowel Incontinence r/t Paraplegia/Neurogenic Bowel. Goal: The resident will have less episodes of incontinence through the review date. Interventions: (continued on next page)

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe pattern of incontinence and initiate toileting schedule if indicated. Provide bedpan. Administer medications per MD order, observe for effectiveness, check resident every two hours as needed and assist with toileting, observe for constipation and administer medication as per MD order. Further review of Resident #3's current care plan revealed no care plan related to his PEG tube removal site. A review of Resident #3's Patient Rounding Notes from a local hospital during the 01/03/2022 through 01/06/2022 hospitalization , revealed, in part, the following: 01/05/2022 at 21:10 p.m., Resident #3's brief changed following bowel movement. Barrier cream placed around previous peg tub site due to redness and drainage with gauze placed over barrier cream to absorb small amounts of drainage. A review of Resident #3's Hospital Records revealed he was admitted to the hospital with diagnoses including Colitis, Constipation and Fecal Impaction on 01/03/2022 through 01/06/2022 and again 01/14/2022 through 01/21/2022. A review of Resident #3's Bowel and Bladder Report revealed he did not have a bowel movement on the following dates: 12/23/2021, 12/24/2021, 12/25/2021, 12/26/2021, 12/27/2021, 12/29/2021, 12/30/2021, 01/31/2022, 01/01/2022, 01/02/2022, 01/03/2022, 01/09/2022, 01/10/2022, 01/11/2022, 01/12/2022, 01/13/2022. 1. In an interview on 03/03/2022 at 1:35 p.m., Resident #3 confirmed he could not feel when he had a bowel movement nor could he feel if he was constipated and the only way he would know was if he became sick. He stated he thought staff were monitoring his bowel movements because it was one of the reasons he had been admitted to the facility. He stated if he knew the staff were not monitoring his bowel movements, he would have tried to keep up with how often he was having them so he would not get sick again. He stated when he was sent to theER on [DATE], he had not had a bowel movement in about two weeks. He also said the last time he was impacted was on 01/14/2022 when he had to be sent by helicopter to another hospital and the experience was not good. He stated it really took a toll on me. In an interview on 03/08/2022 at 4:13 p.m., S7LPN stated she initiated Resident #3's care plan on 12/01/2021 with no updates made to the bowel section since that time. She confirmed Resident #3 was a quadriplegic. After reviewing Resident #3's care plan, she confirmed he was not capable of achieving the identified goal of having less episodes of incontinence nor was he capable of utilizing all of the identified interventions. She stated the following interventions were not appropriate for a quadriplegic resident with neurogenic bowel: to have a toileting schedule initiated because he was not capable of utilizing a toilet or to utilize a bedpan because he was not capable of knowing in advance or controlling the timing of his bowel movements. She confirmed Resident #3's care plan was not accurately individualized and updated to reflect his bowel and skin status or PEG tube site issues. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/08/2022 at 2:30 p.m., S3DON, S2RDCS and S1ED, the deficient findings regarding Resident #3's Care Plan were reviewed and verified by S3DON. In addition, S3DON also confirmed they had been unaware there was an issue with Resident #3 having an outdated care plan that was not updated following status changes, onset of new issues, hospitalization s, etc. S3DON confirmed they had been unaware Resident #3's care plan was not accurately individualized to meet his specific needs. S3DON confirmed she would have expected Resident #3's care plan to be updated and individualized to better meet his needs. S3DON further reviewed Resident #3's care plan, and verified he was not care planned for care regarding his PEG tube site. S3DON confirmed Resident #3 should have been care planned for PEG tube site care. Upon completion of the interview, S2RDCS and S1ED verbalized agreement with the information provided by S3DON and denied having any additional information to add. 2. In an interview on 03/02/2022 at 11:40 a.m., S5MD verified he was not aware of an old PEG tube site that had opened and was draining. He said when Resident #3 returned from the hospital with no wound care orders, he would expect the nurse to call and let him know about the drainage and to obtain wound care orders. S5MD confirmed he was not informed Resident #3 went extended periods between bowel movements and that this issue had occurred on numerous occasions over the past several months. He also confirmed he was not made aware following each of Resident #3's hospitalization s that he had been diagnosed and treated for bowel related issues including colitis, constipation and fecal impaction. In an interview on 03/02/2022 at 4:03 p.m., S6LPN verified no resident should go two weeks without having a bowel movement and not receive a PRN medication. S6LPN confirmed the doctor should be informed when a resident does not have a bowel movement in three or more days. In an interview on 03/04/2022 at 1:45 p.m., S14CNA and S15CNA, both confirmed they could not recall receiving education on monitoring Resident #3's bowel status. S14CNA and S15CNA both confirmed the dashboard in the charting system alerted when a resident had been three days without a bowel movement. S14CNA and S15CNA both confirmed staff frequently forget to document and/or forget to monitor dashboard alerts. S14CNA and S15CNA both stated Resident #3 is with it and able to talk so they felt he would tell them if he were constipated when they asked about the dates on their dashboard alerts. S14CNA and S15CNA both stated they did not recall specifics of when he was over the three day mark but they do recall seeing his name a good bit, sometimes it was accurate, other times it was not up to date. also stated Resident #3 frequently left the faciity on an overnight pass with his mother. S14CNA and S15CNA both said they did not recall ever having asked him about any bowel movements upon his return in order to update his chart and confirmed they had never been trained to do so. In an interview on 03/04/2022 at 1:58 p.m., S16CNA stated she recalled Resident #3 being constipated and was admitted to the hospital on several occasions. She stated no one really used or monitored the dashboard alerts to determine the residents without a bowel movement in 3 days and confirmed she would not know to ask anyone about their last bowel movement otherwise. She stated they document the bowel movements they cleaned up or were made aware of on their shift but did not verbally inform the nurse when a resident had a bowel movement because they can look it up in the computer. She denied she received training or instruction to monitor Resident #3's bowel status. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/04/2022 at 2:13 p.m., S10LPN stated she relied on Resident #3 to let her know if he was constipated. She confirmed Resident #3 was quadriplegic and unaware when he was constipated or if he even had a bowel movement. She stated she was never trained to monitor dashboard alerts for the resident's bowel movements. In an interview on 03/04/2022 at 3:30 p.m., with S3DON, with S4ADON and S6LPN in attendance. S3DON stated she would expect nurses and CNA's to monitor their dashboard at the start and end of every shift to determine if bowel movement alerts were present. S3DON confirmed she would expect a physician to be notified any time medications are administered and/or interventions implemented that did not work as intended. S3DON confirmed immediately upon Resident #3's return to the facility following each hospitalization , she would expect S5MD to have been notified of all diagnoses that required treatment while in-patient; including colitis, constipation and fecal impaction. S3DON also confirmed she would expect staff to have kept S5MD informed each time Resident #3 went longer than 3 days without a bowel movement. S3DON also confirmed she would expect staff to have addressed and confirmed S5MD was aware of Resident #3's frequent lack of regular bowel movements during his weekly rounds. Upon completion of the interview, S4ADON and S6LPN verbalized agreement with the information provided by S3DON and denied having any additional information to add. In an interview on 03/08/2022 at 1:35 p.m., S7LPN stated she has been employed by the facility for two years and was never trained or instructed to monitor the dashboard for alerts of overdue bowel movements. In an interview on 03/08/2022 at 2:30 p.m., all deficient findings related to Resident #3 were reviewed and verified by S3DON with S2RCDS and S1ED present. S3DON confirmed Resident #3 was cognitively intact, but due to his diagnoses was incapable of knowing if he had a bowel movement or was constipated. S3DON reviewed and confirmed the information in Resident #3's Bowel and Bladder Report and confirmed she had been unaware Resident #3 was going three days or more without a bowel movement and not receiving his PRN bowel medications as they were ordered. S3DON also confirmed S5MD was not notified of Resident #3's on-going lack of regular bowel movements. S3DON confirmed she would have expected better monitoring of the three-day window for bowel movements to ensure Resident #3's PRN bowel medications were given as ordered with updates provided to the physician. S3DON also confirmed because of Resident #3's diagnoses, she would have expected nursing staff to closely monitor his bowel movements and not rely on him to inform them when he became constipated. Upon completion of the interview, S2RDCS and S1ED verbalized agreement with the information provided by S3DON and denied having any additional information to add.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41289 44590 Based on interviews and record reviews, the facility failed to provide appropriate treatment and services for a resident with fecal incontinence in accordance with professional standards of practice. The facility failed to ensure: 1. Nursing staff assessed, monitored, implemented ordered interventions and communicated bowel status with the physician for 1 (#3) of 9 (#1, #2, #3, #4, #5, R3, R5, R10, and R11) residents reviewed; and 2. Nursing staff reviewed, clarified, and transcribed hospital discharge orders for 1 (#3) of 9 (#1, #2, #3, #4, #5, R3, R5, R10, and R11) residents. This deficient practice resulted in an immediate jeopardy situation for Resident #3, a quadriplegic with neurogenic bowel and constipation, on 12/26/2021 when the nursing staff failed to recognize the resident did not have a bowel movement over 3 days and administer PRN Milk of Magnesia or other bowel medications per physicians orders. From 12/23/2021 through 01/03/2021, Resident #3 did not have a bowel movement or receive PRN bowel medications. This resulted in Resident #3 being transferred to the local hospital with a diagnosis of Colitis, Constipation and Fecal Impaction. Following the hospitalization , the facility failed to implement the hospital discharge recommendations provided by the GI Specialist for increased fiber, fluid needs and intake/output monitoring. From 01/09/2022 through 01/14/2022, Resident #3 did not have a bowel movement or receive PRN bowel medications, which resulted in him again being transferred to the hospital with diagnosis of Colitis, Recurrent Constipation, Recurrent UTI with Septic Shock secondary to Proteus E. Faecalis Infection. Resident #3 was transferred from the local hospital via helicopter to another hospital on 01/14/2022 to receive a higher level of care due to the deterioration of his condition. S1ED was notified of the Immediate Jeopardy on 03/04/2022 at 6:15 p.m. The Immediate Jeopardy was removed on 03/08/2022 at 4:51 p.m., when the facility submitted an acceptable Plan of Removal. Through observations, interviews and record reviews, the surveyors confirmed the following had been initiated and/or implemented prior to exit: Immediate Action Taken: 1. Administrative staff worked in shifts in the building 24/7 throughout the weekend continuing audits, providing education, etc. 2. Completed 100% audit of resident bowel status and continued to monitor throughout the weekend 3. Completed 100% audit of physician orders for PRN bowel medications and continued to monitor throughout the weekend (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4. Administrative nursing audited to ensure all staff have access to the kiosk to complete documentation monitoring throughout the weekend Resident Specific Action: 1. 03/04/2022 at 6:00 p.m.: Resident #3's current medications were reviewed with physician by the Director of Nursing (DON) to ensure staff can provide services needed to prevent impaction. No new orders were noted. 2. 03/04/2022 at 6:00 p.m.: Resident #3's current bowel movement documentation was reviewed by the Regional Director of Clinical Services. (Regional Director of Clinical Services (RDCS) reviewed Resident # 3's bowel movement documentation and noted resident had a bowel movement documented on 03/02/2022 and 03/04/2022.) 3. 03/04/2022: DON verified Resident #3's gastrointestinal specialist appointment on 03/17/2022 at 9:00 a.m. QAPI: 1. On 03/04/2022 at 6:15 p.m., the Quality Assurance Performance Improvement (QAPI) Committee met to review the F684 Quality of care IJ template and conduct a Root Cause Analysis (RCA) and review policy and procedures for changes. Attendees were the Executive Director (ED) , Director of Nursing (DON), Social Services Director (SSD) , Housekeeping Supervisor (HKS) , RDCS , Activities Director (AD) , Director of Therapy (DOR) , ADON , SDN , MDS nurse , Business Office Manager (BOM) ,Human Resources Director (HRD) , Assistant Business Office Manager (ABOM). The Medical Director (MD) was notified by phone. 2. The RCA determined appropriate treatment and services for residents with fecal incontinence to prevent impaction was not provided due to failure to assess and monitor bowel status, failure to administer PRN bowel medications per physician parameters and failure to provide physician notification regarding change in status and failure to follow through with scheduling specialty consultations. 3. The Notification of Change in Condition and the Medical Consultation policies were reviewed with no change to policy made. Review of Physician's Orders: 1. 03/04/2022 at 6:00 p.m.: The Unit Manager (UM), SDN and the DON conducted a review of all current residents' orders to ensure there were appropriate orders to provide interventions for the residents to prevent constipation or impaction. The review indicated there was a need for additional PRN orders. The UM contacted the physician and noted the orders. 2. Quality monitoring of residents physician orders using the physician order printout in PCC will be conducted by the DON or designee weekly for 2 months then monthly for 3 months to ensure there are interventions to prevent constipation or impaction. Review of Residents with no Bowel Movements in 3 Days: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. 03/04/2022: The RDCS and ADON conducted a quality review to determine Residents that had no BM in 3 days. There were three residents identified as having no bowel. All three resident had PRN bowel medications administered with results of a bowel movement within 24 hours. 2. Ongoing monitoring will be conducted 3 times weekly for 1 month then monthly for 3 months by the DON, ADON, SDN, or UM using the daily bowel movement audit form to identify residents with no bowel movement times 3 days. - To ensure physician orders and parameters were followed for PRN bowel medications. - To ensure nurses are communicating change in condition related to bowel movements using the 24 hour report form to the oncoming shift. - To ensure documentation of bowel movements by nurse aides. Review of Medical Specialty Consultations: 1. 03/05/2022: The RDCS and DON conducted a review of resident's specialty consultation orders for last 30 days. There were no medical specialty consults found to be out of compliance. 2. Ongoing quality monitoring will be conducted by the DON or designee weekly for 2 months then monthly for 3 months to ensure specialty medical consultation appointments are scheduled according to physician orders. 1. Nurse obtaining the specialty medical consult order will call the specialty clinic to schedule the appointment and document appointment date and time on 24 hour report. 2. DON or designee will review 24 hour report in morning clinical meeting and verify appointment with specialty clinic and document appointment on appointment calendar 3. Specialty appointment will be noted on the transportation schedule and reviewed by ED or designee weekly to ensure transport availability. 4. Appointment calendar will be reviewed in morning meeting to ensure appointment occurred and consultation report reviewed and reported to physician. Review of Bowel Movement Documentation by the Nurse Aid: 1. 03/04/2022: The RDCS, DON, and ADON conducted a review of the resident's bowel movement documentation for omissions. It was identified that there were omissions in bowel movement documentation by the nurse aides. Ongoing quality monitoring will be conducted by the DON, ADON, SDN, or UM of the resident's bowel movement documentation 3 times weekly for 2 months then monthly times 3 months to ensure nurse aides are documenting bowel movements. Review of Electronic Medical Record: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. 03/05/2022: RDCS, ADON, and DON conducted a review of all residents electronic medication administration records to ensure routine bowel medications were administered according to the physician orders. 2. Ongoing quality monitoring will be conducted by the DON, ADON, SDN, or UM of the electronic medication administration record to ensure routine bowel medication are administered according to physician's orders with a sample of 20 weekly times 3 months then monthly times 3 months. Review of Care Plans: 03/06/2022: MDS Team reviewed all current residents care plans to ensure care plans were updated to reflect appropriate interventions for residents to prevent constipation or impaction. 1. Care plans will be updated by the MDS Team in the morning meeting to include change in condition, new interventions, and new physician orders to reflect resident's condition. 2. Upon admission the baseline care plan will reflect appropriate interventions for residents to prevent constipation or impaction. 3. Quality monitoring will be conducted by the MDS Regional or designee with a sample of 10 weekly for 1 month then monthly for 3 months to ensure residents plan of care are implemented and performed. Hospital Discharge Summary: 1. Hospital Discharge documents will be reviewed upon resident's return by the DON, ADON, SDN, or UM and MDS nurse to identify any new recommendations and diagnosis to develop a complete plan of care. 2. Attending physician will be notified by admitting nurse or UM of the return and any recommendations and diagnosis. 3. MDS nurse will update comprehensive care plan to reflect residents new recommendations and diagnosis Education: 1. Nursing staff , including agency and contract, will receive training upon hire, annually and as needed with emphasis on the following: - Nurses using electronic health care record dashboard to identify residents with no bowel movement in last 3 days. (59% education completed) - Implementing the as needed (PRN) physician order with parameters if resident had no bowel movement in 3 days. (59% education completed) - Evaluating the Resident for signs and symptoms of constipation or impaction. (59% education completed) (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Notifying physician if no bowel movement in 24 hours after the implementation of the PRN order. (59% education completed) - Scheduling of specialty consultations. (20% education completed) - Hospital Discharge documents review. 2. Nursing staff , including agency and contract , will receive training upon hire, annually and as needed with emphasis on the following: - Documentation of bowel movements in Point Click Care - If for some reason, the Nurse Aide cannot document in Point Click Care they will document on paper form. 3. Nursing staff will receive training upon hire, annually and as needed with emphasis on the following: - Requesting hospital discharge summaries to identify diagnosis so a complete plan of care can be developed. 4. No nurse will work without education. The deficient practice continued at the potential for more than minimal harm for all 91 of the residents currently residing in the facility. Findings: A review of the facility's Best Practices policy revealed in part, the following: The Licensed Nurse will utilize the 24-hour report to communicate information in order to maintain the continuum of safe patient care. The previous days 24 hour report is reviewed during the Daily Clinical Meeting. Documentation: o Documentation should occur each shift (either 8 or 12 hours) o Documentation is by exception. Do not list all current residents on the 24 hour report o Documentation should include but is not limited to the following care areas: New Admissions/Re-admissions (should remain on 24 hour report for 72 hours post admission/re-admission), Change in Condition, Physician orders. Resident #3 (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A Review of Resident #3's clinical record revealed he was admitted to the facility on [DATE] with diagnoses including, in part, the following: Quadriplegia, Unspecified Injury at the Level of the Cervical Spinal Cord, Constipation, Noninfective Gastroenteritis and Colitis, Neurogenic Bowel, Chronic Urinary Tract Infection, Neurogenic Bladder, Chronic Foley Catheter, Multiple Pressure Ulcers, Depression, Suicidal ideations, and Contractures. A review of Resident #3's quarterly MDS with an ARD of 01/13/2022 revealed the resident had a BIMS of 15, indicating he was cognitively intact. Further review revealed he required total assistance from a minimum of two staff members for all areas of care; bed mobility, transfers, dressing, toileting, and personal hygiene. A review of Resident #3's Care Plan as of 03/04/2022 revealed, in part, the following: Problem: Bowel Incontinence r/t Paraplegia/Neurogenic Bowel. Interventions: Administer medications per MD order, observe for effectiveness, check resident every two hours as needed and assist with toileting, observe for constipation, administer medication as per MD order. A review of Resident #3's Physician Orders dated November 2021 through February 2022, revealed in part, the following: 09/09/2021, 11/18/2021, 12/11/2021, 01/21/2022, 03/04/2022, Regular Diet. Regular/Thin Liquid Consistency. Double Portions. 09/09/2021, 11/18/2021, 12/11/2021, Maalox Max Suspension 400-400-40mg/5mL - Give 2400mg by mouth every 4 hours as needed for constipation. 09/09/2021, 11/18/2021, 12/11/2021, Milk of Magnesia Suspension 400mg/5mL - Give 30mL by mouth every 24 hours as needed for constipation or no BM in 3 days. 09/09/2021, 11/18/2021, Bisacodyl Suppository 10mg - Insert 1 suppository rectally every 24 hours as needed for constipation. 09/09/2021, Sodium Phosphate Enema - Insert 19gram rectally every 24 hours as needed for constipation. If no results in the morning after bisacodyl suppository. 01/12/2022, Portable X-Ray (XR) of Pelvis/Abdomen and Lumbar Spine r/t Increased Pain (one time only r/t pain, unspecified for 1 day). 01/13/2022, Magnesium Citrate Solution 1.745gm/10mL - Give 30mL by mouth one time only for constipation for 1 day A review of Bowel and Bladder report for Resident #3 revealed he did not have a bowel movement on the following dates: 12/23/2021, 12/24/2021, 12/25/2021, 12/26/2021, 12/27/2021, 12/29/2021, 12/30/2021, 01/31/2022, 01/01/2022, 01/02/2022, 01/03/2022, 01/09/2022, 01/10/2022, 01/11/2022, 01/12/2022, 01/13/2022 (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of Resident #3's MAR, dated November 2021 through February 2022, revealed the following PRN bowel medications were not administered in the months of November 2021 through February 2022: Maalox Max - Suspension Q4H PRN for Constipation. Milk of Magnesia - Suspension Q24H PRN for Constipation or no BM in 3 days. Bisacodyl Suppository - Q24h prn constipation. Sodium Phosphate Enema - Insert 19 gram rectally every 24 hours as needed for constipation. If no results in the morning after Bisacodyl Suppository. A review of Resident #3's Nurses Notes, dated November 2021 through March 2022, revealed, in part, the following notes related to his bowel status: 01/12/2022 at 2:57 p.m., New order for portable XR of Pelvis/Abdomen and lumbar spine per resident report of increased pain. 01/13/2022 at 1:57 p.m., new order for Mag Citrate related to abdominal XR. 01/14/2022 at 5:29 a.m., Resident #3 was admitted to the hospital with sepsis, C-Diff, and bowel obstruction. Will be transferred to other facility. A review of Resident #3's Hospital Records dated 01/03/2022 through 01/06/2022 revealed he was admitted with diagnoses including Colitis, Constipation, and Fecal Impaction. A review of Resident #3's hospital Gastrointestinal Specialist Consultation Note dated 01/04/2022, in part, revealed the following: Patient noted that he did not have a BM over the last two weeks. XR Abdomen performed on 01/03/2022 at 2:21 p.m. Impression: There is a large amount of retained fecal material and gas scattered within the colon, more evident within the right colon and recto-sigmoid colon. Please correlate for possible constipation and Impaction. A review of the Radiology Reports for Resident #3 dated 01/03/2022 through 01/06/2022 in part, revealed: 01/04/2022 at 8:39 a.m. XR of Abdomen Results: There is a large amount of retained fecal material and gas scattered within the colon, more evident within the right colon and rectosigmoid colon Please correlate for possible constipation and fecal impaction. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	01/04/2022 at 10:26 a.m. CT without Oral Contrast of Abdomen/Pelvis Results: Large amounts of fecal material within the colon and rectum. This appears more pronounced within the somewhat redundant appearing sigmoid colon and rectum. Please correlate for possible constipation and fecal impaction. A review of the Hospital discharge summary dated 01/06/2022 revealed, in part: This patient needs to remain on a high-fiber diet with at least 30g of soluble fiber in his diet every day. He should also be started on a fiber supplement such as Metamucil, Benefiber or Citrucel daily. He should remain on fiber indefinitely He should also be encouraged to drink and consume at least 2L of water every day. His urinary output per day should be at least 2L. If his urine output drops off his water intake should be increased. This goal to titrate his urinary output to his oral water consumption should continue indefinitely. He should also start on Colace 200mg by mouth daily. He is not to be on a stimulant laxative such as Docusate or Senna. New Medication Orders: Psyllium (Metamucil) 3.4 g oral daily. A review of Resident #3's Dietician Notes, dated November 2022 through current revealed the dietician had not visited the resident since 12/28/2021. Further review revealed there was no evidence Dietician was informed of Resident #3's diet recommendations on 01/06/2022. Review of the facility's radiology report for Resident #3 revealed: 01/12/2022 at 12:00 a.m. XR of Lumbar Spine. Results: Diffuse colonic fecal loading. 01/12/2022 at 12:00 a.m. XR of Abdomen. Results: Marked colorectal loading with fecal fecaloma. A review of Resident #3's Hospital Records dated 01/14/2022 through 01/21/2022 revealed he was admitted with diagnosis including Diagnosis: Colitis, Recurrent Constipation, Recurrent UTI with Septic Shock secondary to Proteus Enterococcus Faecalis Infection. Further review revealed a CT of the Abdomen and Pelvis dated 01/20/2022 indicated a stool burden with Colitis. A review of the hospital radiology report for Resident #3 revealed: 01/17/2022 at 10:47 a.m. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	CT of Abdomen/Pelvis Results: Large stool burden, including that appearing impacted within the rectum. Thickening of the rectosigmoid colon with associated peri-intestinal fat stranding also noted, raising concern for colitis. On 02/28/2022 at 1:10 p.m., an interview was conducted with S26RN. She stated on 01/14/2022, Resident #3 was found to have a fecal impaction and sent to the local emergency room . She stated Resident #3 was prone to having fecal impactions. On 02/28/2022 at 2:48 p.m., an interview was conducted with S27LPN who stated she was the facility's Unit Manager on 01/06/2022. She stated she signed off on Resident #3's admission/readmission data collection because S25LPN did not sign it prior to leaving the facility. She confirmed she did not know if the data collection was completed when she signed off on it. She confirmed that she did not lay eyes on nor physically assess Resident #3 upon his return to the facility from the hospital on 01/06/2022 and was not told she needed to review the discharge paperwork. On 03/02/2022 at 10:00 a.m., an interview was conducted with S19CNA, who stated she worked with Resident #3 the night of 01/14/2022. She stated the resident's stomach was swollen and she thought he was impacted. She also stated CNAs document bowel movements in the computer but do not verbally inform the nurse because they are able to access the information in the resident's chart. On 03/02/2022 at 11:23 a.m., a telephone interview was conducted with S25LPN. She stated when Resident #3 returned from the hospital on 01/06/2022 she was responsible for checking him back into the facility on ly, which included getting him settled in and taking his vital signs. She denied having completed any other readmission tasks, including head to toe assessment or review of hospital discharge paperwork. On 03/02/2022 at 1:34 p.m., during a telephone interview with S28LPN, she stated she took care of Resident #3 on 01/03/2022 when he was sent out to the ER for abdominal pain. She stated she was made aware in report that Resident #3 was complaining of abdominal pain but there was no mention of bowel status. She stated the resident continued to complain of abdominal pain and pressure during her shift and told her he was not feeling well. She stated the resident began sweating and his skin tone became flush. She stated a few minutes later the resident told her his symptoms had stopped. She confirmed she did not notify the physician at that time. She stated a little later in the shift, the same symptoms returned plus the resident seemed a little out of it and was not acting himself. She stated the resident was transferred to the ER at that time. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 03/02/2022 at 4:03 p.m., an interview was conducted with S6LPN, who confirmed she was the CNA Supervisor and stated it was the CNAs responsibility to document bowel movements during their shift and a blank entry would indicate no bowel movement occurred. She stated she would expect CNAs to verbally communicate with their nurse if a resident did not have a bowel movement during their shift. She stated she would also expect a nurse to inform their CNA if they had administered PRN medications so the CNA would be aware to monitor more closely. She confirmed she was responsible for staff development, which included providing education for all staff. She confirmed no resident should go 3 days or more without having a bowel movement. She also stated if that were to happen, she would expect a nurse to administer the appropriate medications per orders and notify the physician. She denied having trained staff regarding Resident #3's diagnoses and/or the facility's expectations for monitoring his bowel status. She also denied having provided staff education following Resident #3's return from the hospital on 01/06/2022 regarding the strict monitoring of his intake and output because she was unaware of the dietary and intake/output suggestions made while he inpatient. She confirmed staff education would need to take place regarding the expectations for care, as well as monitoring of bowel movements for Resident #3. On 03/02/2022 at 5:01 p.m., a telephone interview was conducted with S12LPN, who stated before she sent Resident #3 to the emergency roiagnom on [DATE], he complained of abdominal pain and the abdominal x-ray performed at the facility showed stool. She stated she could not recall when the resident's most recent bowel movement was prior to the date he was sent out. On 03/03/2022 at 1:35 p.m., an interview was conducted with Resident #3. Resident #3 stated he could not feel when he had a bowel movement and could not feel if he was constipated. He stated the only way he would know if he were constipated was if he became sick. He explained he would lose track of how many days he went without a bowel movement and relied on staff to monitor it. He stated he thought they were monitoring them because that was one of the reasons he was admitted to the facility. He stated the nursing staff did not ask him about his bowel movements, possible constipation or offer PRN bowel medication unless he was already sick. He stated when it hits, it hits me really fast and I go down quick. He stated he did not ask for additional PRN bowel medications because he thought the nurses were monitoring his bowel movements to give them when he needed to take them. He stated he did not realize nurses would only give him additional medication if he complained of constipation and/or requested it. He stated if he knew no one was monitoring them, he would have tried to keep up with how often he was having a bowel movement so he would not get sick again. He stated when he was sent to theER on [DATE], he had not had a bowel movement in about 2 weeks. He also said the last time he was impacted, on 01/14/2022, he had to be sent by helicopter to a hospital and the experience was not good. He stated it really took a toll on me. On 03/04/2022 at 1:45 p.m., an interview was conducted with S14CNA and S15CNA. S14CNA and S15CNA confirmed Resident #3 was unable to feel if he needed to have or was having a bowel movement. S14CNA and S15CNA both stated the only time Resident #3 was aware he had a BM was if it had an odor. S14CNA and S15CNA both stated the resident would not know if he were constipated unless he started to feel sick. S14CNA and S15CNA both denied being aware of the need to monitor intake or ask Resident #3 about any bowel movements when he returned to the facility from a pass. S14CNA and S15CNA both confirmed they had not been educated to monitor Resident #3's bowel status closely. S14CNA and S15CNA both stated they chart bowel movements in the computer every shift and nurses are able to review that information so they do not always give them updates. S14CNA and S15CNA both said nurses do not always tell them if they gave anything PRN unless they went to them with concerns and a nurse responded ok let me go get some medicine for them. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 03/04/2022 at 1:58 p.m., an interview was conducted with S16CNA. She stated Resident #3 cannot feel if he is constipated or needs to go to the bathroom. She denied receiving training specifically related to monitoring the bowel status of Resident #3. She stated she charts bowel movements in the computer and nurses are able to access that to review it. She said if she were concerned about something, like a large amount of diarrhea, she would talk to the nurse but not having a BM on her shift would not be something she told the nurse. She stated she does not look at the dashboard to see if it has been a while for a bowel movement so she would not be concerned if there were not one on her shift. On 03/04/2022 at 2:10 p.m., an interview was conducted with S10LPN. She stated due to his quadriplegia, he was not capable of feeling if he was constipated or if he had even had a bowel movement. She stated she was aware Resident #3 had issues with constipation that required hospitalization s in the past. She stated she had not received any specific education from the facility about the resident's condition or need for close bowel monitoring. She stated Resident #3 was cognitive and she relied on him to let her know if he was constipated or needed PRN medication to have a bowel movement. On 03/04/2022 at 3:15 p.m., a telephone interview was conducted with S5MD. He stated Resident #3 was a quadriplegic with a neurogenic bowel. He explained Resident #3 had no way of knowing if he had a bowel movement or not. He stated Resident #3 would not know if he was constipated until he had more serious symptoms such as impaction, tachycardia, headache, or pressure/painful sensations. He stated Resident #3 required bowel medications to have a bowel movement. He stated he had implemented PRN orders with set parameters for bowel medication administration. He confirmed he expected the facility staff to monitor Resident #3's bowel status and administer the medications as needed to prevent complications. He confirmed he was not notified when the Resident #3's bowels were not moving in December 2021 and January 2022. He stated if he had be notified, he would have started him on a different medication months ago. He stated he had been out of the facility for the month of January 2022 due to illness and had conducted telehealth visits during that time. He stated the facility did not communicate the bowel issues identified in each of the resident's hospitalization s. He explained he relied on the facility's medical records nurse and floor nurses to communicate the resident's status, any potential areas of concern, or actual issues taking place. He confirmed Resident #3's repeated hospitalization s were directly related to him not having regular bowel movements. He stated the facility should have been more aggressive with monitoring the resident's bowel status, administering PRN bowel medications as ordered and informing him when the resident was not having routine bowel movements. A review of Resident #3's Physician Progress Notes, dated November 2021 through March 2022, revealed in part the following: 01/31/2022 Chief Complaint: Recurrent impaction. Upon completion of this visit an order was written for Linzess with additional adjustments made to previously ordered bowel medications due to the physician now having been made aware of the resident's recurring impactions. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 03/04/2022 at 3:30 p.m., an interview was conducted with S3DON, with S4ADON and S6LPN in attendance. All confirmed Resident #3 was cognitively intact, but due to his diagnosis was unable to know if he was having a bowel movement or constipated. S3DON confirmed CNAs were responsible for and expected to document when a resident had a bowel movement in the electronic system. S3DON stated the nurse is expected to monitor and create a note when a resident was overdue for a bowel movement indicating what PRN medication was administered and the outcome, along with any communication to the physician. S3DON also stated they would expect a physician to be notified any time medications were administered and/or interventions implemented that did not work as intended. S3DON stated the electronic charting system had a dashboard to indicate what residents had not had a bowel movement in three days but it would not create a pop up alert, so it was the nurse's responsibility to monitor the dashboard and implement the appropriate interventions, including the administration of medications. S3DON stated CNAs were also able to see the dashboard and ideally, they would expect nurses and CNAs to thoroughly review their dashboards at the start and end of every shift. They stated CNAs should be checking for accuracy or a need to follow up with a resident and nurses should be looking to determine what alerts are present, any intervention(s) that should be implemented and/or if a physician should be contacted to make a notification. S3DON explained the nurse would also be responsible for updating the 24 Hour Report and verbally communicating bowel concerns, implemented interventions and any interventions needing to be implemented when they give shift handoff report. S3DON confirmed all staff are expected to update and utilize the 24 Hour Report during shift handoff and confirmed the report should have been reviewed in the daily meeting of the department heads per the facility's policy. The findings were reviewed with S3DON, S4ADON and S6LPN. S3DON reviewed Resident #3's bowel report for December 2021 and January 2022 and confirmed the dates identified with no bowel movement in the three day window as he should have. S3DON reviewed Resident #3's MAR for December 2021 and January 2022 and confirmed he did not receive any doses of PRN bowel medications as they would have expected him to given his lack of regular bowel movements during that timeframe. Upon completion of the interview, S4ADON and S6LPN verbalized agreement with the information provided by S3DON and denied having any additional information to add. On 03/08/2022 at 8:46 a.m., an interview was conducted with S8LPN, who stated she did not take care of the resident often but when she did it was not reported to her that Resident #3 was constipated and not having bowel movements. She stated she had not administered Resident #3 any PRN bowel medications. She denied knowing she was expected to monitor dashboard alerts in the electronic charting system or utilize a written 24 Hour Report for shift handoff. On 03/08/2022 at 2:30 p.m., all deficient findings related to Resident #3 were reviewed and verified by S3DON with S2RCDS and S1ED present. S3DON confirmed Resident #3 was cognitively intact, but due to his diagnoses was incapable of knowing if he had a bowel movement or was constipated. S3DON reviewed and confirmed the information in Resident #3's Bowel and Bladd [TRUNCATED]

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44590 Based on interviews and record reviews, the facility failed to 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 residing in the facility. The facility failed to ensure an effective system was in place to ensure: 1. Nursing staff assessed, monitored, implemented interventions per physicians orders, and communicated with the physician regarding bowel status and wound care for 1 (#3) of 9 (#1, #2, #3, #4, #5, R3, R5, R10, and R11) residents reviewed; and 2. Nursing staff utilized the facilities processes for communication including the electronic dashboard system and 24 hour report; 3. Consultations were scheduled as ordered by the physician This deficient practice resulted in an immediate jeopardy situation for Resident #3, a quadriplegic with neurogenic bowel and constipation, on 12/26/2021 when the facility failed to have a system in place to provide an up to date, individualized plan of care to ensure the monitoring and implementation of interventions. This resulted in Resident #3 being transferred to the local hospital with a diagnosis of Colitis, Constipation and Fecal Impaction on 01/03/2022. Following the hospitalization , the facility failed to have a system in place to ensure the review and implementation of new orders and suggestions from the hospital discharge recommendations provided by the GI Specialist for increased fiber, fluid needs and intake/output monitoring. The facility also failed to notify Resident #3's physician of all diagnoses that required treatment while hospitalized and to clarify, transcribe and implement all orders and suggestions made during the hospitalization . From 01/09/2022 through 01/14/2022, the facility still failed to provide an up to date, individualized plan of care that ensured monitoring and implementation of interventions. This resulted in Resident #3 not having a bowel movement or receiving PRN bowel medications leading to another transfer to the hospital with diagnosis of Colitis, Recurrent Constipation, Recurrent UTI with Septic Shock secondary to Proteus E. Faecalis Infection. This hospitalization required Resident #3 to be transferred via helicopter to another hospital on 01/14/2022 to receive a higher level of care due to the deterioration of his condition. S1ED was notified of the Immediate Jeopardy on 03/04/2022 at 6:15 p.m. The Immediate Jeopardy was removed on 03/08/2022 at 5:16 p.m., when the facility submitted an acceptable Plan of Removal. Through interviews and record reviews, the surveyors confirmed the following Plan of Removal had been initiated and/or implemented prior to exit. The Immediate Jeopardy was removed on 03/08/2022 at 4:51 p.m., when the facility submitted an acceptable Plan of Removal. Through observations, interviews and record reviews, the surveyors confirmed the following had been initiated and/or implemented prior to exit: Immediate Action Taken: (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. RDCS (Regional Director of Clinical Services) educated the DON (Director of Nursing), ED (Executive Director) and Assistant Director of Nursing (ADON) on ensuring there is a plan of action for ongoing adequate training and supervision to ensure nursing staff, including agency and contract implement appropriate treatment and services for residents with fecal incontinence. 2. Nursing staff, including agency and contract, will receive training upon hire, annually and as needed. 100% of administration staff have been educated. New hires will be educated in orientation. No administration staff member will work without education. 3. Education and supervision of the nursing staff continued through the weekend on every shift by the RDCS, Director of Nursing (DON), Staff Development Nurse (SDN), Unit Manager (UM) and Assistant Director of Nursing (ADON). QAPI: 1. On 03/04/22 at 6:15 PM the Quality Assurance Performance Improvement (QAPI) Committee met to review the F 835 Quality of care IJ template and conduct a Root Cause Analysis (RCA) and review policy and procedures for changes. Attendees were the ED , DON, Social Services Director (SSD) , Housekeeping Supervisor (HKS) , RDCS , Activities Director (AD) , Director of Therapy (DOR) , ADON , SDN , MDS nurse , Business Office Manager (BOM) ,Human Resources Director (HRD) , Assistant Business Office Manager (ABOM) .The Medical Director (MD) was notified by phone. 2. The RCA determined appropriate treatment and services for residents with fecal incontinence to prevent impaction was not provided due to failure to assess and monitor bowel status, failure to administer as needed (PRN) bowel medications per physician parameters and failure to provide physician notification regarding change in status and failure to follow through with scheduling specialty consultations. 3. In-Service Training policy was reviewed with no change to policy made. Education: Licensed nursing staff, including agency and contract, will receive training upon hire, annually and as needed with emphasis on the following: o Nurses using electronic health care record dashboard to identify residents with no bowel movement in last 3 days. (59% education completed) o Implementing the as needed (PRN) physician order with parameters if resident had no bowel movement in 3 days. (59% education completed) o Evaluating the Resident for signs and symptoms of constipation or impaction. (59% education completed) o Notifying physician if no bowel movement in 24 hours after the implementation of the PRN order. (59% education completed) o Scheduling of specialty consultations. (20% education completed) (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	o Hospital Discharge documents review. Licensed nursing staff and nurse aides, including agency and contract , will receive training upon hire, annually and as needed with emphasis on the following: 1. Documentation of bowel movements in Point Click Care (PCC) 2. If for some reason, the Nurse Aide cannot document in PCC they will document on paper form Nursing staff will receive training upon hire, annually and as needed with emphasis on the following: 1. Requesting hospital discharge summaries to identify diagnosis so a complete plan of care can be developed 2. No nurse will work without education. Ongoing Education: SDN will educate licensed nursing staff, including agency and contract upon hire, annually, and as needed to ensure employees are competent in bowel movement management of residents. Competency of the licensed nurses to include will be verified by the SDN by: 1. Observing nurse use the PCC dashboard to identify residents that have been 3 days with no bowel movement 2. Implementing PRN bowel medication orders 3. Notifying physician when appropriate 4. Communicating to oncoming nurses using the 24 hour report form. DON or ADON will educate registered nurses, including agency and contract upon hire, annually, and as needed to ensure employees are competent in bowel movement management of residents. Competency of registered nurses will be verified by the DON or ADON by: 1. Observing nurse use the PCC dashboard to identify residents that have been 3 days with no bowel movement 2. Implementing PRN bowel medication orders 3. Notifying physician when appropriate 4. Communicating to oncoming nurses using the 24 hour report form. (continued on next page)

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	195324	A. Building B. Wing	03/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fair City Health and Rehab	2000 Main Street Franklinton, LA 70438

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Quality monitoring will be conducted by the RDCS or designee every 3 months to ensure nursing administrative staff are: 1. Conducting education upon hire and ongoing education of nursing staff for proper implementation of resident care and needs consistent with their condition and diagnosis Quality Monitoring of Physician Orders: Quality monitoring of residents physician orders using the physician order printout in Point Click Care (PCC) will be conducted by the DON or designee weekly for 2 months then monthly for 3 months to ensure there are interventions to prevent constipation or impaction. Quality Monitoring of Residents with No Bowel Movement in 3 Days: Ongoing monitoring will be conducted 3 x weekly for 1 month then monthly for 3 months by the DON, ADON, SDN, or UM: 1. Using the daily bowel movement audit form to identify residents with no bowel movement X 3 days. 2. To ensure physician orders and parameters were followed for PRN bowel medications. 3. To ensure nurses are communicating change in condition related to bowel movements using the 24 hour report form to the oncoming shift. 4. To ensure documentation of bowel movements by nurse aides. Quality Monitoring of Medical Specialty Consultations: Ongoing quality monitoring will be conducted by the DON or designee weekly for 2 months then monthly for 3 months to ensure specialty medical consultation appointments are scheduled according to physician orders. 1. Nurse obtaining the specialty medical consult order will call the specialty clinic to schedule the appointment and document appointment date and time on 24 hour report. 2. DON or designee will review 24 hour report in morning clinical meeting and verify appointment with specialty clinic and document appointment on appointment calendar 3. Specialty appointment will be noted on the transportation schedule and reviewed by ED or designee weekly to ensure transport availability. 4. Appointment calendar will be reviewed in morning meeting to ensure appointment occurred and consultation report reviewed and reported to physician. Quality Monitoring of Bowel Movement Documentation by the Nurse Aide: (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ongoing quality monitoring will be conducted by the DON, ADON, SDN, or UM of the resident's bowel movement documentation 3 x weekly for 2 months then monthly x 3 months to ensure nurse aides are documenting bowel movements. Quality Monitoring of Electronic Medication Administration Record: Ongoing quality monitoring will be conducted by the DON, ADON, SDN, or UM of the electronic medication administration record to ensure routine bowel medication are administered according to physician's orders with a sample of 20 weekly x 3 months then monthly x 3 months. Quality Monitoring of Care Plans: Quality monitoring will be conducted by the MDS Regional or designee with a sample of 10 weekly for 1 month then monthly for 3 months to ensure residents plan of care are implemented and performed. Cross Reference: F684, F656 Findings: A review of the facility's Best Practices policy revealed in part, the following: The Licensed Nurse will utilize the 24-hour report to communicate information in order to maintain the continuum of safe patient care. The previous days 24 hour report is reviewed during the Daily Clinical Meeting. Documentation: o Documentation should occur each shift (either 8 or 12 hours) o Documentation is by exception. Do not list all current residents on the 24 hour report o Documentation should include but is not limited to the following care areas: New Admissions/Re-admissions (should remain on 24 hour report for 72 hours post admission/re-admission), Change in Condition, Physician orders. A review of the facility's policy for Notification of Change in Status revealed, in part, the following, the Center to promptly notify the Patient/Resident, the attending physician, and the Resident Representative when there is a change in the status or condition. Procedure: The nurse to notify the attending physician and Resident Representative when there is a(n): o Significant change in the patient/resident's physical, mental, or psychosocial status o Need to alter treatment significantly o New treatment (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the facility's policy for Medical Consultations revealed, in part, the following: Members of the medical staff will request a medical consultation when appropriate. Procedure: 1. The member of the medical staff requesting a consultation will order the consultation and a Request for Consultation will be initiated by nursing to the consulting physician. Resident #3 A Review of Resident #3's clinical record revealed he was admitted to the facility on [DATE] with diagnoses including, in part, the following: Quadriplegia, Unspecified Injury at the Level of the Cervical Spinal Cord, Constipation, Noninfective Gastroenteritis and Colitis, Neurogenic Bowel, Chronic Urinary Tract Infection, Neurogenic Bladder, Chronic Foley Catheter, Multiple Pressure Ulcers, Depression, Suicidal ideations, and Contractures. A review of Resident #3's quarterly MDS with an ARD of 01/13/2022 revealed the resident had a BIMS of 15, which indicated he was cognitively intact. Further review revealed he required total assistance from a minimum of 2 staff members for all areas of care; bed mobility, transfers, dressing, toileting, and personal hygiene. A review of Resident #3's Care Plan dated 03/04/2022 revealed, in part, the following: Problem: Bowel Incontinence r/t Paraplegia/Neurogenic Bowel. Interventions: Administer medications per MD order, observe for effectiveness, check resident every two hours as needed and assist with toileting, observe for constipation, administer medication as per MD order. Further review of Resident #3's current care plan revealed no care plan for the open wound at his PEG removal site. A review of Resident #3's Physician Orders dated November 2021 through February 2022, revealed in part, the following: 09/09/2021, 11/18/2021, 12/11/2021, 01/21/2022 for the resident's currently ordered diet, as of 03/04/2022, Regular Diet. Regular/Thin Liquid Consistency. Double Portions. 10/08/2021 for GI Consult ASAP r/t unhealed PEG Site. 03/02/2022 for Make appointment with GI, Dr. [NAME], phone # [PHONE NUMBER] r/t previous PEG tube site. A review of Bowel and Bladder report for Resident #3 revealed he did not have a bowel movement on the following dates: (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	12/23/2021, 12/24/2021, 12/25/2021, 12/26/2021, 12/27/2021, 12/29/2021, 12/30/2021, 01/31/2022, 01/01/2022, 01/02/2022, 01/03/2022, 01/09/2022, 01/10/2022, 01/11/2022, 01/12/2022, 01/13/2022 A review of Resident #3's MAR, dated November 2021 through February 2022, revealed the following PRN bowel medications were not administered in the months of November 2021 through February 2022: Maalox Max - Suspension Q4H PRN for Constipation. Milk of Magnesia - Suspension Q24H PRN for Constipation or no BM in 3 days. Bisacodyl Suppository - Q24h prn constipation. Sodium Phosphate Enema - Insert 19 gram rectally every 24 hours as needed for constipation. If no results in the morning after Bisacodyl Suppository. A review of Resident #3's Hospital Records dated 01/03/2022 through 01/06/2022 revealed he was admitted with diagnoses including Colitis, Constipation, and Fecal Impaction. A review of Resident #3's hospital Gastrointestinal Specialist Consultation Note dated 01/04/2022, in part, revealed the following: Patient noted that he did not have a BM over the last two weeks. XR Abdomen performed on 01/03/2022 at 2:21 p.m. Impression: There is a large amount of retained fecal material and gas scattered within the colon, more evident within the right colon and recto-sigmoid colon. Please correlate for possible constipation and Impaction. A review of Resident #3's Patient Rounding Notes from the 01/03/2022 through 01/06/2022 hospitalization , revealed, in part, the following: 01/05/2022 at 09:10 p.m. Barrier cream placed around previous peg tub site due to redness and drainage with gauze placed over barrier cream to absorb small amounts of drainage. A review of the Hospital discharge summary dated 01/06/2022 revealed, in part: This patient needs to remain on a high-fiber diet with at least 30g of soluble fiber in his diet every day. He should also be started on a fiber supplement such as Metamucil, Benefiber or Citrucel daily. He should remain on fiber indefinitely He should also be encouraged to drink and consume at least 2L of water every day. His urinary output per day should be at least 2L. If his urine output drops off his water intake should be increased. This goal to titrate his urinary output to his oral water consumption should continue indefinitely. He should also start on Colace 200mg by mouth daily. He is not to be on a stimulant laxative such as Docusate or Senna. New Medication Orders: Psyllium (Metamucil) 3.4 g oral daily. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of Resident #3's Dietician Notes, dated November 2022 through current revealed the dietician had not visited the resident since 12/28/2021. Further review revealed there was no evidence Dietician was informed of Resident #3's diet recommendations following discharge on 01/06/2022. A review of Resident #3's Hospital Records dated 01/14/2022 through 01/21/2022 revealed he was admitted with diagnoses including: Colitis, Recurrent Constipation, Recurrent UTI with Septic Shock secondary to Proteus Enterococcus Faecalis Infection. A review of the hospital radiology report for Resident #3 revealed: 01/17/2022 at 10:47 a.m. CT of Abdomen/Pelvis Results: Large stool burden, including that appearing impacted within the rectum. Thickening of the rectosigmoid colon with associated peri-intestinal fat stranding also noted, raising concern for colitis. Further review of the hospital radiology report for Resident #3 revealed a CT of the Abdomen and Pelvis dated 01/20/2022 indicated a stool burden with Colitis. 1.) On 03/02/2022 at 11:40 a.m., an interview was conducted with S5MD. He verified he was not notified of an old peg site that had opened and was draining. He confirmed if a resident returned from the hospital with no wound care orders, he would expect the nurse to call and let him know about the drainage and obtain wound care orders. On 03/02/2022 at 04:03 p.m., an interview was conducted with S6LPN, who confirmed she was the CNA Supervisor and also responsible for staff development, which included providing education for all staff. She confirmed no training had been provided to staff regarding Resident #3's diagnoses or the expected method for monitoring his bowel status. She also confirmed no education or training was provided upon Resident #3's return from the hospital on 01/06/2022 regarding the strict monitoring of his intake and output. On 03/04/2022 at 01:45 p.m., an interview was conducted with S14CNA and S15CNA, both denied being aware of a need to monitor intake or ask Resident #3 if he had bowel movements upon his return to the facility from a pass. Both confirmed they had not been educated to monitor Resident #3's bowel status closely. On 03/04/2022 at 01:58 p.m., an interview was conducted with S16CNA, who denied having received training related to monitoring bowel status. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 03/04/2022 at 02:10 p.m., an interview was conducted with S10LPN who stated she was very familiar with Resident #3's care and needs but had not received education from the facility about his condition or need for close monitoring. She confirmed the resident was not capable of feeling if he was constipated or if he had a bowel movement; however, he was cognitive so she relied on him to tell her if he was constipated and to request PRN bowel medications. She confirmed she was aware of his hospitalization s for constipation and impaction and denied having been told of anything that should be implemented after. She denied being aware of who should handle paperwork following discharge or specialist appointment. She stated the paperwork usually went to the front desk when the resident arrived back at the facility. She stated she was not aware of a definitive method for scheduling appointments for residents and was not sure who performed that task. On 03/04/2022 at 03:15 p.m., a telephone interview was conducted with S5MD. He confirmed Resident #3's repeated hospitalization s were directly related to him not having regular bowel movements. He also stated the facility should have been more aggressive with monitoring the resident's bowel status, administering PRN bowel medications as ordered and informing him when the resident was not having routine bowel movements. On 03/04/2022 at 03:30 p.m., an interview was conducted with S3DON, with S4ADON and S6LPN in attendance. S3DON stated the nurse is expected to monitor and create a note when a resident was overdue for a bowel movement indicating what PRN medication was administered and the outcome, along with any communication to the physician. S3DON also stated she would expect a physician to be notified any time medications were administered and/or interventions implemented that did not work as intended. S3DON also confirmed she would expect staff to have addressed and confirmed S5MD was aware of Resident #3's frequent lack of regular bowel movements during his weekly rounds. S3DON stated S5MD's Progress Notes and Orders were handwritten and available to the facility on ce he finished rounds. S3DON stated she would expect the progress notes to be reviewed by the floor nurse with all orders transcribed and implemented on the same day with an additional review and sign off performed by the unit manager to ensure accuracy and verify orders were not missed. Upon completion of the interview, S4ADON and S6LPN verbalized agreement with the information provided by S3DON and denied having any additional information to add. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 03/08/2022 at 02:30 p.m., all deficient findings related to Resident #3 were reviewed and verified by S3DON with S2RCDS and S1ED present. S3DON reviewed and verified Resident #3's Medication Administration Record and Bowel and Bladder Report for December 2021 and January 2022. S3DON confirmed she had been unaware Resident #3's bowel status was not being monitored, which resulted in him frequently going three days or more without a bowel movement and not receiving any of his PRN bowel medications throughout December 2021 and January 2022. S3DON also confirmed S5MD was not notified of Resident #3's on-going lack of regular bowel movements. S3DON confirmed she would have expected better monitoring of the three-day window for bowel movements to ensure Resident #3's PRN bowel medications were given as ordered. S3DON confirmed she would expect nurses to notify S5MD when Resident #3 did not have a bowel movement in 3 days. S3DON also confirmed because of his diagnoses, she would have expected nursing staff to closely monitor Resident #'3's bowel movements instead of relying on him to inform them when he became constipated. S3DON stated if nursing staff did not understand how to provide care for a resident with a diagnosis of quadriplegia with neurogenic bowel, she would expect them to look the information up and educate themselves. S3DON confirmed upon Resident #3's return to the facility following each hospitalization , she would expect S5MD to be notified of all diagnoses that required treatment while in-patient. S3DON confirmed there was not a process in place to monitor recurring diagnoses and/or trends related to hospitalization s and re-hospitalization s. S3DON verified Resident #3 had been hospitalized on [DATE] and 01/14/2022 related to bowel impaction. S3DON confirmed because they had not been monitoring, they were not aware of the recurring issue so staff had not received education or training regarding the importance of closely monitoring the frequency of Resident #3's bowel movements for administration of his PRN bowel medications. S3DON confirmed she would have liked to implement steps to try and prevent the recurrence. S3DON reviewed and verified Resident #3's current Care Plan. S3DON confirmed they had been unaware there was an issue with Resident #3 having an outdated care plan that was not updated following status changes, onset of new issues, hospitalization s, etc. S3DON confirmed they had been unaware Resident #3's care plan was not accurately individualized to meet his specific needs. S3DON confirmed she would have expected Resident #3's care plan to be updated and individualized to better meet his needs. S3DON further reviewed Resident #3's care plan, and verified he was not care planned for care regarding his PEG tube site. S3DON confirmed Resident #3 should have been care planned for PEG tube site care. Upon completion of the interview, S2RDCS and S1ED verbalized agreement with the information provided by S3DON and denied having any additional information to add. Upon completion of the interview, S2RDCS and S1ED verbalized agreement with the information provided by S3DON and denied having any additional information to add. 2.) On 03/02/2022 at 04:03 p.m., an interview was conducted with S6LPN, who confirmed she was the CNA Supervisor. She stated it was the CNAs responsibility to document bowel movements during their shift and a blank entry would indicate no bowel movement occurred. She stated she would expect CNAs to communicate with nurses if a resident did not have a bowel movement during their shift. She stated she would also expect a nurse to communicate with their CNAs if they had administered PRN medications so they would be aware to monitor more closely. She confirmed she was responsible for staff development, which included providing education for all staff. She confirmed no training had been provided about assessing and monitoring bowel movements on the dashboard then recording that information on the 24 Hour Report for use during shift handoff report. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 03/04/2022 at 01:45 p.m., an interview was conducted with S14CNA and S15CNA, both stated bowel movements are documented in the computer every shift and nurses are able to review the information so they do not need to report it to them. They also denied having nurses inform them when PRN medications were given so they could help monitor. Both confirmed CNAs use verbal report for shift handoff and had not heard of a 24 Hour Report. On 03/04/2022 at 01:58 p.m., an interview was conducted with S16CNA, who stated she charted bowel movements in the computer and nurses were able to access it for review. She said if she were concerned about something, like a large amount of diarrhea, she would talk to the nurse but someone not having a BM on her shift would not automatically be something she told the nurse. She stated she did not know to look at the dashboard to see if it had been a while for a bowel movement so she would not be concerned if there were not one on her shift. 03/04/2022 at 02:10 p.m. Observed shift report and handoff from day shift CNA to oncoming afternoon CNA. Report was provided verbally with no written documentation utilized. There was no observed mention of residents not have bowel movements. 03/04/2022 at 02:05 p.m. Observed shift report and handoff from day shift Nurse to oncoming afternoon Nurse. Report was provided verbally with no written documentation utilized. There was no observed mention of resident s not have bowel movements. On 03/04/2022 at 02:10 p.m., an interview was conducted with S10LPN who stated she used her own written report sheet during shift change because she had only ever received a verbal report and confirmed she was unaware of any expectation for a written report. She confirmed she was not trained on the facility's expectation for use of dashboard alerts. She stated there was nothing in the charting system that required a response to alerts, nurses had to remember to look and she had not seen many people use it. She said CNAs charted bowel movements but did not verbally report to the nurse; however, she hoped she would be made aware if something unusual happened. On 03/04/2022 at 03:30 p.m., an interview was conducted with S3DON, with S4ADON and S6LPN in attendance. S3DON stated the electronic charting system had a dashboard to indicate what residents had not had a bowel movement in three days but it would not create a pop up alert, so it was the nurse's responsibility to monitor the dashboard and implement the appropriate interventions, including the administration of medications. S3DON stated CNAs were also able to see the dashboard and ideally, they would expect nurses and CNAs to thoroughly review their dashboards at the start and end of every shift. They stated CNAs should be checking for accuracy or a need to follow up with a resident and nurses should be looking to determine what alerts are present, any intervention(s) that should be implemented and/or if a physician should be contacted to make a notification. S3DON explained the nurse would also be responsible for updating the 24 Hour Report and verbally communicating bowel concerns, implemented interventions and any interventions needing to be implemented when they give shift handoff report. S3DON confirmed all staff are expected to update and utilize the 24 Hour Report during shift handoff and confirmed the report should have been reviewed in the daily meeting of the department heads per the facility's policy. Upon completion of the interview, S4ADON and S6LPN verbalized agreement with the information provided by S3DON and denied having any additional information to add. On 03/08/2022 at 11:35 a.m., an interview was conducted with S7LPN. She stated she was never trained or instructed to monitor the dashboard for alerts of overdue bowel movements and was unaware staff were expected to utilize a written 24 Hour Report for shift handoff. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 03/08/2022 at 02:30 p.m., all deficient findings related to Resident #3 were reviewed and verified by S3DON with S2RCDS and S1ED present. S3DON confirmed she had been unaware nurses and CNAs were only performing a very brief verbal report at the end of each shift and not utilizing the written 24 Hour Report as expected per the facility's protocol. S3DON also confirmed she had been unaware most nurses and CNAs did not know they should be monitoring dashboard alerts for overdue bowel movements and confirmed she would expect them to review it at least twice per shift. Upon completion of the interview, S2RDCS and S1ED verbalized agreement with the information provided by S3DON and denied having any additional information to add. 3.) On 03/04/2022 at 02:10 p.m., an interview was conducted with S10LPN, who denied being aware of who should handle paperwork following discharge or specialist appointment. She stated the paperwork usually went to the front desk when the resident arrived back at the facility. She stated she was also not aware of a definitive method for scheduling appointments for residents and was not sure who performed that task. On 03/04/2022 at 03:30 p.m., an interview was conducted with S3DON, with S4ADON and S6LPN in attendance. S3DON who confirmed she was not aware Resident #3's hospital discharge summary and orders, dated 01/06/2022, included recommendations for increased fiber in his diet, increased fluid intake, and intake/output monitoring and were unaware the Dietician had not been notified. They also confirmed they were unaware of the outstanding orders for Resident #3 to have a specialist consultation scheduled. S3DON explained upon a resident's arrival back to the facility, she would expect the floor nurse to review the visit notes/discharge summary then communicate and clarify any suggested changes with the physician for transcription and immediate implementation, then update the 24 Hour Report. S3DON further stated she would expect the unit manager to perform a second review of the visit/discharge paperwork to ensure nothing was missed, all orders were transcribed correctly and to confirm the appropriate notifications had been made. S3DON also stated she expect the medical records nurse to be the third review to ensure accuracy and completion of all necessary steps. S3DON stated if the floor nurse were busy, she would expect the unit manager to be the first review and medical records to be the second. S3DON also stated sometimes, the S3DON, S4ADON or S6LPN would perform the review if they were not busy. S3DON confirmed the process for reviewing discharge paperwork would be the same process she expected to take place following specialty consultation appointments and/or upon receipt of physician progress notes. S3DON confirmed they did not have an actual written policy or [TRUNCATED]