STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335006	A. Building B. Wing	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Katherine Luther Residential Hlth Care & Rehab	110 Utica Road Clinton, NY 13323

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	Provide appropriate treatment and care according to orders, resident's preferences and goals. 46276 Based on record review and interviews during the abbreviated survey (NY00379334), the facility failed to ensure residents received treatment and care according to professional standards of practice, the comprehensive person-centered care plan, and the resident's choices for one (1) of three (3) residents (Resident #1) reviewed. Specifically, Resident #1 developed abdominal distention with pain, had one bowel movement in 6 days, was provided bowel medications without a physician order, and was not assessed by a qualified professional in a timely manner. Subsequently, Resident #1 was hospitalized for a bowel obstruction requiring emergency surgery. This resulted in actual harm to Resident #1 that was not Immediate Jeopardy. Findings include: The facility policy, Bowel Management Protocol, reviewed 3/21/2021, documented certified nurse aides documented bowel movements into the electronic medical record. The licensed nurse monitored the electronic medical record dashboard for alerts of residents with no bowel movements in 72 hours and would initiate the bowel protocol. If no bowel movement for three (3) days, prune juice would be given, then milk of magnesia on the 2nd shift, then a suppository on the 3rd shift. Abnormal findings would be reported to the physician. If findings were normal, a suppository would be given rectally, and results documented in the electronic medical record. For residents with a history of chronic constipation, nursing was to consult with the physician and dietitian for bowel interventions. The facility policy, Notification of Resident Conditions to Providers reviewed 10/25/2022 documented nursing would notify the resident, resident's physician and family representative for a significant change in the resident's physical status that is a deterioration in their health, including non-immediate no bowel movements for three (3) days with a distended abdomen and other abdominal symptoms. Resident #1 had diagnoses including Parkinson's Disease, (a progressive neurological disease), dementia, and constipation. The 1/29/2025 Minimum Data Set assessment documented the resident had moderately impaired cognition, required setup/clean up assistance with eating, had no weight loss, required a therapeutic diet, and required substantial/maximum assistance for toileting, had frequent bladder incontinence and was always continent of bowel. (continued on next page)

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

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

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The Comprehensive Care Plan initiated 8/5/2024 and resolved (discontinued) 12/30/2024 documented Resident #1 had a history of constipation related to Parkinson's Disease. Interventions included: follow the facility bowel protocol, monitor medications for side effects of constipation, keep the physician informed of any problems, monitor/document/report any signs or symptoms of complications related to constipation (change in mental status, sleepiness, inability to maintain posture, agitation, slow/low pulse, abdominal distension, vomiting, small or loose stools). Physician orders documented: - on 8/5/2024, bowel routine as per policy. - on 8/5/2024, MiraLAX oral powder (a laxative used for constipation), 17 grams per scoop, give 1 scoop by mouth once a day for supplement, mix with 9 ounces of juice or water. - on 8/6/2024, Senokot-S tablet, (sennosides-docusate sodium, a stool softener combined with a laxative) 8.6/50 milligrams, give 2 tablets by mouth one time a day for constipation. - on 8/6/2024, Dulcolax suppository (a laxative in suppository form), insert 1 suppository rectally once a day every 3 days to regulate bowel movements. The 1/29/2025 Registered Dietitian #13 quarterly nutritional assessment documented the resident had a decline in their meal intake and had consumed an average of 937 milliliters of fluids during meals, leaving 25% on their tray. Interventions were initiated to add more fluids. The 1/31/2025 resident care instructions documented Resident #1 required substantial/maximum assistance of one (1) staff with toilet transfers and hygiene and required toileting every two hours. The 3/2025 Documentation Survey Report (daily care log) from 3/5/2025 through 3/10/2025 documented the resident did not have a bowel movement (six days). The 3/1/2025-3/10/2025 Clinical and Order Alerts Listing Report (no bowel movement report) did not contain any documentation related to Resident #1. The 3/8/2025, at 6:00 AM Medication Administration Record documented Resident #1 received a Dulcolax suppository (scheduled) by Licensed Practical Nurse #15. There was no documented evidence a registered nurse assessment was completed, or a medical provider was notified the resident had not had a bowel movement for three days. The 3/8/2025 at 2:04 PM Licensed Practical Nurse #6 progress note documented the resident was on the bowel list, (a list generated if a resident had not had a bowel movement in three days, however the resident was not shown on this list when provided to the surveyor), the resident had some abdominal bloating, bowel sounds were active, and they were given as needed (not scheduled) Milk of Magnesia per the bowel protocol. There was no documented evidence a registered nurse assessment was completed, or the medical provider was notified related to the resident's distended abdomen and no bowel movement. There was no documented evidence the medical provider was notified for an order for the Milk of Magnesia that was provided. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The March 2025 Medication Administration Record did not include documentation the Milk of Magnesia was provided, as there was no documented physician order for the medication. The following information related to Resident #1's condition was obtained from staff interviews completed 5/5/2025 to 5/7/2025: - On 3/8/2025 at 6:30 AM, Certified Nurse Aide #5 reported to Licensed Practical Nurse #15 Resident #1's abdomen was hard, bloated, and did not look right. - Licensed Practical Nurse #15 stated they were completing their shift at 6:30 AM on 3/8/2025 (overnight) and passed the information on to Licensed Practical Nurse #6 and advised Licensed Practical Nurse #6 to call a supervisor. - Licensed Practical Nurse #6 was made aware on 3/8/2025 the resident had a suppository with no results and gave the resident Milk of Magnesia. The resident's abdomen was distended, and the resident complained of pain and discomfort. They thought they notified a supervisor but was unsure if an assessment was completed. The nurse stated a physician's order was not required for Milk of Magnesia and was not necessary to document on the Medication Administration Record. - Licensed Practical Nurse #8 worked 3/8/2025 during the 7:00 AM - 3:00 PM shift. The resident's family member discussed the resident's abdomen with them, but Licensed Practical Nurse #8 did not think the resident had any issues. They did not call a supervisor to assess the resident. - Registered Nurse Supervisor #10 was the supervisor on 3/8/2025 from 7:00 AM - 3:00 PM. They were unaware Resident #1 had a change in condition and would have expected to be notified. They did not have documentation Resident #1 was assessed and did not recall being notified for an assessment on their abdomen. - Certified Nurse Aide #3 was assigned to Resident #1 on 3/8/2025 during the 2:00 PM - 10:00 PM shift. The resident's abdomen was noticeably bloated, and the resident did not have a bowel movement all shift. They could not recall if they told a nurse that day. There was no documented evidence a supervisor was notified, or assessment completed on 3/8/2025 related to Resident #1's complaints of discomfort and distended abdomen. The 3/8/2025 at 4:18 PM nursing progress note by Licensed Practical Nurse #7 documented the resident had a large bowel movement. The characteristics of the bowel movement were not documented (loose, formed). There was no documentation related to how Licensed Practical Nurse #7 received the information (per certified nurse aide report or other). The 3/2025 Documentation Survey Report (daily care log) on 3/8/2025 documented the resident did not have a bowel movement. The following information related to Resident #1's condition was obtained from family and staff interviews completed 5/2/2025 to 5/7/2025: (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	- The family representative visited Resident #1 during the weekend of 3/8/2025 - 3/9/2025, their abdomen was bloated, distended, and hard to the touch. The resident complained of abdominal discomfort, constipation, and was squirming. The family representative communicated their concerns to Licensed Practical Nurses #7 and #8. They stated no one came to observe the resident's abdomen and no assessments were completed. - Licensed Practical Nurse #7 stated Resident #1 had a large loose bowel movement on 3/8/2025 on the 3:00 PM - 11:00 PM shift. On 3/9/2025, during the 3:00 PM - 11:00 PM shift the resident complained of discomfort and no bowel movement. The nurse gave the resident prune juice with no results and did not document it. By 11:00 PM, the resident's abdomen was more distended, the resident was complaining of discomfort, and Registered Nurse Supervisor #11 was notified. Licensed Practical Nurse #7 insisted on sending the resident to the hospital as the resident's abdomen was clearly more distended and the resident was uncomfortable, complaining they could not have a bowel movement. Registered Nurse Supervisor #11 declined to assess the resident as the resident had a recent bowel movement and did not think it was necessary based on a previous hospital transport when the diagnosis was only gas. Licensed Practical Nurse #7 disagreed and attempted to advocate for the resident to no avail. - Registered Nurse Supervisor #11 worked double evenings and overnight shifts on weekends. Resident #1 had a history of constipation and received a routine suppository. The resident had a history of complaining about gas and their bowels and the supervisor thought it was behavioral. They were not aware Resident #1 had not had a bowel movement and expected the licensed practical nurses to let them know if the resident had an issue. They would have documented a nursing progress note if they assessed the resident. There was no documented evidence nursing or medical staff addressed concerns related to Resident #1's complaints of discomfort, constipation, or abdominal distention on 3/9/2025. The 3/10/2025 at 4:29 AM progress note entered by Licensed Practical Nurse #7 documented the resident's abdomen was distended, hard to the touch, with bowel sounds, complaints of gas pain. Registered Nurse Supervisor #11 was made aware. The routine gas pill was given, and staff were to continue to monitor for changes in condition. There was no documented evidence of an assessment by a registered nurse or notification of a medical provider following the 3/10/2025 at 4:29 AM progress note. The 3/10/2025 at 8:49 AM nursing progress note by Registered Nurse #9 documented an assessment was performed on Resident #1, bowel sounds were absent, they directed an (unnamed) licensed practical nurse to give Milk of Magnesia, the medical provider was notified, and an x-ray of the kidneys, ureters, and bladder was obtained. The 3/10/2025 at 9:40 AM x-ray report documented critical findings of colonic ileus (paralysis of the large intestine) versus obstruction (blocked intestinal tract), that correlated clinically (symptoms similar, could not differentiate). The 3/10/2025 at 10:44 AM nursing progress note by Registered Nurse #9 documented Resident #1's x-ray results were abnormal, and the resident was sent to the hospital emergency room for evaluation and the family was notified. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The 3/10/2025 hospital record documented: - Resident #1 arrived in the emergency room due to abdominal distention, abdominal discomfort, and an abnormal x-ray. The resident complained of constipation and a decreased appetite. - Computed Axial Tomography Scan (a type of imaging that uses X-ray technique to create detailed images of the body) results documented the resident had severe fecal impaction and a dilated (enlarged) intestine. There was evidence a cecal volvulus (a condition where the first part of the intestine twists around itself) and surgical consultation was recommended - Resident #1 was seen for a surgical consult, surgery was recommended to untwist the intestine and remove the blockage. If the surgery was not completed, a life-threatening condition would have occurred where the intestine became ischemic (loss of blood flow to the tissue) and would have also required emergency surgery. - The Surgical Operative Report documented the resident had an open sigmoid resection with an end colostomy (a surgical procedure where the sigmoid colon is removed through an open incision and the remaining portion is diverted to an artificial opening created in the abdominal wall). During an interview on 5/5/2025 at 12:00 PM with Registered Nurse Manager #9, they stated when they arrived for their shift on 3/10/2025 at 7:00 AM, they were alerted by nursing staff Resident #1 had not had a bowel movement in six days. They assessed the resident, and their abdomen was distended to the extent they appeared as if they were going to have a baby, and their abdomen was hard to the touch. Registered Nurse Manager #9 stated Licensed Practical Nurse #7 documented the resident had a large bowel movement, but it was not documented in the point of care documentation, so they questioned it. There was no bowel movement documented for the resident for six days. The facility's bowel management protocol was initiated when a resident did not have a bowel movement for three days. Bowel protocol medications (Milk of Magnesia, suppository) required a physician order. They could not understand how staff did not notice the amount of abdominal distention they had. They were unaware of any assessments on the overnight shift. They notified the medical provider, and an x-ray of their abdomen was ordered. The resident was transferred to the hospital for abnormal x-ray results. Registered Nurse Manager #9 stated the resident should have been assessed at an earlier date and sent to the hospital. It was important to do an assessment because bowel issues could be serious. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on 5/5/2025 at 1:00 PM with Nurse Practitioner #12, they stated a physician order for a bowel protocol was a blanket order that meant if a resident had constipation issues, it could be implemented. Medications on the bowel protocol required a physician order and should be listed on the electronic medication administration records if/when administered. If a nurse had to administer Milk of Magnesia for constipation, they would expect to be notified first, as they would have prescribed an alternative medication such as lactulose (a synthetic sugar used to treat constipation) for Resident #1. Assessments should have been done every other day if a resident had a history of constipation and had been taking multiple bowel medications. They would expect a registered nurse to do an assessment and notify them of any concerns. Resident #1 had sennosides-sodium, Dulcolax suppositories and MiraLAX ordered routinely. There was no physician order for Milk of Magnesia and it was not shown on the electronic medication administration record. If nursing administered Milk of Magnesia, there should have been an order. They were not notified of Resident #1's change in condition and were not aware the resident had not had a bowel movement in six days. They stated Resident #1's bowel medications were not effective and the hospitalization and bowel obstruction was not a planned outcome. During an interview on 5/9/2025 at 1:20 PM, the Medical Director stated Resident #1 had constipation issues from time to time. They expected to be notified if a resident had not had a bowel movement in three days. Resident #1 should have had an abdominal assessment; they expected a registered nurse to do the assessment and report any abnormal findings. Licensed practical nurses could not assess and should have alerted a registered nurse if Resident #1 had not had a bowel movement and had abdominal distention. The Medical Director stated a volvulus occurred when the intestines twisted on itself and caused an obstruction. It could occur from constipation, or the volvulus could occur and cause constipation. The Medical Director stated it was difficult to state a cause, and that even one or two days of constipation could be life-threatening. It was important to notify a medical provider to get an x-ray to determine the seriousness of a resident's condition. 10 NYCRR 415.12