STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105550	A. Building B. Wing	04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookwood Gardens Rehabilitation and Nursing Cente	1990 S Canal Drive Homestead, FL 33035

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 - Actual harm Residents Affected - Few	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** 45019 Based on record review and interviews, the facility failed to ensure one (Resident #2) out of three sampled residents was free from abuse and neglect and is determined to be at a level of harm, as evidenced by: the facility's staff failure to implement interventions for constipation and prevention of fecal impaction that resulted in the fecal impaction of Resident # 2 who subsequently expired after being transferred to the hospital. There were 155 residents residing in the facility at the time of the survey. The findings included: Review of Resident #2's medical records revealed the resident was initially admitted to the facility on [DATE] and readmitted on [DATE]; and discharged to the hospital on [DATE]. Resident # 2's clinical diagnoses included but not limited to: Cachexia, Anorexia, Nutritional anemia, type 2 diabetes mellitus (DM) and Disease of esophagus and Dementia. Review of the Physician's Orders Sheet for October to [DATE] revealed Resident #2 had orders that included but not limited to: Docusate sodium oral tablet 100 mg- give 1 capsule orally two times a day related to constipation,. Elder tonic liquid, give 15 ml orally two times a day related to eating disorder, unspecified. Diet-Regular diet, Regular texture, Regular/Thin consistency. Record review of Resident # 2's Discharge Return anticipated Minimum Data Set (MDS) dated [DATE] revealed: Section C for Cognitive Patterns documented a Brief Interview of Mental status Score (BIMS) of 11, on a ,d+[DATE] scale indicating the resident is cognitively moderately impaired. Section GG for Functional Status documented the resident required supervision for transfer, walking, toilet use, personal hygiene, and limited assistance for dressing. Section H for Bowel and Bladder Documented the resident is continent of bowel and bladder. Section K for Nutritional Status documented the resident was 67 inches tall, weighed 80 pounds and had no unknown weight loss/gain. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 - Actual harm Residents Affected - Few	Review of Resident #2 's Care Plans Reference Date [DATE]. revision date [DATE] documented Resident is at risk for bowel/ bladder incontinence related to impaired mobility. Interventions include- Ensure the resident has had unobstructed path to the bathroom. Monitor and document intake and output as per facility policy. Monitor/document for signs and symptoms of Urinary Tract Infection: pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. Monitor/ document/ report as needed any possible causes of incontinence: bladder, infection, constipation, loss of bladder tone, weakening of control muscles, decreased bladder capacity, diabetes, Stroke, medication side effects. Review of Resident #2 's Care Plans Reference Date [DATE] documented Resident has a potential risk for constipation, Interventions include: Encourage by mouth fluids as tolerated, follow facility bowel protocol for bowel management., Monitor medications for side effects of constipation. Keep physician informed of any problems, Monitor/document/report as needed signs and symptoms of complications related to constipation: Change in mental status, new onset: confusion, sleepiness, inability to maintain posture, agitation, Bradycardia (slow, low pulse), Abdominal distension, vomiting, small loose or stools, fecal smearing, Bowel sounds, Diaphoresis, Abdomen: tenderness, guarding, rigidity, fecal compaction. Record bowel movement pattern each day, every shift. Describe amount, color, and consistency. Review of Resident #2 's Care Plans Reference Date [DATE] documented Resident is at risk for falls. Interventions include Anticipate and meet the resident's need. Follow facility fall protocol. Physical Therapy to evaluate and treat patient as ordered. Review of the progress notes dated [DATE] timestamped at 10:44 AM documented: At 10:38 AM Resident was sitting in wheelchair outside patio and fell out of wheelchair on floor as per report by bystanders. Observed in right side lying position upon arrival to scene by assigned nurse. Management on scene. Resident was alert and oriented x 2, verbally responsive, no sign and symptoms of injuries. At 10:39 AM Fire rescue called by assigned staff while other staff nurse and management assisted patient to room. Head to toe assessment was completed with no visual injuries observed. Family notified spoke with resident's emergency contact after 3 attempts to contact resident's son by the phone number on record. Nurse Practitioner notified, Fire rescue arrived and assessed resident and left the facility at 11:10 AM to [local hospital] with the resident. Review of Resident #2's hospital records revealed on [DATE] upon arrival to the hospital's emergency department (ED) the patient was hypotensive (low blood pressure) BP (Blood Pressure) of ,d+[DATE],, Hypothermic (low body temperature) with temperature of 33 degrees Celsius/91.4 degrees Fahrenheit. The resident's final diagnoses included Septic shock, Fecal Impaction of Colon, Metabolic Acidosis, and Closed Traumatic Brain Injury. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 - Actual harm Residents Affected - Few	Interview on [DATE] at 1:19 PM with the Director of Nursing (DON). The DON stated: On [DATE] the resident was on the smoking patio sitting having a conversation with another resident, the other resident was waving to the staff because [Resident # 2] was pale and started sliding from the wheelchair, staff responded, took the resident to her room, evaluated the resident, took her vital signs, documented the vitals in the situation, background, assessment and resolution (SBAR), the resident was alert, her blood pressure was low and she looked confused, normally she is alert and oriented, while she was in the room with the staff the resident had a bowel movement and was stating that she needed her purse. We called the resident's physician and was told to transfer the resident to the hospital for evaluation. 911 arrived shortly, they checked on the resident, she was responding to all their questions, the only thing that they found was she had low blood pressure, Rescue initially, did not want to take the resident to the hospital, but we insisted because we notice a change in the resident. The day the resident fell she had a bowel movement in the room during the time the staff was assessing her. The Certified Nursing Assistants (CNAs) are responsible for recording the residents' bowel movement every shift. Regarding this resident, she is very independent, and she used to go to the bathroom by herself but sometimes she needed help. The CNAs ask the resident if she have a bowel movement to notify them about it and we educated the resident about making sure she let nursing staff know when she wants to use the bathroom and when she has a bowel movement, also about safety regarding using the call light for help when she goes to the bathroom. The resident was also educated to leave the toilet unflushed after being used for bowel movement and notify the staff so they could see the amount and type of bowel movement. According to the documentation on the task list on [DATE] was the last documented bowel movement for this resident. I know for sure the resident had a bowel movement on [DATE] after the fall when she was in her room being assessed by the nurse. My follow up was trying to contact the resident's son, on [DATE] there was no answer on the phone; the hospital then called later in the day for family contact information for the resident. On [DATE] the resident's son called the facility, and stated he changed his number, I let the resident's son know we needed his new information to update the records. The resident's son notified me that he was coming to the facility the following week. He came to the facility a few days later, me, NHA (Nursing Home Administrator) and business office staff met with him about his mother's purse-he wanted to retrieve the purse, he was given his mother's purse. At that time the resident's son did not request any medical records or voiced any concerns about his mother's care in the facility and apologized for the incident we had with other family members coming to the facility and going through the resident's belongings in her room looking for documents on [DATE]. We did not know that the resident incurred any injuries after the fall, she was alert, was able to move all her extremities. On [DATE] we called the facility liaison at the hospital; the resident was still in the emergency room , and she did not have any update for us at that time. When we followed up with the liaison afterwards, we found out the resident passed away, but we were not given any diagnosis or results. When the admission department contacted the hospital, they received a report that the resident had constipation complications. We are still waiting for the resident's records from the hospital. (continued on next page)

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Brookwood Gardens Rehabilitation and Nursing Cente	1990 S Canal Drive Homestead, FL 33035

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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 - Actual harm Residents Affected - Few	Interview on [DATE] at 2:02 PM Licensed Practical Nurse (Staff A) stated: on [DATE] I was called to the patio to check on the resident, I was the resident's assigned nurse that day, I went to the patio, the resident was on the floor in front of her wheelchair, management and other staff was already there. I did a quick assessment of the resident, I asked the resident was she ok, the resident responded yes, The resident was on the floor, and I was not sure how she got there, my immediate response after assessing her was to call 911, I called 911 and other nurses on the scene were assisting the resident back to her wheelchair. We took her to her room, I did another assessment on the resident, vital signs, her blood pressure was on the low side. I do not recall if the resident had a bowel movement, it was a long time ago. While we were in the room with the resident rescue arrived, they did not want to take her to the hospital at first, we let them know she had fallen, and her blood pressure was low. Rescue decided to take the resident to the hospital. The family and the resident's physician were notified. This resident usually went to the bathroom by herself, the Certified Nursing Assistants (CNAs) would communicate with the resident about her bowel movements, she was very alert, she did not complain about any pain to me before the fall. Interview on [DATE] at 2:06 PM Certified Nursing assistant (CNA) (Staff B) stated: I have been employed in the facility for 8 years. After I assist a resident with incontinence care I record the bowel movement daily using the tablet on the electronic system. If I notice a resident does not have a bowel movement for a few days I report it to the nurse. Interview on [DATE] at 2:10 PM. Certified Nursing assistant (CNA) (Staff C) stated: I have residents on my assignment who are continent of bowel and bladder. I keep a record of their bowel movements by asking them throughout the day and updating it in the electronic system. If there is a resident who has not had any bowel movements in a couple days, I report it to the nurse. Interview on [DATE] at 2:13 PM CNA (Staff D) stated: I have been employed in this facility since 2019. I have residents who are incontinent. I record their bowel movements by looking in the incontinent brief and recording in the point of care electronic system what type, size, and color I see. If a resident does not have a bowel movement in a couple days I report it to the nurse. Review of the Bowel and Bladder Task list revealed the last bowel movement was documented on [DATE] at 23:29 bowel movement/large/formed/normal. Last toileting use documented was on [DATE] at 23:30. Review of the Transfer Details Report documented on [DATE] at 10:45 AM. Reason for transfer post status fall. Clinical events/presentation which led to this transfer: lethargic. Transfer Date/Time: [DATE], 10:48 am transfer to: [local hospital]. Vitals signs: temperature: 97.7, pulse: 57, respiration:16, blood pressure: , d+[DATE], oxygen saturation: 95%, blood sugar 90. Continent status: continent of bowel and bladder. Date of last Bowel movement: [DATE]. (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 - Actual harm Residents Affected - Few	Review of the Situation Background Assessment Transfer Report (SBAR) documented on [DATE] at 10:44 AM post status fall, Vitals: blood pressure ,d+[DATE], pulse- 66, respiration 16, temperature 97.9 blood glucose 90, oxygen saturation 97%. At 10:38 AM Resident was sitting in wheelchair outside patio and fell out of wheelchair on floor as per report by bystanders. Observed in right side lying position upon arrival to scene by assigned nurse. Management on scene. Resident was alert and oriented x 2, verbally responsive, no sign and symptoms of injuries. At 10:39 AM Fire rescue called by assigned staff while other staff nurse and management assisted patient to room. Head to toe assessment was completed with no visual injuries observed. Family notified spoke with resident's emergency contact after 3 attempts to contact resident's son by the phone number on record. Nurse Practitioner notified, Fire rescue arrived and assessed resident and left the facility at 11:10 AM to [local hospital] with the resident. Reviewed Training on Abuse, Neglect, Exploitation and Restraints, most recently completed for all facility staff on [DATE] to [DATE]. Review of the facility's policy and procedure titled Prevention of Resident Abuse, Neglect, Mistreatment or Misappropriation of Property dated [DATE] states: It is the policy of this Center that each resident has the right to be free from verbal, sexual, physical, and mental abuse; corporal punishment; involuntary seclusion; mistreatment of any kind, exploitation, and misappropriation of property. In addition, each resident will also be protected from those practices and omissions, which if left unchecked, could lead to abuse. Further, each resident will be treated with respect and dignity at all times. The Center will foster an environment that recognizes the worth and uniqueness of all individuals with regards to person-centered care and to promote respect and set standards of care. Residents will not be subjected to abuse by anyone, including but not limited to, Center staff, other residents, consultants, volunteer staff, contract staff, family members, friends, or others. Neglect: Neglect means the failure of the center, its associates or service providers, to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.

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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 - 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** 45019 Based on record review and interviews, the facility failed to ensure one (Resident #2) out of three sampled residents received care and treatment in accordance with professional standards of practice related to consistency in the resident's bowel management; that include but not limited to interventions for constipation and prevention of fecal impaction. Resident # 2 expired in the hospital and was diagnosed with fecal impaction. This deficient practice was determined to be at the level of harm. There were 155 residents residing in the facility at the time of the survey. The findings included: Review of the undated facility policy and procedures titled, Quality of Care Attain and Maintain Each resident must receive, and the facility will provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Guidelines: 1. This facility will monitor the resident to prevent unavoidable deterioration by identification, interventions, and analysis. 3. The facility will ensure that the resident obtains optimal improvement or does not deteriorate within the limits of a resident's right to refuse treatment and within the limits of recognized pathology and normal aging process. Review of Resident #2's medical records revealed the resident was initially admitted to the facility on [DATE] and readmitted on [DATE]; and discharged to the hospital on [DATE]. Resident # 2's clinical diagnoses included but not limited to: Cachexia, Anorexia, Nutritional anemia, type 2 diabetes mellitus (DM) and Disease of esophagus. Review of the Physician's Orders Sheet for October -[DATE] revealed Resident #2 had orders that included but not limited to: Docusate sodium oral tablet 100 mg- give 1 capsule orally two times a day related to constipation, unspecified. Ferrous sulfate tab 325 Milligram (mg)- give 1 tablet orally one time a day related to anemia. Calcium tablet 600 mg-give 1 tablet orally one time a day for vitamin deficiency, unspecified. Elder tonic liquid, give 15 ml orally two times a day related to eating disorder, unspecified. Diet-Regular diet, Regular texture, Regular/Thin consistency. Review of Resident # 2's Discharge Return anticipated Minimum Data Set (MDS) dated [DATE] revealed: Section C for Cognitive Patterns documented a Brief Interview of Mental status Score (BIMS) of 11, on a , d+[DATE] scale indicating the resident is cognitively moderately impaired. Section GG for Functional Status documented the resident required supervision for transfer, walking, toilet use, personal hygiene, and limited assistance for dressing. Section H for Bowel and Bladder Documented the resident is continent of bowel and bladder. Section K for Nutritional Status documented the resident was 67 inches tall, weighed 80 pounds and had no unknown weight loss/gain. (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 0684 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #2 's Care Plans Reference Date [DATE]. revision date [DATE] documented Resident is at risk for bowel/ bladder incontinence related to impaired mobility. Interventions include- Ensure the resident has had unobstructed path to the bathroom. Monitor and document intake and output as per facility policy. Monitor/document for signs and symptoms of Urinary Tract Infection: pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. Monitor/ document/ report as needed any possible causes of incontinence: bladder, infection, constipation, loss of bladder tone, weakening of control muscles, decreased bladder capacity, diabetes, Stroke, medication side effects. Review of Resident #2 's Care Plans Reference Date [DATE] documented Resident has a potential risk for constipation, Interventions include: Encourage by mouth fluids as tolerated, follow facility bowel protocol for bowel management., Monitor medications for side effects of constipation. Keep physician informed of any problems, Monitor/document/report as needed signs and symptoms of complications related to constipation: Change in mental status, new onset: confusion, sleepiness, inability to maintain posture, agitation, Bradycardia (slow, low pulse), Abdominal distension, vomiting, small loose or stools, fecal smearing, Bowel sounds, Diaphoresis, Abdomen: tenderness, guarding, rigidity, fecal compaction. Record bowel movement pattern each day, every shift. Describe amount, color, and consistency. Review of Resident #2 's Care Plans Reference Date [DATE] documented Resident is at risk for falls. Interventions include Anticipate and meet the resident's need. Follow facility fall protocol. Physical Therapy to evaluate and treat patient as ordered. Review of the progress notes dated [DATE] timestamped at 10:44 AM documented: At 10:38 AM Resident was sitting in wheelchair outside patio and fell out of wheelchair on floor as per report by bystanders. Observed in right side lying position upon arrival to scene by assigned nurse. Management on scene. Resident was alert and oriented x 2, verbally responsive, no sign and symptoms of injuries. At 10:39 AM Fire rescue called by assigned staff while other staff nurse and management assisted patient to room. Head to toe assessment was completed with no visual injuries observed. Family notified spoke with resident's emergency contact after 3 attempts to contact resident's son by the phone number on record. Nurse Practitioner notified, Fire rescue arrived and assessed resident and left the facility at 11:10 AM to [local hospital] with the resident. Review of Resident #2's hospital records revealed on [DATE] upon arrival to the hospital's emergency department (ED) the patient was hypotensive (low blood pressure), Hypothermic (extremely low body temperature). The resident was diagnosed with Septic shock, Fecal Impaction of Colon, Metabolic Acidosis, and Closed Traumatic Brain Injury. (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 0684 Level of Harm - Actual harm Residents Affected - Few	Interview on [DATE] at 1:19 PM with the Director of Nursing (DON). The DON stated: On [DATE] the resident was on the smoking patio sitting having a conversation with another resident, the other resident was waving to the staff because [Resident # 2] was pale and started sliding from the wheelchair, staff responded, took the resident to her room, evaluated the resident, took her vital signs, documented the vitals in the situation, background, assessment and resolution (SBAR), the resident was alert, her blood pressure was low and she looked confused, normally she is alert and oriented, while she was in the room with the staff the resident had a bowel movement and was stating that she needed her purse. We called the resident's physician and was told to transfer the resident to the hospital for evaluation. 911 arrived shortly, they checked on the resident, she was responding to all their questions, the only thing that they found was she had low blood pressure, Rescue initially, did not want to take the resident to the hospital, but we insisted because we notice a change in the resident. The day the resident fell she had a bowel movement in the room during the time the staff was assessing her. The Certified Nursing Assistants (CNAs) are responsible for recording the residents' bowel movement every shift. Regarding this resident, she is very independent, and she used to go to the bathroom by herself but sometimes she needed help. The CNAs ask the resident if she have a bowel movement to notify them about it and we educated the resident about making sure she let nursing staff know when she wants to use the bathroom and when she has a bowel movement, also about safety regarding using the call light for help when she goes to the bathroom. The resident was also educated to leave the toilet unflushed after being used for bowel movement and notify the staff so they could see the amount and type of bowel movement. According to the documentation on the task list on [DATE] was the last documented bowel movement for this resident. I know for sure the resident had a bowel movement on [DATE] after the fall when she was in her room being assessed by the nurse. My follow up was trying to contact the resident's son, on [DATE] there was no answer on the phone; the hospital then called later in the day for family contact information for the resident. On [DATE] the resident's son called the facility, and stated he changed his number, I let the resident's son know we needed his new information to update the records. The resident's son notified me that he was coming to the facility the following week. He came to the facility a few days later, me, NHA (Nursing Home Administrator) and business office staff met with him about his mother's purse-he wanted to retrieve the purse, he was given his mother's purse. At that time the resident's son did not request any medical records or voiced any concerns about his mother's care in the facility and apologized for the incident we had with other family members coming to the facility and going through the resident's belongings in her room looking for documents on [DATE]. We did not know that the resident incurred any injuries after the fall, she was alert, was able to move all her extremities. On [DATE] we called the facility liaison at the hospital; the resident was still in the emergency room , and she did not have any update for us at that time. When we followed up with the liaison afterwards, we found out the resident passed away, but we were not given any diagnosis or results. When the admission department contacted the hospital, they received a report that the resident had constipation complications. We are still waiting for the resident's records from the hospital. (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 0684 Level of Harm - Actual harm Residents Affected - Few	Interview on [DATE] at 2:02 PM. Licensed Practical Nurse (Staff A) stated: on [DATE] I was called to the patio to check on the resident, I was the resident's assigned nurse that day, I went to the patio, the resident was on the floor in front of her wheelchair, management and other staff was already there. I did a quick assessment of the resident, I asked the resident was she ok, the resident responded yes, The resident was on the floor, and I was not sure how she got there, my immediate response after assessing her was to call 911, I called 911 and other nurses on the scene were assisting the resident back to her wheelchair. We took her to her room, I did another assessment on the resident, vital signs, her blood pressure was on the low side. I do not recall if the resident had a bowel movement, it was a long time ago. While we were in the room with the resident rescue arrived, they did not want to take her to the hospital at first, we let them know she had fallen, and her blood pressure was low. Rescue decided to take the resident to the hospital. The family and the resident's physician were notified. This resident usually went to the bathroom by herself, the Certified Nursing Assistants (CNAs) would communicate with the resident about her bowel movements, she was very alert, she did not complain about any pain to me before the fall. Interview on [DATE] at 2:06 PM. Certified Nursing assistant (CNA) (Staff B) stated: I have been employed in the facility for 8 years. After I assist a resident with incontinence care I record the bowel movement daily using the tablet on the electronic system. If I notice a resident does not have a bowel movement for a few days I report it to the nurse. Interview on [DATE] at 2:10 PM. Certified Nursing assistant (CNA) (Staff C) stated: I have residents on my assignment who are continent of bowel and bladder. I keep a record of their bowel movements by asking them throughout the day and updating it in the electronic system. If there is a resident who has not had any bowel movements in a couple days, I report it to the nurse. Interview on [DATE] at 2:13 PM CNA (Staff D) stated: I have been employed in this facility since 2019. I have residents who are incontinent. I record their bowel movements by looking in the incontinent brief and recording in the point of care electronic system what type, size, and color I see. If a resident does not have a bowel movement in a couple days I report it to the nurse. Review of the Bowel and Bladder Task list revealed the last bowel movement was documented on [DATE] at 23:29 bowel movement/large/formed/normal. Last toileting use documented was on [DATE] at 23:30. Review of the Transfer Details Report documented on [DATE] at 10:45 AM. Reason for transfer post status fall. Clinical events/presentation which led to this transfer: lethargic. Transfer Date/Time: [DATE], 10:48 am transfer to: [local hospital]. Vitals signs: temperature: 97.7, pulse: 57, respiration:16, blood pressure: , d+[DATE], oxygen saturation: 95%, blood sugar 90. Continent status: continent of bowel and bladder. Date of last Bowel movement: [DATE]. (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 - Actual harm Residents Affected - Few	Review of the Situation Background Assessment Transfer Report (SBAR) documented on [DATE] at 10:44 AM post status fall, Vitals: blood pressure ,d+[DATE], pulse- 66, respiration 16, temperature 97.9 blood glucose 90, oxygen saturation 97%. At 10:38 AM Resident was sitting in wheelchair outside patio and fell out of wheelchair on floor as per report by bystanders. Observed in right side lying position upon arrival to scene by assigned nurse. Management on scene. Resident was alert and oriented x 2, verbally responsive, no sign and symptoms of injuries. At 10:39 AM Fire rescue called by assigned staff while other staff nurse and management assisted patient to room. Head to toe assessment was completed with no visual injuries observed. Family notified spoke with resident's emergency contact after 3 attempts to contact resident's son by the phone number on record. Nurse Practitioner notified, Fire rescue arrived and assessed resident and left the facility at 11:10 AM to [local hospital] with the resident. Review of the undated facility policy and procedures titled Bowel Protocol documents: Bowel Protocol-To promote elimination via non-medical interventions when able to prevent constipation. 1. Residents who have not had a bowel movement for 3 days are identified and considered to be at risk for constipation. 2. Nursing staff will encourage the resident to increase ingestion of fluids. 3. Nursing Staff will encourage daily mobility as capable of helping increase peristalsis and help keep bowels moving. 4. Residents will continue to be monitored by nursing staff for bowel movements following each step of the protocol and document results as appropriate. 5. An alert will be generated in electronic health record notifying nursing staff when a resident has not had a bowel movement for three consecutive days. Day 1 bowel protocol-Milk of Magnesia, Day 2 bowel protocol-Suppository, Day 3 bowel protocol-Enema.