STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255182	A. Building B. Wing	03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeview Nursing Center	16411 Robinson Road Gulfport, MS 39503

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21029 Based on record reviews, staff interviews, resident interviews, Resident Representative (RR) interview, job description reviews, and policy and procedure reviews, the facility failed to prevent neglect of a resident (Res) #1 from occurring by neglecting to document/record the treatment and services accessible to five (5) of five sampled residents reviewed for bowel functioning programs. Res. #1, #2, #3, #4 and #5. This failure had the potential to affect all residents in the facility. Resident #1 was admitted to the hospital with vomiting and stomach pain on [DATE] and later died from aspiration due to vomiting as a result of a bowel impaction on [DATE]. Resident #1 had no documented bowel movements (BM's) for 11 days prior to the hospital admission on [DATE]. 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 [DATE] when Res #1 began vomiting and complaining of stomach pain. Res #1 was admitted to the local hospital on [DATE] with vomiting and stomach pain and died on [DATE] as a result of aspiration from vomiting due to a bowel impaction. On [DATE] at 5:30 PM, the SA notified the facility Administrator (ADM) and the Director of Nursing (DON) of the IJ and SQC and provided the facility with the IJ template. The facility submitted an acceptable Removal Plan on [DATE], in which the facility alleged that the immediacy of the Jeopardy was removed on [DATE] the IJ was removed on [DATE]. (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The SA validated the Removal Plan on [DATE], and determined the IJ was removed on [DATE], 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 [DATE] 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 [DATE] 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 [DATE] 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 incidents to the Nursing Supervisor . (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Interviews on [DATE] 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 [DATE]. 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 ,d+[DATE] and ,d+[DATE] shifts. The DON revealed that for over a year the CNA's charted manually on paper charts and on [DATE] 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. Interview on [DATE] 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 [DATE]. The DON thought that the med cart nurses were supervising the CNA's more closely, but they had not. The DON stated that the Bowel policy and procedure had not been followed and the ADL sheets had not been documented appropriately for each resident and the licensed nurses had not documented in the progress notes appropriately or often enough for each resident . She stated the documented information needed for bowel movements on (Res #1) was not in the medical records. Resident #1: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Interview with the DON on [DATE] at 9:00 AM, revealed that Res #1 had been admitted to the hospital from the facility on [DATE] due to vomiting coffee ground looking substances (emesis) and for stomach pain. The DON stated that Res #1 was diagnosed at the hospital on [DATE] with an impaction and on [DATE] 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 ultimately led to her death from an impaction. Record review of the facility's Care Tracker Documentation Record ADL care sheets for January-[DATE] 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 [DATE]-[DATE]. The record review revealed that Res #1 had one (1) BM during the 3:00 PM-11:00 PM shift on [DATE]; on [DATE] there was one (1) BM documented on the 7:00 AM-3:00 PM shift; and on [DATE] the CNA's documented one (1) BM during the 7:00 AM -3:00 PM shift. From [DATE]-[DATE], 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 [DATE] 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 [DATE]. 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 [DATE], and1 BM on [DATE] during the 7:00 AM-3:00 PM shift. Res #1 had no BM's recorded on the ADL care sheets from [DATE]-[DATE]. The facility documentation that was provided for Res #1's BM's for [DATE]-[DATE] 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 [DATE] at 2:39 PM revealed: Acute Visit [DATE] 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. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Record review of the medical records from the hospital dated [DATE]-[DATE] 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 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 [DATE]. Interview on [DATE] 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 [DATE] at 2:15 PM, with the DON she stated that they knew on [DATE] 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 [DATE] 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 [DATE] when the NP had called for her to assess Res #1, who was vomiting. ADON went to Res #1 and found her with coffee ground vomit on her clothing and on the floor. The ADON stated that Res #1 was complaining of stomach pain and her stomach was distended. She called 911 and stayed with Res #1 until the ambulance came to pick up Res #1. The ADON stated that she reported to the NP that Res #1 appeared to possibly have a GI bleed from the looks of the coffee ground vomit. ADON stated that she learned the next day that Res #1 had passed away at the hospital on [DATE] 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 [DATE] 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 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 [DATE] for vomiting and then Resident #1 died on [DATE]. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Interview on [DATE] 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 [DATE] 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-[DATE] 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 [DATE] at 10:25 AM, with the ADON she confirmed that after the death of Res #1 on [DATE] that the facility had a QA committee meeting to discuss the lack of documentation for the BM's of Res #1 and the lack of nursing progress notes. The facility also discussed the need to return to using the kiosk so the monitoring would be easier to track. The facility reinstated the CNA's kiosk system on [DATE]. 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 [DATE] at 1:00 PM, with the Resident Representative (RR) of Resident #1 revealed that she had been at the facility visiting Res #1 on [DATE] or [DATE] 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 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 [DATE] 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. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Interview on [DATE] 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 (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 [DATE] at 2:00 PM, with the DON (RN#1) revealed that she had learned in the Attorney General's (AG's) in-service that neglect was defined as when services are not provided to residents that may cause disfavorable out comes. The DON stated that Res #1's death met the definition of neglect. Resident #2: Observation of Res #2 on [DATE] 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 [DATE] revealed Res #2 had no BM's recorded for five (5) consecutive days for [DATE]-[DATE]. 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 documented on the ADL sheets for three (3) consecutive days from [DATE]-[DATE]; and Res #2 had no BM's recorded on the ADL sheets for five (5) consecutive days of [DATE]-[DATE]. 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 [DATE] and one (1) progress note recorded for [DATE]. No progress notes were recorded/documented for Res #2 pertaining to her ADL care and services for [DATE]-[DATE]. Interview on [DATE] at 12:35 PM, with CNA#1 stated that she was the CNA for Res #2 on [DATE]. 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 admitted [DATE] and diagnosis of Hemiplgia following cerebral infraction affecting right dominant side, among other diagnoses. Record review revealed a MDS dated [DATE] that contained a BIMS score of 3 which indicated that Res #2 was severely cognitively impaired. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Resident #3: Observation on [DATE] at 12:20 PM revealed that Res #3, was lying in her bed. Res #3 was not interviewable. Record review of the Care Tracker Documentation Record ADL sheets for January 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 [DATE] 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 admitted [DATE] 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 [DATE] which did not address Res #3's ADL's or bowel program. Res #3 had one (1) documented progress note dated [DATE] written by the social worker. No progress notes were documented for [DATE] by nursing staff. Interview on [DATE] at 1:00 PM with CNA #2 stated that she was assigned to work with Res #3 on [DATE] on the first (1st) shift. CNA#2 stated that she documented on the ADL sheets prior to [DATE] the BM's for residents on every shift. She stated that currently when she completed a shift she documented in the kiosk at the end of each eight (8) hour shift the ADL's and the BM's. If a resident does not have a BM on the eight (8) hour shift it is reported to the med cart nurse. The med cart nurse was responsible for checking the resident after the CNA reported to them. Resident #4: Interview and observation on [DATE] 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 [DATE] - [DATE]. Interview on [DATE] 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. (continued on next page)

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Record review of Res #4's Minimum Data Set (MDS) dated [DATE] 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 admitted [DATE] and diagnoses of Chronic Obstructive pulmonary disease; Gastro-escophageal reflux disease; among other diagnoses. Record review revealed that Res #4 had one (1) progress note date [DATE] and one (1) progress note written on [DATE] neither of which addressed her ADL's or bowel functioning. Res #4 had no progress notes documented for [DATE]. Resident #5: On [DATE] at 9:55 AM, during an interview and observation with Res #5 revealed she was lying in bed. She did answer questions asked of her. She stated that she wears briefs and has been incontinent of bowel and bladder. Res #5 stated that she has to have the assistance of staff for all her ADL's. Res #5 stated that the CNA's change her briefs for her on a regular basis. She stated that she had never been offered a stool softener or a laxative. She stated that a very few times she had been constipated and she had asked the nurse for Metamucil. Res #5 was unable to recall when the event occurred for the medication for constipation. Res #5 stated that she had more times that she had diarrhea or loose stools rather than constipation. She stated that she had never been offered Prune Juice and had never asked for Prune Juice. Res #5 stated that she had to have total assistance for all her ADL's. Record review of the Face Sheet for Res #5 revealed a re-admitted [DATE]. 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 [DATE] contained a BIMS score of 14 which indicated that she was cognitively intact. Record review of the Care Tracker Documentation Record [DATE] - [DATE] bowel function ADL sheet had Res #5 documented as having no bowel movements from [DATE]-[DATE] (3 consecutive days with no bowel movement) and from [DATE]-[DATE] (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 ,d+[DATE], 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-[DATE]. Summary: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	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 [DATE] and ultimately led to the death of Res #1 at the hospital on [DATE]. The

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21029 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 [DATE] from the facility with a bowel impaction that ultimately caused Res #1 to die in the hospital on [DATE] 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 Jeopardy (IJ) and Substandard Quality of Care (SQC) that began on [DATE] when the facility failed to report the neglect that resulted in Res #1 being admitted to the local hospital on [DATE] with vomiting and stomach pain and died on [DATE] as a result of aspiration from vomiting due to a bowel impaction. On [DATE] 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 [DATE], in which the facility alleged that the immediacy of the Jeopardy was removed on [DATE] the IJ was removed on [DATE]. The SA validated the Removal Plan on [DATE], and determined the IJ was removed on [DATE], 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 [DATE] 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 [DATE] 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 (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review the facility policy titled Recognizing Signs and Symptoms of Abuse, Neglect, Exploitation/Misappropriation with a revision date of [DATE] revealed . Signs of Physical Neglect: Improper use/ administration of medication; Inadequate provision of care Interview on [DATE] 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 (SA) in the past three months (Jan-[DATE]). Interview on [DATE] 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 [DATE] 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 [DATE] - [DATE] confirmed that the facility had not provided the treatments and services to Res #1 to prevent constipation and/or a bowel impaction. Record review of the facility's ADL care sheets for January -[DATE] 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 [DATE] revealed the CNA's had documented that Res #1 had three (3) BM's during the dates of [DATE]-[DATE]. From [DATE]-[DATE], 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 [DATE] 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 [DATE]. 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 [DATE]-[DATE] 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. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the NP progress note date [DATE] at 2:39 PM revealed: Acute Visit [DATE] 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 [DATE]-[DATE] 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 [DATE]. Interview on [DATE] 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 for Res #1. Interview on [DATE] at 2:15 PM, with the DON stated that they knew on [DATE] 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 [DATE] 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 [DATE], the ADM confirmed that on [DATE] at 5:00 AM she called the incident of alleged neglect in to the required State Agencies (SA). Summary: (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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 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 [DATE] and ultimately led to the death of Res #1 at the hospital on [DATE]. 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 [DATE]-February 2023 and that on [DATE] 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 [DATE]. 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 [DATE] at 5:00 AM as per the facility IJ Removal Plan. The facility provided an acceptable Removal Plan on [DATE]. Review of the facility's Removal Plan revealed the facility took the following actions to remove the IJ: Removal Plan: On [DATE], Resident #1 began vomiting coffee ground emesis and was transferred to the hospital and expired at the hospital on [DATE]. 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 [DATE] 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 [DATE] 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 [DATE]. 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 [DATE]. 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 [DATE]. No staff will be allowed to work until the in-service training has been completed. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	CNA's have documented bowel movements via the kiosk on [DATE]. 45 minutes prior to the end of each shift the medication nurse on each hall checked CNA documentation for completion, beginning [DATE]. 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 [DATE] and no staff will be allowed to work until the in-service training has been completed. On Friday [DATE] and Monday [DATE] 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//,d+[DATE] 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 [DATE]. 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 [DATE]. 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 [DATE]. 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 [DATE] and the IJ was removed on [DATE]. VALIDATION: On [DATE], 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 [DATE] 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. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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 [DATE] had attended in-service training beginning on [DATE] 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 [DATE] 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 [DATE]. 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 [DATE] and on Monday [DATE] 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 [DATE] 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 [DATE] with in-servicing of facility staff. The ADM confirmed through interview that the QA meeting on [DATE] 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 [DATE] 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 [DATE] had all required members present including the MD and the IP. Staff interviewed on [DATE] 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.

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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 - Immediate jeopardy to resident health or safety Residents Affected - Many	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** 21029 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 the hospital on [DATE] and her death on [DATE] 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 [DATE] when Res #1 began vomiting and complaining of stomach pain. Res #1 was admitted to the local hospital on [DATE] with vomiting and stomach pain and died on [DATE] as a result of aspiration from vomiting due to a bowel impaction. On [DATE] 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 [DATE], in which the facility alleged that the immediacy of the Jeopardy was removed on [DATE] the IJ was removed on [DATE]. The SA validated the Removal Plan on [DATE], and determined the IJ was removed on [DATE], 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: 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 [DATE] 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). (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	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 incidents to the Nursing Supervisor . Interviews on [DATE] 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 [DATE]. 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. Interview on [DATE] 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 [DATE] 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 ,d+[DATE] x week (,d+[DATE] times per week) to next review [DATE] .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. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Record review of the facility's ADL care sheets for January-[DATE] 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 [DATE]-[DATE]. The record review revealed that Res #1 had one (1) BM during the 3:00 PM-11:00 PM shift on [DATE]; on [DATE] there was one (1) BM documented on the 7:00 AM-3:00 PM shift; and on [DATE] the CNAs' documented one (1) BM during the 7:00 AM -3:00 PM shift. From [DATE]-[DATE], 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 [DATE] 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 [DATE]. 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 [DATE], and 1 BM on [DATE] during the 7:00 AM-3:00 PM shift. Res #1 had no BM's recorded on the ADL care sheets from [DATE]-[DATE]. The facility documentation that was provided for Res #1's BM's for [DATE]-[DATE] 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 [DATE] at 9:00 AM, 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 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 [DATE] at 2:15 PM with the DON, she stated that they knew on [DATE] 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 [DATE] 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 [DATE] 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 [DATE], 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. 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. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Interview on [DATE] 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 [DATE] 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 admitted [DATE]. 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 [DATE] 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 [DATE]-31, 2023 that had many days of missing documentation under the Bowel Function section [DATE] 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 [DATE]-[DATE]. Res #2 had no BM's recorded for five (5) consecutive days for [DATE]-[DATE]. 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 [DATE]-[DATE]; no BM's recorded on the ADL sheets for five (5) consecutive days of [DATE]-[DATE]. 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 [DATE] and one (1) progress note recorded for [DATE]. No progress notes were recorded/documented for Res #2 pertaining to her ADL care and services for [DATE]-[DATE]. Resident #3: Record review of Res #3 revealed a Care Plan dated [DATE] that read: At constipation risk r/t (in reference to) advanced age, impaired mobility, meds. Goal: Will have soft formed stool ,d+[DATE] x week (,d+[DATE] times per week) to next review [DATE] .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 [DATE] which did not address Res #3's ADL's or bowel program. No progress notes were documented for [DATE] 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 [DATE] that contained a Brief Interview of Mental Status (BIMS) score of 0 (Blank) which indicated that Res #3 was severely cognitively impaired. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Record review of the Face Sheet revealed Resident #3 was admitted to the facility on [DATE] 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 [DATE] 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 [DATE] 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 formed stool ,d+[DATE] x week (,d+[DATE] times per week) to next review [DATE]. 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 [DATE] 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 [DATE] 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 [DATE] 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 been offered Prune Juice and had never asked for Prune Juice. Record review of Res #5's Care Plan dated [DATE] 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 ,d+[DATE] x week (,d+[DATE] times per week) by [DATE]. 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. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Record review of the [DATE] - [DATE] bowel function ADL sheet had Res #5 documented/recorded as having no bowel movements from [DATE]-[DATE] (three (3) consecutive days with no bowel movement). The ADL sheet had no BM's documented/recorded for Res #5 from [DATE]-[DATE] (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 ,d+[DATE], 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 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-[DATE]. 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 [DATE] with diagnoses that included Acute heart disease of native coronary artery and Acute systolic (congestive) heart failure Record review of the MDS dated [DATE] 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 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 [DATE] and ultimately led to the death of Res #1 at the hospital on [DATE]. 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 [DATE]-February 2023 and that on [DATE] 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 [DATE]. The facility provided an acceptable Removal Plan on [DATE]. Review of the facility's Removal Plan revealed the facility took the following actions to remove the IJ: Removal Plan: (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On [DATE], Resident #1 began vomiting coffee ground emesis and was transferred to the hospital and expired at the hospital on [DATE]. 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 [DATE] 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 [DATE] 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 [DATE]. 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 [DATE]. 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 [DATE]. No staff will be allowed to work until the in-service training has been completed. CNAs' have documented bowel movements via the kiosk on [DATE]. 45 minutes prior to the end of each shift the medication nurse on each hall checked CNAs documentation for completion, beginning [DATE]. 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 [DATE] and no staff will be allowed to work until the in-service training has been completed. On Friday [DATE] and Monday [DATE] 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. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	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//,d+[DATE] 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 [DATE]. 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 [DATE]. 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 [DATE]. 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 [DATE] and the IJ was removed on [DATE]. VALIDATION: On [DATE], 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 [DATE] 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) CNAs' working in the building on all three (3) shifts on [DATE] had attended in-service training beginning on [DATE] 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 [DATE] 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 [DATE]. 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. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	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 [DATE] and on Monday [DATE] 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 [DATE] 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 [DATE] with in-servicing of facility staff. The ADM confirmed through interview that the QA meeting on [DATE] 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 [DATE] 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 [DATE] had all required members present including the MD and the IP. Staff interviewed on [DATE] 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.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21029 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 [DATE]. On [DATE], 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. The State Agency (SA) identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) that began on [DATE] when Resident #1 began vomiting and complaining of stomach pain. Resident #1 was admitted to the local hospital on [DATE] with vomiting and stomach pain and died on [DATE] as a result of aspiration from vomiting due to a bowel impaction. On [DATE] 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 [DATE] at 1:30 PM the SA provided IJ temple for F 835 to the facility. The facility submitted an acceptable Removal Plan on [DATE], in which the facility alleged that the immediacy of the Jeopardy was removed on [DATE]. The IJ was removed on [DATE]. The SA validated the Removal Plan on [DATE], and determined the IJ was removed on [DATE], 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 [DATE], 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). Review of the facility's policy and procedure titled: Activities of Daily Living (ADLs') dated ,d+[DATE] Date Reviewed/Revised: [DATE] 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. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	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. Real time charting is required .17. Immediately report any changes in resident's condition or incidents to the Nursing Supervisor . Interview on [DATE] 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 ,d+[DATE] and ,d+[DATE] shifts. The DON revealed that for over a year the CNAs charted manually on paper charts and on [DATE] 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 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. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Interview on [DATE] 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 to her admission to the hospital on [DATE]. 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 [DATE] at 9:00 AM revealed that (Res #1) had been transferred to the hospital from the facility on [DATE] due to vomiting coffee ground looking substances (emesis) and for stomach pain. DON stated that Res #1 was diagnosed at the hospital on [DATE] with an impaction. The DON stated that on [DATE], 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 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 [DATE]. 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. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Record review of the Care Plan for Res #1 dated [DATE] 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 ,d+[DATE] x week (,d+[DATE] times per week) to next review [DATE] 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 [DATE] through [DATE] 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 [DATE] through [DATE], 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 [DATE] through [DATE]. The record review revealed that Res #1 had one (1) BM during the 3:00 PM-11:00 PM shift on [DATE]; on [DATE] there was one (1) BM recorded/documented by the CNAs for Res #1 on the 7:00 AM-3:00 PM shift; and on [DATE] 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 [DATE] 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 [DATE]. Record review revealed there were four (4) progress notes in [DATE], 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 [DATE], and one (1) BM on [DATE] during the 7:00 AM-3:00 PM shift. Res #1 had no (zero) BMs documented/recorded on 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 [DATE] at 2:39 PM, revealed: Acute Visit [DATE] 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. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Record review of the medical records from the hospital dated [DATE]-[DATE] 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 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 [DATE]. Interview on [DATE] 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 [DATE]. 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 [DATE] at 2:15 PM with the DON (RN#1) revealed the facility knew on [DATE], 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 [DATE] at 2:50 PM with the Assistant Director of Nursing (ADON-RN#3) revealed that she had been working at the facility since [DATE]. She stated that no one 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 [DATE] 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 [DATE], 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. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Interview on [DATE] 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 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 [DATE] 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 [DATE] 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-[DATE] for Res #1. They both 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 [DATE] at 10:25 AM, with the ADON-RN#3, revealed that after the death of Res #1 on [DATE] 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 [DATE]. 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 [DATE] 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 [DATE], 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 [DATE] 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 [DATE] and she began in-services with all staff on [DATE]. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Interview on [DATE] at 1:00 PM with the Resident Representative (RR) of Resident #1 revealed that she had been at the facility visiting Res #1 on [DATE] or [DATE] 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 [DATE], 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 [DATE] 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 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 [DATE] and ultimately led to the death of Res #1 at the hospital on [DATE]. Resident #2: Observation of Res #2 on [DATE] at 12:30 PM revealed that Res #2 was sitting in a wheelchair outside of her room. Res #2 was not interviewable. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Record review of Res #2's Care Plan dated [DATE] 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 admitted [DATE] 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 [DATE] 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 [DATE] through [DATE], revealed documentation under the Bowel Function section as follows Res #2 had no BM's recorded for five (5) consecutive days for [DATE] through [DATE]. Res #2 had no BM's recorded/documented on the ADLs sheets for three (3) consecutive days from [DATE]-[DATE]; and Res #2 had no BM's recorded on the ADLs sheets for five (5) consecutive days of [DATE]-[DATE]. 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 [DATE] and one (1) progress note recorded for [DATE]. No progress notes were recorded/documented for Res #2 pertaining to her ADLs care and services for [DATE]-[DATE]. Interview on [DATE] at 12:35 PM with CNA#1 revealed that she was the CNA for Res #2 on [DATE]. 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 [DATE] 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 [DATE] that contained a Brief Interview of Mental Status (BIMS) score of 0 (Blank) which indicated that Res #3 was severely cognitively impaired. Res #3 had a face sheet that contained an admitted [DATE] and diagnoses of Heart Failure; Hemiplegia following cerebral infract 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 [DATE] which did not address Res #3's ADLs' or bowel program. Res #3 had one (1) documented progress note dated [DATE] written by the social worker. No progress notes were documented for [DATE] 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. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Record review of Res #3 revealed a Care Plan dated [DATE] that read: At constipation risk r/t (in reference to) advanced age, impaired mobility, meds. Will have soft formed stool ,d+[DATE] x week (,d+[DATE] times per week) to next review [DATE]. 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 [DATE] at 1:00 PM with CNA #2 she stated that she had been working at the facility as a CNA since [DATE]. She 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 [DATE] 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 [DATE]. 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 [DATE] 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 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 [DATE] 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 [DATE] 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 [DATE] 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 ,d+[DATE] x week (,d+[DATE] times per week) to next review [DATE]. 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. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Record review of Res #4's Minimum Data Set (MDS) dated [DATE] 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 da [TRUNCATED]

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	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** 21029 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 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 [DATE] when Res #1 began vomiting and complaining of stomach pain. Res #1 was admitted to the local hospital on [DATE] with vomiting and stomach pain and died on [DATE] as a result of aspiration from vomiting due to a bowel impaction. On [DATE] at 5:30 PM the SA notified the facility Administrator, and the Director of Nursing of the IJ and SQC and on [DATE] at 1:30 PM the SA provided IJ template for F835 to the facility. The facility submitted an acceptable Removal Plan on [DATE], in which the facility alleged that the immediacy of the Jeopardy was removed on [DATE] and the IJ was removed on [DATE]. The SA validated the Removal Plan on [DATE], and determined the IJ was removed on [DATE], 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 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 [DATE] 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 . (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Record review of the facility policy and procedure titled Abuse Neglect and Exploitation/Misappropriation Policy with a revision date of [DATE] 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 [DATE] 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 [DATE] 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 [DATE] 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 state and federal regulations to include . Care Plans, and patient records . (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Interviews on [DATE] 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 [DATE]. 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 ,d+[DATE] and ,d+[DATE] 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 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-[DATE]). In an interview on [DATE] 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 documentation for Res #1 that she had BM's prior to her admission to the hospital on [DATE]. 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 [DATE], 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: (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Record review of the Nurse Practitioner's (NP) progress note date [DATE] at 2:39 PM revealed: Acute Visit [DATE] 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 [DATE]-[DATE] 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 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 [DATE]. In an interview with the DON on [DATE] at 9:00 AM, revealed that Res #1 had been admitted to the hospital from the facility on [DATE] due to vomiting coffee ground looking substances (emesis) and for stomach pain. Res #1 was diagnosed at the hospital on [DATE] with an impaction and on [DATE] 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 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. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Record review of the facility's Care Tracker Documentation Record ADL care sheets for January-[DATE] 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 [DATE]-[DATE] 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 [DATE]-[DATE]. The record review revealed that Res #1 had one (1) BM during the 3:00 PM-11:00 PM shift on [DATE]; on [DATE] there was one (1) BM recorded on the 7:00 AM-3:00 PM shift; and on [DATE] the CNAs documented (1) BM during the 7:00 AM -3:00 PM shift. The record review revealed that the progress notes for [DATE] 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 [DATE]. 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 [DATE], and one (1) BM on [DATE] during the 7:00 AM-3:00 PM shift). Res #1 had no (zero) BM's documented/recorded on the ADL care sheets from [DATE]-[DATE]. The facility documentation that was provided for Res #1's BM's for [DATE]-[DATE] 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 [DATE] 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 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 [DATE] at 2:15 PM, with the DON, she stated that they knew on [DATE] 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 [DATE] at 2:50 PM, with the Assistant Director of Nursing (ADON-RN#3) revealed that she had been working at the facility since [DATE]. 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. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Interview on [DATE] 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. 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 [DATE] for vomiting and then Resident #1 died on [DATE]. In an interview on [DATE] 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 [DATE], 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-[DATE] 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 [DATE]-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 [DATE]-[DATE]. 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 [DATE]-[DATE], and no BM's recorded on the ADL sheets for five (5) consecutive days of [DATE]-[DATE]. No progress notes were documented for Res #2 pertaining to her ADL care and services for [DATE]-[DATE]. Record review of Res #2 revealed a Face Sheet with an admitted [DATE] and diagnoses of Hemiplegia following cerebral infraction affecting right dominant side, Dysphagia, and dementia, among other diagnoses. Record review revealed a Minimum Data Set (MDS) dated [DATE] that contained a Brief Interview for Mental Status (BIMS) score of 3 which indicated that Res #2 was severely cognitively impaired. Resident #3: (continued on next page)

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	255182	A. Building B. Wing	03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeview Nursing Center	16411 Robinson Road Gulfport, MS 39503

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	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 [DATE] 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 admitted [DATE] 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 [DATE] 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 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 [DATE] - [DATE]. Record review of Res #4's MDS dated [DATE] 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 admitted [DATE] and diagnoses of Chronic Obstructive pulmonary disease; and Gastro-escophageal reflux disease; among other diagnoses. Resident #5: In an interview and observation on [DATE] 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 [DATE] - [DATE] Care Tracker Documentation Record bowel function ADL sheet had Res #5 documented/recorded as having no bowel movements from [DATE]-[DATE] (three (3) consecutive days with no bowel movement). The ADL sheet had no BM's documented for Res #5 from [DATE]-[DATE] (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. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	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 ,d+[DATE], 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-[DATE]. Record review for Res #5 revealed that she had a Face Sheet revealed a re-admitted [DATE]. 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 [DATE] contained a 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 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 [DATE] and ultimately led to the death of Res #1 at the hospital on [DATE]. 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 [DATE]-February 2023 and that on [DATE] 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 [DATE]. The facility provided an acceptable Removal Plan on [DATE]. Review of the facility's Removal Plan revealed the facility took the following actions to remove the IJ: Removal Plan: On [DATE], Resident #1 began vomiting coffee ground emesis and was transferred to the hospital and expired at the hospital on [DATE]. 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. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The State Survey Agency (SA) called Immediate Jeopardy (IJ) and provided the facility with IJ templates on [DATE] 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 [DATE] 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 [DATE]. 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 [DATE]. 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 [DATE]. No staff will be allowed to work until the in-service training has been completed. CNAs' have documented bowel movements via the kiosk on [DATE]. 45 minutes prior to the end of each shift the medication nurse on each hall checked CNAs documentation for completion, beginning [DATE]. 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 [DATE] and no staff will be allowed to work until the in-service training has been completed. On Friday [DATE] and Monday [DATE] 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//,d+[DATE] 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 [DATE]. 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 [DATE]. 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. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	An Emergency QA meeting was held on [DATE]. 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 [DATE] and the IJ was removed on [DATE]. VALIDATION: On [DATE], 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 [DATE] 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 [DATE] had attended in-service training beginning on [DATE] 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 [DATE] 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 [DATE].