STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065269	A. Building B. Wing	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Pueblo	2118 Chatalet LN Pueblo, CO 81005

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 0550 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51160 Based on record review and interviews the facility failed to ensure residents were treated with dignity and respect for three (#1, #12 and #9) of four residents out of 13 sample residents. Resident #1, who was non-weight bearing on his right leg due to a broken ankle required staff assistance to transfer from his wheelchair to and from the toilet. According to Resident #1, certified nurse aide (CNA) #1 was rude to him when he requested assistance with transferring to the toilet and told him he could use the bathroom himself. CNA #1 did assist the resident onto the toilet, however when Resident #1 requested assistance to transfer back to his wheelchair after using the bathroom, CNA #1 entered the resident's room and refused to assist him. CNA #1 informed the resident we are not doing this again and left the resident's room without assisting him. Resident #1 said he had to remain on the toilet until another CNA responded to his call light and came to assist him from the toilet back to his wheelchair. Resident #1 said the experience made him feel humiliated. On another occasion, Resident #1 said CNA #1 approached him in the dining room and when he did not respond to her, she laughed at him and rudely said What's the matter with you, you don't have a mouth now and That's right, you're mad at me. Resident #1 again said the experience with CNA #1 humiliated him. Resident #1 said CNA #1 entered his room to answer his call light and he asked her to leave because he did not want to receive care from her due to his past experiences with her. The resident said he told CNA #1 he was going to report her behavior to the nursing home administrator (NHA) and CNA #1 responded by saying I've already told therapy about you. Resident #1 said her statement made him feel scared. Resident #1 said he was afraid other staff would treat him poorly if CNA #1 was bad-mouthing him. Resident #1 said he reported CNA #1's behavior to the NHA, however, he said nothing had changed and CNA #1 now snickered at him and heckled him in the hallway when he passed by. He said she sometimes stood outside his room and stared at him or laughed at him. He said he had started to keep his door closed when CNA #1 was working but he preferred to have his door open. Due to the facility's failure to ensure Resident #1 was treated with respect and dignity by CNA #1 and the facility's failure to follow up effectively with CNA #1 to ensure CNA #1's behaviors toward Resident #1 were corrected, Resident #1 suffered psychosocial harm due to feelings of humiliation from the treatment he received and fear that other staff would also treat him poorly. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065269	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/07/2024
NAME OF PROVIDER OR SUPPLIER Life Care Center of Pueblo		STREET ADDRESS, CITY, STATE, ZIP CODE 2118 Chatalet LN Pueblo, CO 81005	

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 0550 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Additionally, Resident #12 and Resident #9 reported they were not treated with dignity and respect by staff on occasion. The residents felt staff were rude, degrading and did not care for them. Findings include: I. Facility policy and procedure The Dignity policy and procedure, dated September 2023, was provided by the nursing home administrator (NHA) on 8/7/24 at 3:12 p.m. It read in pertinent part, Each resident has the right to be treated with dignity and respect. Interactions with staff must focus on maintaining and enhancing the resident's self-esteem and self-worth, as well as honor and value their input. The facility must protect and promote the rights of the resident. II. Resident #1 A. Resident status Resident #1, age less than 65, was admitted on [DATE]. According to the August 2024 computerized physician orders (CPO), diagnoses included fracture of upper and lower end of right fibula, closed fracture with routine healing, lack of coordination, muscle weakness, difficulty in walking and pressure ulcer of the right ankle. The 6/17/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The resident was dependent on staff assistance for toilet transfers. The assessment revealed the resident was strictly non-weight bearing on his right extremity related to his fractured fibula. B. Resident interview Resident #1 was interviewed on 8/5/24 at 4:31 p.m. Resident #1 said he was admitted to the facility for rehabilitation after breaking his ankle. He said he was unable to bear any weight on his right ankle related to the surgery. He said because of his surgery, he needed staff assistance to get on and off of the elevated commode that was placed over the toilet in his bathroom. Resident #1 said he had used his call light to request assistance transferring from his wheelchair onto the commode. He said CNA #1 was rude and refused to help him. Resident #1 said CNA #1 told him he could go to the bathroom by himself. Resident #1 said he told her he could not because he was non-weight bearing and weak. He said CNA #1 told him that it was (expletive language) that he needed assistance. Resident #1 said while he was seated on the commode after having a bowel movement he used the call light to request assistance to transfer back to his wheelchair. Resident #1 said CNA #1 entered his bathroom in response to the call light, said we're not doing this again and exited the room. He said she left him seated in the bathroom soiled. He said he felt humiliated. Resident #1 said he had to continue to push the call light until another CNA came to the bathroom to assist him. (continued on next page)

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F 0550

Level of Harm - Actual harm

Residents Affected - Few

Note: The nursing home is disputing this citation.

Resident #1 said he was approached on another occasion in the dining room by CNA #1. He said she was rude and hateful toward him. Resident #1 said CNA #1 aske him What's the matter with you, you don't have a mouth now? He said she then laughed at him and said That's right, you're mad at me and walked away. Resident #1 said again he felt humiliated.

Resident #1 said he no longer wanted to receive care from CNA #1. He said CNA #1 came into his room another time, after he pushed the call light. He said he asked her to leave and he would wait for another CNA or nurse to come assist him. He said CNA #1 argued with him about leaving. Resident #1 said he told CNA #1 that he was going to report her behavior to the NHA. Resident #1 said, in response, she told him I've already told therapy about you. He said CNA #1's statement made him feel scared. Resident #1 said he was afraid other staff would treat him poorly if CNA #1 was bad-mouthing him.

Resident #1 said he reported CNA #1 to the NHA, however, he said her behavior toward him had not changed. Resident #1 said after he reported CNA #1's behavior to the NHA, she began to bully him in the hallways. He said she snickered and heckled him while passing him in the hallways. Resident #1 said CNA #1 had begun to stand outside his doorway and stared or laughed at him. He said he had begun to keep his door shut during her scheduled shifts, however, he said he preferred for his door to remain open.

C. Record Review

Review of Resident #1's August 2024 CPO revealed a physician's order that indicated the resident was to 7/26/24 continue strict non-weight bearing to his right lower extremity for four more weeks.

D. Staff interviews

The NHA and the director of nursing (DON) were interviewed together on 8/5/24 at 5:35 p.m. The NHA said he remembered receiving a complaint from Resident #1 about CNA #1. The NHA said Resident #1 had been upset with CNA #1 because she had been rude. The NHA said the resident was unable to express an exact allegation and had reported the complaint to him in the hallway.

The NHA said he had not spoken with CNA #1 because he had been unsure exactly what to speak to her about.

The DON said she had spoken with CNA #1. The DON said Resident #1 had reported that CNA #1 had been rude to him on a Friday, however, she said CNA #1 did not work on Fridays. The DON said when she approached CNA #1 about Resident #1's complaint, CNA #1 told her she had no issues with the resident. The DON said it may be easy for a resident to become confused as to the day of the week.

The NHA said CNA #1 had been told not to provide cares to Resident #1 unless it was necessary, such as when another staff member could not provide assistance to the resident.

The NHA said the facility did not change the hallway assignment for CNA #1 so she would no longer be providing care for Resident #1 because she had been told not to answer his call light. The NHA said he did not investigate or file a grievance on Resident #1's behalf because it had appeared to be a customer service issue.

(continued on next page)

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F 0550 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	-However, per Resident #1's interview, he continued to have problems with CNA #1 (see resident interview above). The NHA was interviewed again on 8/7/24 at 10:15 a.m. The NHA said a Resident's Rights training had been attended by every employee during their orientation and then annually thereafter. III. Resident #12 A. Resident status Resident #12, age greater than 65, was admitted on [DATE]. According to the August 2024 CPO, diagnoses included chronic respiratory failure, chronic obstructive pulmonary disease (COPD), dependence on oxygen, weakness and difficulty in walking. The 5/22/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. The resident required assistance with activities of daily living (ADL). B. Resident interview Resident #12 was interviewed on 8/7/24 at 2:00 p.m. Resident #12 said most staff treated her with dignity and respect. However, she said today (8/7/24) the bath aide (CNA #7) was an (expletive language) to her. She said CNA #7 refused to put lotion or ted hose (compression stockings) back on her after her shower. She said CNA #7 told her she did not have time. She said this morning (8/7/24) her breakfast tray came late and her coffee was cold. She said this happened frequently so she asked when her tray was picked up to have two cups of hot coffee brought to her. However, Resident #12 said, this morning (8/7/24) CNA #8 told her she did not have time to go get the hot coffee so she would have to wait until lunch. Resident #8 said it made her feel like she was not important and it was degrading to her. She said she tried not to bother the staff unless she needed to. She said she had complained in the past, but it did not do any good. Resident #12 said the CNAs gossiped about residents who complained. C. Staff interview The NHA was interviewed on 8/7/24 at 2:30 p.m. The NHA said he was informed of the above interview with Resident #12. He said the resident should have received the care she requested. He said he would investigate the situation and go talk to Resident #12. He said the facility staff could use some training on customer service. He said he would talk to the dietary manager about the coffee being cold. IV. Resident #9 A. Resident status Resident #9, age greater than 65, was admitted on [DATE]. According to the August 2024 CPO, diagnoses included COPD, type II diabetes mellitus with neuropathy, heart failure, neurocognitive disorder with Lewy bodies and hemiplegia and hemiparesis (weakness to one side of the body). (continued on next page)

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F 0550 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The 5/10/24 MDS assessment revealed the resident had moderate cognitive impairment with a BIMS score of nine out of 15. B. Resident interview Resident #9 was interviewed on 8/6/24 at 9:05 a.m. Resident #9 said licensed practical nurse (LPN) #1 did not treat her with respect and dignity. She said LPN #1 was rude and would not listen to her. She said when she had chest pain LPN #1 would not believe her. Resident #9 said LPN #1 just did not care for her. She said she tried to avoid her when she was the nurse for the day. C. Staff interview The social service assistant (SSA) was interviewed on 8/6/24 at 9:30 a.m. The SSA spoke with Resident #9 about her concern and told the resident she would investigate. The SSA said the staff were to treat residents with respect. She said Resident #9 was able to make her needs known. She said she would check in with the resident periodically to see how she was doing.

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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** 51160 Based on record review and interviews, the facility failed to ensure residents had the right to be free from physical abuse for one (#3) of three residents reviewed for abuse out of 13 sample residents. Resident #3 was admitted to the facility on [DATE] with a diagnosis of constipation. On [DATE], in the early morning hours, Resident #3 called for assistance. The resident told the staff that she was constipated and needed assistance or she wanted to go to the hospital. Registered nurse (RN) #1 came to her room. Certified nurse aide (CNA) #5 assisted Resident #3 to roll over. RN #1 began to insert a suppository and felt a hard stool in the resident's rectum. As RN #1 removed the stool from Resident #3's rectum, the resident was crying and yelling in pain and asking RN #1 to stop. However, RN #1 continued to proceed with the removal of the stool, while the resident was crying in pain, which caused mental anguish, emotional distress and fear for Resident #3. Additionally, the facility failed to document any information related to Resident #3's fecal impaction and the procedure that occurred in Resident #3's electronic medical record (EMR). Findings include: I. Professional references According to Setya A, [NAME] G, Cagir B. (2023). Fecal Impaction. National Institutes of Health, retrieved on [DATE] from https://www.ncbi.nlm.nih.gov/books/NBK448094/, Fecal impaction is a significant but preventable problem in the elderly population within hospitals and other institutions. The best way to treat it is to prevent it from developing in the first place. The cause of constipation should be identified early and managed appropriately. The treatment options are the rectal administration of stool softening agents, usually enemas or suppositories or a digital evacuation of the impacted fecal mass.The procedure is best done using ample lubrication and gently removing the impacted stool with the index finger. Treas, L.S., [NAME], K.L., & [NAME], M.H. (2022) Basic Nursing, Thinking, Doing and Caring, (Third edition), pages ,d+[DATE], retrieved on [DATE], read in pertinent part, Position patient on left side which helps with medication retention because the descending colon is on the left side, it also helps relax the external anal sphincter (rectum). The patient should not experience pain during the administration of a suppository, but they will feel pressure. Encourage deep breathing to aid in relaxation of the sphincter. Pushing a suppository through a constricted sphincter causes discomfort. II. Facility policy and procedure (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The Abuse and Neglect policy and procedure, dated [DATE], was provided by the nursing home administrator (NHA) on [DATE] at 9:11 a.m. It read in pertinent part, Nursing homes must incorporate clear-cut policies and practices that demonstrate a hardline, zero-tolerance approach to resident abuse. It is the policy and practice of this facility that all residents will be protected from all types of abuse. Prohibiting and preventing all forms of abuse. Identifying what constitutes abuse. Reporting abuse. III. Physical abuse by RN #1 toward Resident #3 on [DATE] The [DATE] facility investigation was received from the nursing home administrator (NHA) on [DATE] at 12:45 p.m. The investigation was related to an allegation of sexual abuse on [DATE]. Resident #3 was interviewed by the facility on [DATE] at 4:00 p.m. Resident #3 said she had been feeling constipated and had requested a suppository. Resident #3 said RN #1 had inserted more than three fingers inside her rectum, moving them around, during the medication administration. Resident #3 told RN #1 that it was hurting and to stop, but RN #1 did not stop. Resident #3 said she was told by RN #1 not to push her call light again after the incident. Resident #3 said she did not feel safe in the facility. The roommate of Resident #3 was interviewed by the facility on [DATE] at 9:15 a.m. The roommate reported that RN #1 said she had come off of her break to deal with Resident #3. The roommate said Resident #3 had repeatedly yelled for RN #1 to stop. The roommate said RN #1 had hurt Resident #3 and she had heard her scream. The roommate said she had begun to pray for Resident #3. RN #1 was interviewed by the facility on [DATE] at 11:15 a.m. RN #1 said she administered a suppository after digitally removing stool from the Resident #3's rectum. RN #1 said the care only lasted 15 to 20 seconds. RN#1 said Resident #3 never told her to stop. The facility unsubstantiated Resident #3's sexual abuse related to the resident's emergency department (ED) visit had not noted trauma to the resident's rectal area. -However, according to the ED visit documentation, the resident's rectum was mildly red (see record review below). IV. Resident #3 A. Resident status Resident #3, age greater than 65, was admitted on [DATE] and discharged to home on [DATE]. According to the [DATE] computerized physician orders (CPO), diagnoses included constipation, gastro-esophageal reflux disease (GERD), nausea, diabetes mellitus type 2, end stage renal disease and left leg below the knee amputation. The [DATE] minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The MDS assessment documented the resident was receiving renal dialysis. V. Resident's representative interview (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The resident's representative was interviewed on [DATE] at 12:55 p.m. The representative said Resident #3 resided at the facility, until she moved her from the facility on [DATE]. She said her mother had experienced a traumatic event at the facility. She said her mother had a history of constipation. She said Resident #3's mother had died at an early age of a bowel obstruction and so Resident #3 was very cautious about her bowels. She said Resident #3 told her she was held down while RN #1 gave her a suppository. She said Resident #3 was crying out to stop and RN #1 did not stop. She said the resident was afraid to stay in the facility. The resident's representative said Resident #3 was a religious woman and she felt she was rectally assaulted to the extent that she continued to have nightmares about the abuse. She said the resident was humiliated and embarrassed and that was why she did not report the abuse the night the incident occurred. She said Resident #3 told the social worker at the dialysis center of the abuse. The representative said the dialysis center social worker (DSW) reported the incident to adult protective services. VI. Record Review The admission record dated [DATE] revealed Resident #3 admitted to the facility with a medical diagnosis of a history of constipation. A [DATE] emergency department report for Resident #3 documented there was a small external hemorrhoid at the 11 o'clock position of the resident's rectum that was not bleeding and there were no overt tears, trauma, bleeding or bruising. The note documented the rectum did not appear to be irritated but was mildly red inside. A [DATE] facility nursing progress note documented a facility RN got a report from the emergency department that Resident #3 was alright and did not have bleeding or tears from the rectum. Another [DATE] facility nursing progress note documented Resident #3 had come back from the emergency department and was hungry. The [DATE] nurse practitioner note documented the nurse practitioner followed-up regarding the resident's sexual assault allegation. The note said the resident voiced to the nurse practitioner that she was constipated and the nurse forcefully digitally stimulated her. The note documented the resident was seen at the hospital and no evidence of trauma was noted on the exam. The note documented an investigation of the incident was in progress with nursing staff. A review of the resident's EMR did not reveal other documentation regarding the procedure that was done on [DATE] that prompted the resident to go to the emergency department, the allegation made, or any psychosocial harm on [DATE]. VII. Staff interviews RN #1 was interviewed on [DATE] at 7:24 p.m. RN #1 said Resident #3 had requested a suppository (laxative). RN #1 said she entered Resident #3's room with CNA #5 to administer the suppository. RN #1 said she had explained the need for digital disimpaction (procedure of removing stool from the rectum with the index finger) to Resident #3. RN #1 said the resident was educated that the stool needed to be removed for the suppository to work properly. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	RN #1 said she had heard the resident moaning as stool was removed from the rectum. RN #1 said the resident did say to stop, but it had been after the disimpaction and after her finger had already entered the rectum to administer the suppository. RN #1 then said she had never heard the resident say to stop. RN #1 said after the event she had heard from others that the resident had said to stop. RN #1 said the resident may have said stop, but she did not hear it until she was done. RN #1 said she may have forgotten to chart the administration of the suppository. Certified nurse aide (CNA) #5 was interviewed on [DATE] at 7:24 p.m. CNA #5 said Resident #3 had complained of constipation and had been turning her call light on every fifteen minutes asking for something to help her with her constipation. CNA #5 said Resident #3 had told her that the day shift nursing staff had not given her anything to relieve her of her constipation. CNA #5 said Resident #3 said she had been passing hard little balls of feces throughout the day and evening shifts. CNA #5 said she told RN #1 and that it took her a while to come into Resident #3's room to give her the suppository. CNA #5 said that Resident #3 understood the procedure. CNA #5 said once RN #1 came in to give the suppository, she helped roll Resident #3 onto her right side and held Resident #3's hand with her right hand and had her left hand on Resident #3's hip. CNA #5 said RN #1 did explain the procedure to her, that she needed to get the feces out for the suppository to work. CNA #5 said Resident #3 was crying and yelling for RN #1 to stop because the digging was painful. CNA #5 said RN #1 did not stop. CNA #5 said RN #1 was really digging the bowel movement out and RN #1 should have stopped when Resident #3 was yelling for her to stop. CNA #5 said she did not feel comfortable asking RN #1 to stop because she was a new CNA and also because RN #1 was the charge nurse on duty. A frequent visitor (FV) was interviewed on [DATE] at 9:24 a.m. She said she got a phone call from the resident's representative the morning of [DATE]. The FV said the resident's representative told her Resident #3 had been receiving a suppository and was digitally probed to the point where it felt as if she had been sexually assaulted, so much so that the representative took her to the emergency department for a sexual assault examination. The FV said the resident's representative told her that Resident #3 was fearful and traumatized from the experience. The NHA and the director of nursing (DON) were interviewed together on [DATE] at 10:15 a.m. The DON said RN #1 should have applied lubrication to her gloved finger before she inserted her finger into Resident #3's rectum. The DON said RN #1 should have removed as much stool as required to administer the suppository. The DON said RN #1 should have stopped when told to stop by the resident. The DON said if a resident said stop, it was their right and it did not matter what care was being performed at the time. The DON said RN #1 should have stopped the procedure and provided education to the resident. She said RN #1 should have provided options (continuing with the disimpaction, stopping the procedure completely or calling a provider) and allowed the resident to decide how they proceeded. The DON said there should be documentation in the resident's electronic medical record (EMR) of the digital stool removal. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The NHA said he was the abuse coordinator for the facility. The NHA said on [DATE] he was notified of a sexual abuse allegation by Resident #3's dialysis center. The NHA said after he had received a notification of sexual abuse, he contacted the DON and the regional director. The NHA said he did not remember who notified him. The NHA said he called the DON, the regional team, the ombudsman and the police. He said he then reported Resident #3's allegation of rape to the State Agency reporting site. The NHA said the investigation had begun immediately upon the facility's notification of the allegation. The NHA said RN #1 and CNA #5 were placed on administrative suspension for approximately five days during the investigation. The NHA read aloud the facility-conducted interview of Resident #3's roommate. The NHA said he had seen and read the interview before. The NHA said his first instinct would have been that there had been potential abuse. The dialysis center social worker (DSW) returned a phone call (placed during the survey) and was interviewed on [DATE] at 9:33 a.m. The DSW said on [DATE] Resident #3 arrived for dialysis appearing disheveled, tearful and her demeanor was out of character. The DSW said as the dialysis staff attempted to calm down Resident #3, she had begun to shake and had cried. The DSW said Resident #3 told the dialysis staff that a CNA held her down and a nurse forced a suppository inside her. The DSW said Resident #3 said she had told them to stop, never mind, she did not want the suppository anymore, she just wanted to go to sleep. Resident #3 said the nurse did not stop. The DSW said Resident #3 used the words, fearful, scared, and retaliation. 51163

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Pueblo	2118 Chatalet LN Pueblo, CO 81005

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 51160

Based on record review and interviews, the facility failed to have evidence that all alleged abuse were thoroughly investigated for one (#3) of three residents reviewed for abuse of 13 sample residents.

Specifically, the facility failed to thoroughly investigate an allegation of abuse.

Findings include:

I. Facility policy and procedure

The Abuse and Neglect policy and procedure, dated [DATE], was provided by the nursing home administrator (NHA) on [DATE] at 9:11 a.m. It read in pertinent part, The facility must develop and implement written policies and procedures to investigate any such allegations. Have evidence that all alleged allegations of abuse are thoroughly investigated.

II. Resident #3

A. Resident status

Resident #3, age greater than 65, was admitted on [DATE] and discharged to home on [DATE]. According to the [DATE] computerized physician orders (CPO), diagnoses included constipation, gastro-esophageal reflux disease (GERD), nausea, diabetes mellitus type 2, end stage renal disease and left leg below the knee amputation.

The [DATE] minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15.

B. Resident's representative interview

The resident's representative was interviewed on [DATE] at 12:55 p.m. The representative said Resident #3 resided at the facility, until she moved her from the facility on [DATE]. She said her mother had experienced a traumatic event at the facility. She said her mother had a history of constipation. She said Resident #3's mother had died at an early age of a bowel obstruction and so Resident #3 was very cautious about her bowels. She said Resident #3 told her she was held down while registered nurse (RN) #1 gave her a suppository. She said Resident #3 was crying out to stop and RN #1 did not stop. She said the resident was afraid to stay in the facility.

The resident's representative said Resident #3 was a religious woman and she felt she was rectally assaulted to the extent that she continued to have nightmares about the abuse. She said the resident was humiliated and embarrassed and that was why she did not report the abuse the night the incident occurred. She said Resident #3 told the social worker at the dialysis center of the abuse.

Cross-reference F600 for failure to keep a resident free from abuse.

(continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	C. Facility investigation of incident between RN #1 and Resident #3 The [DATE] facility investigation was provided by the nursing home administrator (NHA) on [DATE] at 12:45 p.m. The investigation was related to an allegation of sexual abuse in the early morning hours of [DATE]. The roommate of Resident #3 was interviewed by the facility on [DATE] at 9:15 a.m. The roommate reported that RN #1 said she had come off of her break to deal with Resident #3. The roommate said Resident #3 had repeatedly yelled for RN #1 to stop. The roommate said RN #1 had hurt Resident #3 and she had heard her scream. The roommate said she had begun to pray for Resident #3. RN #1 was interviewed by the facility on [DATE] at 11:15 a.m. RN #1 said she administered a suppository after digitally removing stool from the Resident #3's rectum. RN #1 said the care only lasted 15 to 20 seconds. RN #1 said Resident #3 never told her to stop. On [DATE] at approximately 3:00 p.m. the facility interviewed certified nurse aide (CNA) #5. CNA #5 said she helped RN #1 administer the suppository by rolling Resident #3 onto her side. CNA #5 said the nurse had to remove feces to get the suppository placed inside Resident #3. CNA #5 said RN #1 told Resident #3 I can't stop because I am trying to pull feces out so I can put the suppository in. Resident #3 was interviewed by the facility on [DATE] at 4:00 p.m. Resident #3 said she had been feeling constipated and had requested a suppository. Resident #3 said RN #1 had inserted more than three fingers inside her rectum, moving them around, during the medication administration. Resident #3 told RN #1 that it was hurting and to stop, but RN #1 did not stop. Resident #3 said she was told by RN #1 not to push her call light again after the incident. Resident #3 said she did not feel safe in the facility. The investigation revealed the facility interviewed one additional staff member who was working the floor at the time of the incident. -However, the two additional staff members who were working at the time of the incident were not interviewed as part of the investigation. According to review of the facility's investigation, three additional staff members from different shifts were interviewed and asked if they had ever witnessed staff members being sexually inappropriate with residents and if they had any concerns about the way staff members handled residents. The facility interviewed five additional residents, asking each of them the following questions: -Has a staff member ever been sexually inappropriate with you; -Are you fearful of any staff members; -Do you feel safe; and, -Is there anything else you want the facility to know? (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-However, the facility failed to ask the residents any questions related to if any of them had ever experienced any care from staff that they felt had been provided in a forceful physical way. The facility unsubstantiated Resident #3's sexual abuse related to the resident's emergency department (ED) visit had not noted trauma to the resident's rectal area. -However, the facility failed to investigate the potential that physical abuse occurred due to the forceful way RN #1 administered the suppository to Resident #3, despite Resident #3 asking the nurse to stop. D. Record Review An emergency department (ED) visit progress note, dated [DATE] at 3:23 p.m., documented Resident #3 appeared to be nervous. Resident #3 said she had been rectally assaulted, possibly for disimpaction, but against her will. The note documented the resident had a small external hemorrhoid at the 11 o'clock position of the rectum that was not bleeding and there were no overt tears, trauma, bleeding or bruising. The note further documented the rectum did not appear to be irritated but was mildly red inside. III. Staff interviews The NHA and the director of nursing (DON) were interviewed together on [DATE] at 10:15 a.m. The NHA said he was the abuse coordinator for the facility. He said he was notified of a sexual abuse allegation on [DATE]. The NHA said he followed the investigation procedure for a sexual abuse allegation. The DON said the facility had not substantiated the sexual abuse allegation because the emergency room discharge stated no signs of trauma or assault. The DON said RN #1 had been interviewed by a CNA who was helping out the social services department and was not a licensed social worker. The DON said she had not conducted the interviews because RN #1 was the DON's sister, so she had removed herself from the investigation. She said she did not think the assistant director of nursing (ADON) had conducted an interview with RN #1 in her place when she removed herself from the investigation. The NHA said the interviews during the investigation should have been conducted by a qualified social worker or someone from the management team, and not the CNA who was not a licensed social worker. During the interview, the NHA read aloud the interview that the facility had conducted with Resident #3's roommate. After reading the interview, the NHA said his first instinct would have been that there had been potential physical abuse, however, he said he did not recognize it at the time of the incident. The NHA said every staff member who was working on the shift when the incident occurred should have been interviewed. 51163

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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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51160 Based on record review and interviews, the facility failed to develop and implement an effective discharge plan for one (#3) of three residents reviewed for discharge planning out of 13 sample residents. Specifically the facility failed to assist Resident #3 in the development of a safe and appropriate discharge plan. Findings include: I. Facility policy and procedure The Against Medical Advice (AMA) Discharges policy and procedure, August 2023, was provided by the nursing home administrator (NHA) on 8/7/24 at 2:30 p.m. It read in pertinent part, If a resident wishes to be discharged prior to the completion of medical treatment or against the advice of the attending physician to a setting that does not appear to meet their needs or appears unsafe, the facility will treat this a refusal of care. The facility will complete the required documentation and provide written discharge instructions as with any discharge. If a discharge AMA cannot be prevented, a practitioner must evaluate the resident's mental capacity to be sure that the resident can understand the condition, the nature and effect of the proposed treatment, and the inherent risk/benefit in pursuing the treatment and not pursuing the treatment. Documentation should include the resident's decision-making capacity, disclosed risks, and the resident's understanding of those risks. As with any discharge, the facility is required to provide written discharge instructions, including follow-up with practitioners, medication management, the need for continued therapy, and any durable medical equipment necessary. Notify the resident practitioner, the facility's social services department, and a facility administrator of the resident's desire to leave the facility AMA. The AMA documentation includes: decision-making capacity, discussion of treatment goals (risks of not completing goals with resident understanding those risks), date and time the practitioner was notified of residents desire to discharge AMA, discharge arrangements made with caregiver/family member, written discharge instructions provided, person to whom resident was discharged , signed copy of the AMA form, physical assessment findings and education provided to resident and family (with understanding of that teaching). II. Resident #3 A. Resident status (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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #3, age greater than 65, was admitted on [DATE] and discharged to home on 6/7/24. According to the June 2024 computerized physician orders (CPO), diagnoses included constipation, gastro-esophageal reflux disease (GERD), nausea, diabetes mellitus type 2, end stage renal disease and left leg below the knee amputation. The 4/24/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. She required a hoyer lift for transfers related to a recent left leg below the knee amputation. The MDS assessment did not indicate the resident had an ongoing discharge plan. B. Resident's representative interview The resident's representative was interviewed on 8/7/24 at 12:55 p.m. The resident's representative said her mother had informed her of an incident which occurred in the early morning of 6/5/24. She said her mother had told her later in the morning (6/5/24) that she was scared and did not want to continue to live at the facility. The resident's representative said she spoke with the NHA to inform him of the abuse allegation. The resident's representative said Resident #3 went to dialysis on 6/5/24 and then to the hospital to be examined for a sexual assault allegation. The resident's representative said Resident #3 returned to the facility on [DATE] so the family could have time to obtain a Hoyer lift (mechanical lift) and a medical bed in order to make preparations so Resident #3 could be discharged from the facility to live with her. The resident's representative was a certified nurse aide (CNA) and an emergency medical technician (EMT). The resident's representative said she had told the facility she wanted Resident #3 to discharge home with her, however, she needed time to prepare. The resident's representative said the NHA told her if she was taking Resident #3 out of the facility it would be AMA and he had forced her to sign the AMA paperwork on the discharge date of [DATE]. The resident's representative said the facility did not send any discharge instructions, medications or a list of the current medications that Resident #3 was currently prescribed. She said Resident #3 went nearly two weeks without her blood thinner medication and other medications. The resident's representative said the facility did not send any paperwork with the resident. The resident's representative said the facility did not provide any assistance with the discharge planning process. C. Record review The AMA form, dated 6/7/24, was signed by the resident's daughter, the ombudsman and a registered nurse (RN). The discharge form documented, in pertinent part, I am being discharged against the advice of the attending physician and the facility administration. I acknowledge that I have been informed of the risks involved and hereby release the attending physician and the facility from all responsibility for and from anything that may result from such discharge. I am also aware that I will be responsible for any costs incurred tha my insurance company refuses to cover. -Review of Resident #3's electronic medical record (EMR) did not reveal documentation indicating the facility had assisted the resident with discharge goals. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The EMR failed to document the reasons for the AMA discharge, who had made the decision for the AMA discharge or if the interdisciplinary team (IDT) was involved with the decision to discharge the resident AMA. -The EMR failed to document if the resident's physician or the medical director (MD) was notified of Resident #3's AMA discharge. -A review of Resident #3's June 2024 CPO did not reveal a physician's order for the resident's discharge. -The EMR did not reveal documentation to indicate that a discharge summary or any discharge documentation was sent with the resident. III. Staff interviews The NHA and the director of nursing (DON) were interviewed together on 8/7/24 at 10:15 a.m. The DON said it was not been safe for Resident #3 to discharge home with family. The DON said the family had told the facility they were unable to care for the resident at home. The DON said the resident did return to the facility after dialysis and the emergency department on 6/5/24 and was not discharged AMA until 6/7/24. The DON said the facility had wondered why Resident #3 had come back to the facility after her emergency department visit if the family had not wanted her there. The DON said when the resident was first admitted to the facility she had planned to return home with her family. The DON said the resident's representative and the resident had made the decision to stay at the facility, as it was going to be difficult for the resident's representative to care for the resident at home. The DON said the facility made the decision to discharge Resident #3 AMA due to the fact that the resident's representative had told them she could not take care of her at home but was insisting on taking the resident home anyway. The DON said the resident's physician had not been notified prior to Resident's #3's discharge or that the resident left AMA. The DON said Resident #3's EMR should have included documentation that she had been discharged home. The DON said it was standard practice for the facility to notify adult protective services (APS) when a resident was discharged AMA, however, the DON said APS had not been contacted by the facility regarding Resident #3's AMA discharge. The social services director (SSD), and the DON were interviewed together on 8/7/24 at 2:45 p.m. The SSD said a discharge summary should have been written and given to the family upon discharge. The SSD said she did not know why a physician's discharge order was not obtained. The SSD said although she was newly employed and was not hired at the time of Resident #3's discharge, she said the practice was for the social worker to lead the discharge planning process. She said the social worker was to offer services and make referrals when needed. The SSD said the IDT was to complete a summary of the resident's stay. The SSD said she reviewed Resident #3's EMR and said there was not any documentation or evidence which showed the resident was offered any services or discharge planning assistance. She said pertinent phone numbers, such as advocacy contact numbers, were not provided. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The MD was interviewed on 8/7/24 at 3:19 p.m. via telephone. The MD said there should have been a physician's discharge order when Resident #3 was discharged from the facility. The MD said the attending physician should have been notified and participated in the AMA discharge process. The MD said he was not notified that Resident #3 had been discharged AMA. The dialysis center social worker (DSW) was interviewed on 8/15/24 at 9:33 a.m. via telephone. The DSW said the facility had not completed a safe discharge for Resident #3. The DSW said the facility left the resident's representative on her own with the discharge. The DSW said the facility did not provide discharge instructions, a medication list or the necessary equipment for Resident #3 to successfully discharge. The DSW said she picked up oxygen supplies at a medical supply company for Resident #3. 51163

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51160 Based on record review and interviews, the facility failed to provide treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan for one (#3) of three residents reviewed for quality of care out of 13 sample residents. Specifically the facility failed to: -Follow the physician's standing orders for bowel management for Resident #3; -Document the bowel medications that were administered to Resident #3; -Document the nursing medication reassessment; -Document the nursing abdominal and peri-rectal assessment; and, -Document the digital fecal disimpaction (procedure of removing stool from the rectum with a finger) procedure for Resident #3. Findings include: I. Professional reference Setya A, [NAME] G, Cagir B. (2023). Fecal Impaction. National Institutes of Health. Retrieved on [DATE] from https://www.ncbi.nlm.nih.gov/books/NBK448094/. It read in pertinent part, Fecal impaction is a significant but preventable problem in the elderly population within hospitals and other institutions. The best way to treat it is to prevent it from developing in the first place. The cause of constipation should be identified early and managed appropriately. The treatment options are the rectal administration of stool softening agents, usually enemas or suppositories or a digital evacuation of the impacted fecal mass. The procedure is best done using ample lubrication and gently removing the impacted stool with the index finger. Treas, L.S., [NAME], K.L., & [NAME], M.H. (2022) Basic Nursing, Thinking, Doing and Caring, (Third edition), page 2065 was retrieved on [DATE]. It read in pertinent part, A health record permanently documents: the care, in chronological order, performed by healthcare providers, responses to medications, interventions, and procedures. Document the medication, time, dose, and route given, preadministration assessments, and your signature. Document all therapeutic and adverse effects of the medication. Also document your nursing interventions and teaching of potential adverse effects. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Treas, L.S., [NAME], K.L., & [NAME], M.H. (2022) Basic Nursing, Thinking, Doing and Caring, (Third edition), pages ,d+[DATE] was retrieved on [DATE]. It read in pertinent part, Position patient on left side which helps with medication retention because the descending colon is on the left side, it also helps relax the external anal sphincter (rectum). The patient should not experience pain during the administration of a suppository, but they will feel pressure. Encourage deep breathing to aid in relaxation of the sphincter. Pushing a suppository through a constricted sphincter causes discomfort. II. Facility policy and procedure The Bowel Protocol policy and procedure, dated [DATE], was provided by the NHA on [DATE] at 8:44 a.m. It read in pertinent part, Provide effective interventions for signs and symptoms of constipation. Nursing staff will record, in the electronic health record (EHR), each time a resident has a bowel movement. The Nursing Facility Standing Orders and Constipation policy and procedure, dated [DATE], was provided by unit care coordinator (UCC) #1 on [DATE] at 12:12 p.m. It read in pertinent part, The nurse may order the following if no bowel movement for three days: milk of magnesia; dulcolax suppository, fleets enema or senna. If standing orders are followed and not effective, report assessment of impaction, bowel sounds, vital signs, last BM (bowel movement) quality and quantity, presence of blood in stool, recent administration of narcotics and fluid intake. III. Resident #3 A. Resident status Resident #3, age greater than 65, was admitted on [DATE] and discharged home on [DATE]. According to the [DATE] computerized physician orders (CPO), diagnoses included constipation, gastro-esophageal reflux disease (GERD), nausea, diabetes mellitus type 2, end stage renal disease and left leg below the knee amputation. The [DATE] minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The MDS assessment revealed dependent status required two staff assistance with hoyer for transfers. B. Resident's representative interview The resident's representative was interviewed on [DATE] at 12:55 p.m. The representative said Resident #3's mother died at an early age from a bowel obstruction and therefore she was always concerned about her bowel regimen because she was fearful of an obstruction. C. Record review The [DATE] CPO revealed the following physician's order for bowel management: -Standing order/protocols, ordered on [DATE]; -Colace 100 mg (milligrams) (laxative) oral capsule as needed, ordered on [DATE]; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Fleet enema ,d+[DATE] grams (g) per 118 milliliter (ml) enema as needed, ordered on [DATE]; -Miralax (3350 powder) 17 g with 120 to 240 ounces (oz) of fluid as needed, ordered on [DATE]; -Bisacodyl 10 mg suppository as needed, ordered on [DATE]; -Miralax (1450 powder) 17 g with eight oz ounces of fluid was ordered daily, ordered on [DATE] (started after the disimpaction procedure on [DATE]); and, -Senna-docusate sodium 8XXX,d+[DATE] mg oral tablet was ordered nightly, ordered on [DATE] (started after the disimpaction procedure on [DATE]). The bowel and bladder elimination tracking record ([DATE] to [DATE]) revealed the following: On [DATE], the resident had a large bowel movement. On [DATE], it was documented a response was not required. On [DATE], it was documented a response was not required On [DATE], there was no documentation. On [DATE], it was documented a response was not required. On [DATE] at 12:55 a.m., it was documented a response was not required On [DATE] at 5:39 p.m., it was documented the resident had a small bowel movement. On [DATE], it was documented a response was not required. On [DATE] at 12:51 a.m., it was documented the resident had a medium bowel movement. -According to the [DATE] medication administration record (MAR) the resident did not receive any as needed laxatives, softeners or enemas after she had gone four days ([DATE] to [DATE]) without any bowel movement. -The facility failed to follow the standing physician's orders for bowel management. -Review of Resident #3's electronic medical record (EMR) did not reveal documentation regarding RN #1's assessment of the resident's bowel status or the procedure for the fecal disimpaction and suppository administration in the early morning hours of [DATE] (see interviews below). IV. Staff interviews (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Unit care coordinator (UCC) #1 was interviewed on [DATE] at 12:00 p.m. UCC #1 said all medications that were administered needed to be documented as administered in the resident's EMR. UCC #1 said there was a standing order list (a list of common medical issues with steps and medications for the nurses to utilize). UCC #1 said constipation was one of the common issues that occurred with residents that was included on the standing physician's orders. The director of nursing (DON) was interviewed on [DATE] at 3:48 p.m. The DON said residents' bowel movements were charted by the certified nurse aides (CNA). The DON said the standing physician's orders for bowel protocol began with the most gentle laxative and increased in strength if it was found to be unsuccessful. The DON said the nurses would give a stool softener, then milk of magnesia (laxative), then a suppository or enema. The DON said registered nurse (RN) #1 did not document in Resident #3's EMR that she performed a fecal disimpaction or administered the suppository on [DATE]. RN #1 was interviewed on [DATE] at 7:24 p.m. RN #1 said Resident #3 had complained of constipation on the previous day ([DATE]). RN #1 said she had given Resident #3 milk of magnesia (laxative) and miralax (laxative) which helped the resident have a few small bowel movements. RN #1 said the resident had requested a Bisacodyl suppository (laxative). -However, RN #1 did not document that she had administered the resident milk of magnesia, miralax or the suppository (see record review above). RN #1 said as part of her assessment, she had listened to bowel sounds, palpated her stomach and verified that the resident was able to pass gas. RN #1 said she had explained to the resident that there was a need for digital fecal disimpaction. RN #1 said the resident was educated that stool needed to be removed for the suppository to work properly. RN #1 said she lubricated her finger and massaged the lubrication around the edge of the rectum. She said some small stool exited the rectum with the lubrication and palpation around the resident's rectum. RN #1 said there were many little, hard, shaped balls of stool in different sizes from small to quarter sized. RN #1 said she may have forgotten to chart the administration of the suppository and the fecal disimpaction. The DON was interviewed a second time on [DATE] at 10:15 a.m. The DON said RN #1 should have documented the abdominal and rectal assessment, digital stool removal and the fecal disimpaction. The DON said all medications and treatments given to residents should be documented on the MAR when given.