

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675976	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/12/2024
NAME OF PROVIDER OR SUPPLIER Winfield Rehab & Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 1108 E Loop 304 Crockett, TX 75835	
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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43872 Based on interview and record review, the facility failed to notify and consult with the resident's physician when there was a need to alter treatment for 1 of 8 residents (Resident #1) reviewed for notification of changes. The facility failed to ensure the physician was notified of a change in condition when Resident #1 did not have a bowel movement for 14 days. Resident #1 had contained fecal perforation in her rectum and expired at the hospital on [DATE]. The noncompliance was identified as PNC. The IJ began on [DATE] and ended on [DATE]. The facility had corrected the noncompliance before the survey began. This failure could place residents at risk of not receiving appropriate medical treatments, deterioration of health, hospitalization , and death. Findings included: Review of face sheet dated [DATE] indicated Resident #1 was [AGE] years old, admitted on [DATE] with diagnoses of hemiplegia and hemiparesis (paralysis and weakness to one side of the body) following cerebral infarction (stroke) affecting left non-dominant side, adjustment disorder with mixed disturbance of emotions and conduct, feeding difficulties, cognitive communication deficit, contracture to right and left hand and wrists, and visual loss. Review of quarterly MDS, dated [DATE], revealed Resident #1 had a BIMS score of 15, indicating no cognitive impairment and a score of 03 for bowels, indicating always incontinent. Review of care plan revised [DATE], revealed Resident #1's had interventions in place for not eating food to include providing supplements, monitor bowel movements, notify physician as needed for constipation, administer stool softeners/laxatives as ordered PRN and document effectiveness, and report to nurse any changes in loss of appetite and constipation. Review of MARS between [DATE] through [DATE] for Resident #1 indicated routine pain medication of Tylenol 650 mg three times a day, Biscadoyl 5 mg every other day for constipation, and hydrochlorothiazide 12.5 mg once a day as diuretic were administered as ordered and a PRN order for MiraLax every 24-hours as needed for constipation was not administered for the month of [DATE]. (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of hospital records, dated [DATE], reflected Resident #1 was sent to the hospital with labored breathing and change in mental status. Hospital records reflected she had diagnoses of respiratory failure, altered mental status, hypotension, sepsis, hyperkalemia, and hyponatremia. Review of x-ray dated [DATE] reflected Resident #1 had a CT of abdomen and pelvis and included findings of a large stool likely to reflect stercoral colitis (chronic constipation leading to stagnation of fecal matter, increase in volume, impaction, and eventual deformation of the colon). Review of facility investigation synopsis, dated [DATE], revealed the following: Tuesday, [DATE] 08:00 am: Facility [CNA] reported to facility nurse that [Resident #1] was acting different, resident was not drinking out of a straw like she normally does. Resident was unable to verbalize what was wrong when asked by facility nurse. MD was notified of above orders and orders were received for stat UA, CBC, and CMP. Lab notified of new order, awaiting results. 12:10 pm: Resident noted with a decline in condition; Resident was noted by facility nurse as having labored breathing and facility nurse was unable to obtain)2 sat; 911 notified and MD [MD] was notified of transfer via EMS to ER for evaluation and treatment. RP notified of transfer to the ER for evaluation and treatment. Wednesday, [DATE] 3:00 pm: [RP C] arrived at the facility requesting to visit with the facility administrator, he presented the administrator with a written letter from the resident's [RP D] requesting the following information under the open records act: - o A copy of resident's medical record chart for the last 30 days reflecting when resident had a bowel movement - o Policy and procedures on what the proper channels are for when a patient doesn't have a bowel movement in three days. - o When was the last time resident has been examined by a licensed physician? - o What time and what's the staff member or nurse that found resident in medical distress and what happened at that point? An investigation was initiated by facility administrator and director of nursing. An in service was conducted with facility staff on bowel monitoring clinical practice guidelines with post test. facility staff completed bowl assessment on all residents identified with no bowel movements x 3 days; residents identified as no bowel movement x 3 days were placed in monitoring for signs/symptoms of Constipation and MD notified of any abnormal symptoms. Upon completion of bowel assessments on all facility residents, there were no residents identified with no bowel movements x 3 days. (continued on next page)		

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A QAPI meeting was held with this facility's medical director by phone conversation to discuss above mentioned incident and facility follow up to sustain compliance. Review of in-service, dated [DATE], revealed education was provided to nursing staff on bowel movement monitoring and to report when a resident has no bowel movement for three days. Review of in-service, dated [DATE], revealed education was provided to nursing staff on notification of changes and when and how to report a resident that had a change in condition. Review of in-service, dated [DATE], revealed education was provided to supervisory staff on obtaining bowel monitoring reports. Review of task sheet for bowel incontinence for Resident #1, dated [DATE], revealed no bowel movement was recorded for 14 days between [DATE] and [DATE]. During an interview on [DATE] at 10:15 AM, the Administrator, DON, and MDS Nurse said the DON said Resident #1 was sent out to the hospital because she was starting to have a change in condition with her mental and breathing status. The Administrator said Resident #1's hospital diagnosis was sepsis. The Administrator, DON, and MDS Nurse said there were concerns reviewed for fecal impaction and the hospital ER records revealed Resident #1's abdomen was soft, non-distended with no swelling but that there were concerns reviewed for fecal impaction and in-services were provided to nursing staff on notification of residents not going to the bathroom over 3 days on [DATE] and [DATE]. During an interview on [DATE] at 12:20 PM, CNA A said that she had been employed at the facility for two years and that CNA's are responsible for monitoring and documenting bowel movements. CNA A said she had received training on bowel monitoring during in-services yesterday and that she would notify her nurse if a resident had not had a bowel movement after 3 days. She said she normally did not work with Resident #1. During an interview on [DATE] at 12:42 PM, CNA B said she had been employed at the facility for two years. CNA B said she last took care of Resident #1 on Friday, [DATE] and that she had no bowel movement on her shift while she was taking care of her. CNA B said she had received training of bowel monitoring and that she would report to the nurse if a resident had not had a bowel movement for 3 days. (continued on next page)		

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 1:01 PM, CNA E said she had been employed at the facility for [AGE] years and provided care for Resident #1 on a routine basis. CNA E said CNA's were responsible for recording resident bowel movements and would report to the nurse if someone did not go to the bathroom for three to four days. CNA E said the only resident with a concern for bowel monitoring on her hall was Resident #1 and that she had two bowel movements the day she was sent out to the hospital but no bowel movements for several days prior. CNA E said she did not report to the nurse that she had missed a bowel movement for over 3 days because she was not made aware during report that it was a concern during shift change. CNA E said on the day Resident #1 got sent out to the hospital after she gave her a bed bath in the morning, she was very weak and she had two small putty (clay like) stools, but the day before she was okay and did a 180 degree turnaround. CNA E said she notified the ADON of her change in condition and that Res #1's stomach was swelling on the Friday or Sunday before she was sent out and thought she had to have a bowel movement because her stomach was cramping. CNA E said that was the first time she reported cramping, has never had constipation, and goes to the bathroom. CNA E said the nurse tried to give her a laxative then around the weekend before she was sent to the hospital, but Resident #1 refused, and they also offered to send her to the hospital then and she refused. CNA E said sometimes Resident #1 would go a couple of days without a bowel movement at her baseline. CNA E said Resident #1 would only drink liquids ever since she last got Coronavirus Disease of 2019 (severe acute respiratory syndrome aka SARS-COV-2) and had not been eating food for months. CNA E said Res #1 would drink a health shake, soda, and water at every meal. CNA E said she felt bad Resident #1 declined rapidly that day and hoped she improved to come back to the facility. She said that ultimately CNA's were responsible for documenting and reporting bowel movements. She said it was important for staff to report a resident not having a bowel movement over 3 days because it could cause bowel blockage and possible hospitalization . She said she had received training by in-services yesterday and when to report changes in resident condition. During an interview on [DATE] at 1:23 PM, LVN G said she had been employed 2 years at the facility. LVN G said she did not normally provide care for Resident #1 but that she was the one that sent her out to the hospital. LVN G said on [DATE] at 8:00 AM she was notified by the CNA that Resident #1 could not drink anything through her straw, MD was notified and stat labs were ordered. LVN G said she continued to monitor Resident #1 and at noon she significantly declined and was struggling to breath before the stat labs were completed and LVN G sent her to the emergency room . LVN G said Resident #1 was not having any kind of pain or swelling in her abdomen during that time and was having a decline in her mental status. LVN G said the nurses are responsible for monitoring bowel movements that the CNA's document. LVN G said CNA's notify her if there are any concerns regarding residents not going to the bathroom for several days. LVN G said she had received training on bowel monitoring and that CNA's report to the nurse if it has been more that 3 days or if a resident complained of abdominal pain. LVN G said she did not review anything about Resident #1's bowel movements in her shift change reports. LVN G said she felt CNA's were documenting appropriately. LVN G said she had no concerns related to fecal impaction for Resident #1 the day she sent her to the hospital and that it was not her main concern when she assessed Resident #1. She said it was important for CNA's to notify her of any residents not using the bathroom after three days because it could prevent fecal impaction, sepsis, deterioration of health, hospitalization , or even death. (continued on next page)		

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a phone interview on [DATE] at 8:48 AM, RP D said Resident #1 had a severe case of sepsis and large ball of bowel that appeared to have punctured her colon and thought they might have to cut her colon out. RP D said Resident #1 was on life support and there was nothing they could do for her at the hospital. RP D said he had asked weeks ago when Resident #1 lost her appetite and was notified she was not eating. RP D said he had a camera in her room and his cousin visited Resident #1 and spoke to her this last Sunday before she expired. RP D said on Sunday, [DATE], she was not talking as much because about 2 weeks ago she said her side was hurting when the ADON was in the room. RP D said the facility then gave Resident #1 Tylenol and he spoke with the nurse, got notes from the nurse the night before and she did not have any complaints. RP D said staff informed the family they heard Resident #1 complain about her stomach, but they did not wish to be named. RP D said at the hospital Resident #1's stomach was hard and was told she would die instantly if they had the surgery. RP D said Resident #1 was paralyzed and legally blind and there was nothing wrong with her mind and did not have any medicine except for blood pressure medicine. RP D said Resident #1 expired from severe sepsis shock. During an interview on [DATE] at 10:46 AM, the ADM and DON said Resident #1 expired on Saturday, [DATE], at the hospital and that they have requested and refused hospital records. At 11:00 AM, the DON said she did not receive a report that Resident #1 having side pain or constipation but that the NP had ordered MiraLax PRN if she needed it. The DON said she provided in-services on bowel monitoring because of concerns brought to their attention from Resident #1's RP and started monitoring bowels to make sure that staff were documenting and reporting if they had not gone to the bathroom every 3 to 4 days. The DON said staff did not report Resident #1 not going to the bathroom and believed it may have been missed due to other nurse aides on the hall not communicating between shifts. The DON said Resident #1 had a bowel movement that morning before she was transported to the hospital. The DON said nurse aides report to their charge nurse and document if they have had a bowel movement so it will alert the nurse on electronic health record system to check the resident. The DON said now in their morning meetings, if there is an alert on the electronic health record staff review it in the morning meetings. The DON said that there were currently no additional residents since Resident #1 that had not had a BM in over three days. The DON said interventions were put in place to ensure it does not happen again to include pulling a full bowel movement report and completing in-services with our nursing staff to pull bowel movement report very shift. The DON said the charge nurses are pulling the bowel movement report and aides would be responsible for monitoring bowel movements. The DON said nurse aides could not see the history of bowel movements. The DON said she looked at Resident #1's bowel movement report with their computer and have had problems with internet outages and have contacted the help desk due to the weather. The DON said it was important to notify the charge nurses of a resident having no bowel movement within ,d+[DATE] days and know the resident's bowel schedule because of the different complications that can occur such as what happened to Resident #1. The DON said with the nurse aides, they know their residents well and if they do not have something ordered for constipation, staff are expected to notify the physician to ensure efforts are made to ensure the residents avoids complications or deterioration in health. (continued on next page)		

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 11:08 AM, the HA said she had been employed at the facility for almost a year. The HA said the aides monitor bowel movements and that they have not provided training on bowel monitoring but that she has not returned to the facility since Resident #1 was sent out. The HA said Resident #1 was on the hall she last worked and the last time she saw her would be the prior Sunday before last, [DATE]. The HA said Resident #1 was talking to her like she always did and was not complaining. The HA said Resident #1 did not have a bowel movement with her for two weeks. The HA said she changed her at 8:00 PM, 12:00 AM, and 4:00 AM and would always ask for things. The HA said Resident #1 was never having any pain in her abdomen. The HA said she did not know that she should have notified someone about Resident #1 not having a bowel movement and said she was just being trained. The HA said nobody notified her that Resident #1 was not having a bowel movement. The HA said the computer system should have prompted a red flag and that made her think she was at least having a bowel movement during the day but come to find out it had been 2 weeks. The HA said she was not sure if Resident #1 was aware that she was not having a bowel movement. The HA said she acknowledged Resident #1 going over 4 days without a bowel movement should have been reported to avoid her being sent out to the hospital and that if they would have kept up with her bowel movement monitoring Resident #1 may still be alive today. The HA said she had not seen her eat food and that she would drink a shake and did not eat much since she has been there. During an interview on [DATE] at 12:21 PM, the Administrator said she received letter from an attorney the day Resident #1 expired on [DATE] with request to maintain all records possibly from RP D. The Administrator said it had been months since they talked to RP D. The Administrator said RP J asked the facility to comb her hair recently but that was her main concern and she informed her that she would get one of her staff down there to fix her hair. The Administrator said family for Resident #1 had a camera in her room to communicate with her and had a family friend visit that reported no concerns. The Administrator said she expected staff to report after three days of no bowel movement. The Administrator said for Resident #1 they had reviewed for weeks in morning meeting that her only intake was ensure and water and there was a concern with her not eating but not for her bowel movements. The administrator said the aides were responsible for monitoring bowel movements and reporting concerns and are making sure staff pulls the report every morning in meeting. The Administrator said Resident #1 had the ability to express what was going on with her and believed losing the internet due to weather was part of the problem for documenting and reporting. The Administrator said the facility lost power the weekend before she was sent to the hospital and on [DATE]st, 2024, that weekend it was down all weekend and was not notified until coming to work on Monday. (continued on next page)		

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 1:00 PM, the ADON said she had been employed at the facility for 8 years. The ADON said she last saw Resident #1 on [DATE] and she was doing good. The ADON said she did not know when it was, but around last month Resident #1 was complaining about her side and the ADON listened to her bowel sounds at abdomen for movement. The ADON said Resident #1's family was on the camera and reported she was hurting so they offered her Tylenol and she refused. The ADON said her family wanted her to go out to the hospital and she refused to go and after the pain medication she did not complain anymore and had no tenderness to the area. The ADON said on that day, Resident #1 kept saying both sides were hurting and had a routine stool softener she would take but would not take the MiraLax. The ADON said she talked to CNA E the next day and reported she had a small bowel movement. The ADON said Resident #1 had not been eating for a while and ever since she had COVID-19 upon recovery she stopped eating food and would only eat a couple bites of food sometimes brought in from family. The ADON said the nurse aides were responsible for reporting if a resident had not had a bowel movement for over 3 days and said she thinks Resident #1's bowel movements were not reported due to a lack of communication and that they should have relayed that information during their shift report. The ADON said staff is expected to notify the nurse if a resident was not having a bowel movement in report and that it does prompt up on the electronic dashboard in their system if they had not had one for several days but with the weather causing internet failure staff may have not documented yet or seen the prompt. The ADON said paper charting was completed during internet outage. The ADON said the facility has provided training on bowel movement monitoring by conducting in-services with all staff. The ADON said they had reviewed this morning about pulling up reports on the computer to see if someone did not have a bowel movement for the last 3 days. The ADON said prior to Resident #1 being sent to the hospital they used to run the bowel movement sheet and go talk to that person or aide to see if they may have had one or was documentation accurate so they would go visit each person. The ADON said she has reviewed bowel movement reports and did not have any similar constipation concerns with any other residents. The ADON said CNA E was usually pretty good about reporting bowel movements and she may get busy but usually is good about reporting. The ADON said signs and symptoms of possible fecal impaction included nausea, abdomen hard or tender, and decreased appetite. The ADON said she had no changes other than Resident #1's side pain a couple of weeks ago and that was the last time she heard her complain and her family tried to send her out to the ER, and she refused to go. During a phone interview on [DATE] at 3:00 PM, the NP said she has been off for the last three weeks and visits the facility twice a month. The NP said if she had seen Resident #1 it would only be during one of those on-site visits and she could not recall when she last saw her. The NP said the nurses will tell her which residents have concerns when she is there. The NP said staff normally report residents not having any bowel movements and said she would assume they would report a resident not having one for over 3 days. The NP said if she was aware Resident #1 had not had a bowel movement for several days she would have assessed her medicines, prescribed stool softeners, and review medicine like MiraLax and most of the time there are already PRN orders in place to administer, and request to do an x-ray scan if medicine was not effective. The NP said she had no concerns with care and services provided by the facility and was not aware that Resident #1 had not had a bowel movement for that long. The NP said it would be important to report if a resident had not had a bowel movement for over 3 days because it could indicate a possible bowel blockage. The NP said staff they report concerns appropriately when she is at the facility. (continued on next page)		

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 3:11 PM, the hospital ICU Nurse said Resident #1 was admitted on [DATE] at 5:37 PM with a diagnosis of septic shock, respiratory failure, septic shock that was first unclear on etiology and including UTI, pneumonia, and then abdominal because she showed colitis on her imaging. The hospital ICU Nurse said on [DATE] a CAT scan revealed she had a fecal contained severe constipation and contained perforation along the rectum. The hospital ICU Nurse said x-rays were showing severe colonic distension and constipation and the outside hospital (hospital she was transferred from) showed stercoral colitis. Review of facility policy, titled Clinical Practice Guideline: Bowel Monitoring, review date [DATE], revealed the following: Anticipated Outcome The aim of this guideline is [to] provide guidance to avoid constipation or fecal incontinence in order to achieve evacuation of the bowel. Fundamental information A stooling frequency of less than 3 times a week may still be considered normal if not associated with abdominal discomfort in the absence of bowel sounds. A daily bowel movement is not necessary, but a resident that has not had a bowel movement for ,d+[DATE] days should be monitored closely for signs and symptoms of Constipation. Stool softeners, suppositories and enemas may be used to assist the resident with rectal evacuation. Process - o Bowel movements are monitored by nursing staff observation that a patient has had a bowel movement or a report from the patient that a bowel movement has occurred. - o If the patient has not had a bowel movement for ,d+[DATE] days monitor for signs and symptoms of constipation; abdominal distension, pain, nausea/vomiting, loss of appetite, decrease bowel sounds - o Notify the Physician of the abnormal symptoms - o Provide the patient with fluids and juices as indicated. - o Administer stool softener, suppositories, enemas and fibers as ordered. - o Continue to monitor the patient during 4 to 7 days for bowel movement, adverse signs and symptoms. - o Notify the physician if there is increased tenderness, rigidity, distinction, absence or decrease vowel sound for abnormal bowel movement e.g. blood or mucus in stool. - o Monitor [EHR] reports Documentation (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Winfield Rehab & Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 1108 E Loop 304 Crockett, TX 75835	
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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Progress Notes, Medication Administration Record During an interview on [DATE] at 5:23 PM, the Administrator requested an IJ PNC and provided additional information to include a QAPI meeting and in-service documentation. Review of Performance Improvement Project Report, titled Bowel Movement Monitoring, start date of [DATE] revealed the following: .Goal: Establish a procedure for to avoid constipation or fecal impaction in order to achieve evacuation of the bowel that optimizes therapeutic benefits and minimizes associated risks . 4.) DON/Designee to pull no BM x 3 days report; resident is to be monitored for signs/symptoms of constipation and notify MD of any abnormal symptoms. 5.) Results of no BM x 3 days report will be discussed with admin/DON during morning clinical start up meeting. 6.) review findings monthly at QAPI meeting for three months to ensure compliance. Review of Clinical and Order Alerts Listing Report, dated [DATE] through [DATE], revealed bowel movement report was generated. Review of Daily Census Report, dated [DATE] and signed by the DON, revealed a bowel assessment validation was completed on all facility residents and no residents were identified [with] no bowel movements for 3 days. During a phone interview on [DATE] at 9:24 AM, CNA K said she had been employed for one to two years at the facility and had received in-service training on bowel monitoring and notification of changes yesterday, [DATE], and the week prior. CNA K said that if a resident does not have a bowel movement for 3 to 4 days, she would notify her nurse. CNA K said she had no residents she had that were going that long without a bowel movement. During a phone interview on [DATE] at 9:31 AM, CNA L said she had been employed as an aide at the facility for over a year. CNA L said the timeframe she would report bowel concerns was 3 days of a resident not going to the bathroom. CNA L said there were in-services over bowel monitoring and notifying staff of changes last week. She said all of her residents were going to the bathroom within the timeframe Resident #1 was documented as not going to the bathroom and that she works with the same residents every time she works. An IJ PNC was determined on [DATE] at 11:06 AM. The administrator was provided with updated template on [DATE] at 11:06 AM. The surveyor confirmed PNC had been implemented sufficiently to remove the Immediate Jeopardy by: - o Completion of Investigation Synopsis Timeline of Events - o Like Resident: bowel assessment validation completed on [DATE], on all facility residents; no residents identified with no bowel movements over 3 days; (continued on next page)		

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	o Inservice completed on [DATE], on clinical practice guidelines: bowel movement monitoring and reporting no bowel movement for 3 days with post-test; o Inservice completed on [DATE], on notification of changes with post-test; o Inservice completed on J [TRUNCATED]		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43872 Based on interviews and record reviews the facility failed to provide residents treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan for 1 of 8 residents reviewed for quality of care. (Resident #1) The facility failed to monitor Resident #1's significant change of no bowel movements for 14 days between [DATE] through [DATE]. Resident #1 was sent to the emergency roiaom on [DATE] and x-ray showed she had a contained fecal perforation in her rectum and expired at the hospital on [DATE]. The noncompliance was identified as PNC. The IJ began on [DATE] and ended on [DATE]. The facility had corrected the noncompliance before the survey began. This failure could place residents at risk for deterioration of health, hospitalization , or death. Findings included: Review of face sheet dated [DATE] indicated Resident #1 was [AGE] years old, admitted on [DATE] with diagnoses of hemiplegia and hemiparesis (paralysis and weakness to one side of the body) following cerebral infarction (stroke) affecting left non-dominant side, adjustment disorder with mixed disturbance of emotions and conduct, feeding difficulties, cognitive communication deficit, contracture to right and left hand and wrists, and visual loss. Review of quarterly MDS, dated [DATE], revealed Resident #1 had a BIMS score of 15, indicating no cognitive impairment and a score of 03 for bowels, indicating always incontinent. Review of care plan revised [DATE], revealed Resident #1's had interventions in place for not eating food to include providing supplements, monitor bowel movements, notify physician as needed for constipation, administer stool softeners/laxatives as ordered PRN and document effectiveness, and report to nurse any changes in loss of appetite and constipation. Review of MARS between [DATE] through [DATE] for Resident #1 indicated routine pain medication of Tylenol 650 mg three times a day, Biscadoyl 5 mg every other day for constipation, and hydrochlorothiazide 12.5 mg once a day as diuretic were administered as ordered and a PRN order for MiraLax every 24-hours as needed for constipation was not administered for the month of [DATE]. Review of hospital records, dated [DATE], reflected Resident #1 was sent to the hospital with labored breathing and change in mental status. Hospital records reflected she had diagnoses of respiratory failure, altered mental status, hypotension, sepsis, hyperkalemia, and hyponatremia. Review of x-ray dated [DATE] reflected Resident #1 had a CT of abdomen and pelvis and included findings of a large stool likely to reflect stercoral colitis (chronic constipation leading to stagnation of fecal matter, increase in volume, impaction, and eventual deformation of the colon). Review of facility investigation synopsis, dated [DATE], revealed the following: (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Tuesday, [DATE] 08:00 am: Facility [CNA] reported to facility nurse that [Resident #1] was acting different, resident was not drinking out of a straw like she normally does. Resident was unable to verbalize what was wrong when asked by facility nurse. MD was notified of above orders and orders were received for stat UA, CBC, and CMP. Lab notified of new order, awaiting results. 12:10 pm: Resident noted with a decline in condition; Resident was noted by facility nurse as having labored breathing and facility nurse was unable to obtain)2 sat; 911 notified and MD [MD] was notified of transfer via EMS to ER for evaluation and treatment. RP notified of transfer to the ER for evaluation and treatment. Wednesday, [DATE] 3:00 pm: [RP C] arrived at the facility requesting to visit with the facility administrator, he presented the administrator with a written letter from the resident's [RP D] requesting the following information under the open records act: - o A copy of resident's medical record chart for the last 30 days reflecting when resident had a bowel movement - o Policy and procedures on what the proper channels are for when a patient doesn't have a bowel movement in three days. - o When was the last time resident has been examined by a licensed physician? - o What time and what's the staff member or nurse that found resident in medical distress and what happened at that point? An investigation was initiated by facility administrator and director of nursing. An in service was conducted with facility staff on bowel monitoring clinical practice guidelines with post test. facility staff completed bowl assessment on all residents identified with no bowel movements x 3 days; residents identified as no bowel movement x 3 days were placed in monitoring for signs/symptoms of Constipation and MD notified of any abnormal symptoms. Upon completion of bowel assessments on all facility residents, there were no residents identified with no bowel movements x 3 days. A QAPI meeting was held with this facility's medical director by phone conversation to discuss above mentioned incident and facility follow up to sustain compliance. Review of in-service, dated [DATE], revealed education was provided to nursing staff on bowel movement monitoring and to report when a resident has no bowel movement for three days. Review of in-service, dated [DATE], revealed education was provided to nursing staff on notification of changes and when and how to report a resident that had a change in condition. (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of in-service, dated [DATE], revealed education was provided to supervisory staff on obtaining bowel monitoring reports. Review of task sheet for bowel incontinence for Resident #1, dated [DATE], revealed no bowel movement was recorded for 14 days between [DATE] and [DATE]. During an interview on [DATE] at 10:15 AM, the Administrator, DON, and MDS Nurse said The DON said Resident #1 was sent out to the hospital because she was starting to have a change in condition with her mental and breathing status. The Administrator said Resident #1's hospital diagnosis was sepsis. The Administrator, DON, and MDS Nurse said there were concerns reviewed for fecal impaction and the hospital ER records revealed Resident #1's abdomen was soft, non-distended with no swelling but that there were concerns reviewed for fecal impaction and in-services were provided to nursing staff on notification and monitoring of residents not going to the bathroom over 3 days on [DATE] and [DATE]. During an interview on [DATE] at 12:13 PM, the Ombudsman said her of her main concerns during her visit was no documentation of bowel movements. During an interview on [DATE] at 12:20 PM, CNA A said that she had been employed at the facility for two years and that CNA's are responsible for monitoring and documenting bowel movements. CNA A said she had received training on bowel monitoring during in-services yesterday and that she would notify her nurse if a resident had not had a bowel movement after 3 days. She said she normally did not work with Resident #1. During an interview on [DATE] at 12:42 PM, CNA B said she had been employed at the facility for two years. CNA B said she last took care of Resident #1 on Friday, [DATE] and that she had no bowel movement on her shift while she was taking care of her. CNA B said she had received training of bowel monitoring and that she would report to the nurse if a resident had not had a bowel movement for 3 days. (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 1:01 PM, CNA E said she had been employed at the facility for [AGE] years and provided care for Resident #1 on a routine basis. CNA E said CNA's were responsible for recording resident bowel movements and would report to the nurse if someone did not go to the bathroom for three to four days. CNA E said the only resident with a concern for bowel monitoring on her hall was Resident #1 and that she had two bowel movements the day she was sent out to the hospital but no bowel movements for several days prior. CNA E said she did not report to the nurse that she had missed a bowel movement for over 3 days because she was not made aware during report that it was a concern during shift change. CNA E said on the day Resident #1 got sent out to the hospital after she gave her a bed bath in the morning, she was very weak and she had two small putty (clay like) stools, but the day before she was okay and did a 180 degree turnaround. CNA E said she notified the ADON of her change in condition and that Res #1's stomach was swelling on the Friday or Sunday before she was sent out and thought she had to have a bowel movement because her stomach was cramping. CNA E said that was the first time she reported cramping, has never had constipation, and goes to the bathroom. CNA E said the nurse tried to give her a laxative then around the weekend before she was sent to the hospital, but Resident #1 refused, and they also offered to send her to the hospital then and she refused. CNA E said sometimes Resident #1 would go a couple of days without a bowel movement at her baseline. CNA E said Resident #1 would only drink liquids ever since she last got Coronavirus Disease of 2019 (severe acute respiratory syndrome aka SARS-COV-2) and had not been eating food for months. CNA E said Res #1 would drink a health shake, soda, and water at every meal. CNA E said she felt bad Resident #1 declined rapidly that day and hoped she improved to come back to the facility. She said that ultimately CNA's were responsible for documenting and reporting bowel movements. She said it was important for staff to report a resident not having a bowel movement over 3 days because it could cause bowel blockage and possible hospitalization . She said she had received training on bowel monitoring by in-services yesterday and when to report changes in resident condition. During an interview on [DATE] at 1:23 PM, LVN G said she had been employed 2 years at the facility. LVN G said she did not normally provide care for Resident #1 but that she was the one that sent her out to the hospital. LVN G said on [DATE] at 8:00 AM she was notified by the CNA that Resident #1 could not drink anything through her straw, MD was notified and stat labs were ordered. LVN G said she continued to monitor Resident #1 and at noon she significantly declined and was struggling to breath before the stat labs were completed and LVN G sent her to the emergency room . LVN G said Resident #1 was not having any kind of pain or swelling in her abdomen during that time and was having a decline in her mental status. LVN G said the nurses are responsible for monitoring bowel movements that the CNA's document. LVN G said CNA's notify her if there are any concerns regarding residents not going to the bathroom for several days. LVN G said she had received training on bowel monitoring and that CNA's report to the nurse if it has been more that 3 days or if a resident complained of abdominal pain. LVN G said she did not review anything about Resident #1's bowel movements in her shift change reports. LVN G said she felt CNA's were documenting appropriately. LVN G said she had no concerns related to fecal impaction for Resident #1 the day she sent her to the hospital and that it was not her main concern when she assessed Resident #1. She said it was important for CNA's to notify her of any residents not using the bathroom after three days because it could prevent fecal impaction, sepsis, deterioration of health, hospitalization , or even death. (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 2:24 PM, RN H said she had been employed since [DATE]. RN H said Res #1 was normally hers and last saw her on Sunday, [DATE] at baseline. RN H said she was not having any problems with constipation that was reported to her and nobody informed her Res #1 did not have a bowel movement for several days. RN H said CNA E did not tell her Resident #1 did not have a bowel movement the last two days she worked, Sunday and Monday. RN H said anytime the CNA's notify her of concerns with bowel movements her protocol would be to then pull up the task to see the last time it was documented and go to orders to see if the resident has a stool softener to administer, and if not she would call the doctor. RN H said if someone had told her Resident #1 was not having a bowel movement in those two days, Sunday and Monday ([DATE] and [DATE]), I would have done something about it. RN H said it would be important for CNA's to report the resident had not had a bowel movement because it could cause constipation, could rupture the intestine, and could cause fecal impaction. RN H said CNA E gave her fluids as normal and Res #1 had no complaints of anything, no facial grimacing or anything noted. RN H said she was not here the day Resident #1 was sent out to the hospital. RN H said since this was her first day returning to work, she was running a report of bowel movement records for all residents together. RN H said she was not aware of any additional resident's had constipation concerns and felt it was an isolated incident. RN H said Res #1's children would have called her if they knew she was constipated because they were very observant and involved and had placed a camera in her room. RN H said the facility has provided training on bowel movement documentation and monitoring through in-services prior to returning to work since the incident. During a phone interview on [DATE] at 3:00 PM, the MD said LVN G texted him that Resident #1 was not looking good, and he sent her to the ER. MD said at that time he was not notified of any concerns with her bowel movements. The MD said he was not aware of any constipation or fecal impaction concerns with Resident #1 and that he was available by phone if there were any concerns, he needed to know about so that he could ensure residents were receiving proper care. During a phone interview on [DATE] at 3:16 PM, the MD said staff are usually good at letting him know if there was someone that did not have a bowel movement with ,d+[DATE] hours. The MD said if a resident had not a bowel movement for 14 days, he would order some lab work and abdominal x rays, review medication and order an enema. The MD said Resident #1 was on Biscadoyl already and had Miralax PRN, but she refused to take the Miralax. The MD said the NP saw her on [DATE] and she was not having a bowel movement and when you would talk to Resident #1, she would say everything was fine. The MD said he did not have any concerns with the facility believed Resident #1 was 4 days out from not having a bowel movement, but he was not in front of his computer and would talk to the Administrator about it. The MD said the facility usually notifies him and expects them to notify him within ,d+[DATE] hours of any concerns. The MD said some residents can go 3 to 4 days without a bowel movement at their baseline, but it depended on the resident and expected to be notified after 3 to 4 days. The MD said he was not sure why it was not reported to him for several days and was not aware she went 14 days without a bowel movement but that he was not in front of his computer. The MD said he met with the facility regarding Resident #1 and felt it was an isolated incident. He said today was the first time he had heard she did not have a bowel movement for 14 days and that if he would have known he would have ordered her an x-ray and reviewed medication. During an interview on [DATE] at 1:31 PM, the MD said he did not have a continued concern about the facility not notifying him of residents with no bowel movements. The MD said that it was a concern he was not notified about Resident #1 not having one for several days, but believed it was an isolated incident and protocols were put in place during the QAPI meeting to ensure it did not happen again. The MD said he had already discussed with the facility and put things in place after the meeting. The MD said there were no concerns moving forward and had discussed protocols to include staff training and contacts updated. The MD said the facility had since updated him of constipation concerns since the protocols were put in place. (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a phone interview on [DATE] at 8:48 AM, RP D said Resident #1 had a severe case of sepsis and large ball of bowel that appeared to have punctured her colon and thought they might have to cut her colon out. RP D said Resident #1 was on life support and there was nothing they could do for her at the hospital. RP D said he had asked weeks ago when Resident #1 lost her appetite and was notified she was not eating. RP D said he had a camera in her room and his cousin visited Resident #1 and spoke to her this last Sunday before she expired. RP D said on Sunday, [DATE], she was not talking as much because about 2 weeks ago she said her side was hurting when the ADON was in the room. RP D said the facility then gave Resident #1 Tylenol and he spoke with the nurse, got notes from the nurse the night before and she did not have any complaints. RP D said staff informed the family they heard Resident #1 complain about her stomach, but they did not wish to be named. RP D said at the hospital Resident #1's stomach was hard and was told she would die instantly if they had the surgery. RP D said Resident #1 was paralyzed and legally blind and there was nothing wrong with her mind and did not have any medicine except for blood pressure medicine. RP D said Resident #1 expired from severe sepsis shock. During an interview on [DATE] at 10:46 AM, the ADM and DON said Resident #1 expired on Saturday, [DATE], at the hospital and that they have requested and refused hospital records. At 11:00 AM, the DON said she did not receive a report that Resident #1 having side pain or constipation but that the NP had ordered MiraLax PRN if she needed it. The DON said she provided in-services on bowel monitoring because of concerns brought to their attention from Resident #1's RP and started monitoring bowels to make sure that staff were documenting and reporting if they had not gone to the bathroom every 3 to 4 days. The DON said staff did not report Resident #1 not going to the bathroom and believed it may have been missed due to other nurse aides on the hall not communicating between shifts. The DON said Resident #1 had a bowel movement that morning before she was transported to the hospital. The DON said nurse aides report to their charge nurse and document if they have had a bowel movement so it will alert the nurse on electronic health record system to check the resident. The DON said now in their morning meetings, if there is an alert on the electronic health record staff review it in the morning meetings. The DON said that there were currently no additional residents since Resident #1 that had not had a BM in over three days. The DON said interventions were put in place to ensure it does not happen again to include pulling a full bowel movement report and completing in-services with our nursing staff to pull bowel movement report very shift. The DON said the charge nurses are pulling the bowel movement report and aides would be responsible for monitoring bowel movements. The DON said nurse aides could not see the history of bowel movements. The DON said she looked at Resident #1's bowel movement report with their computer and have had problems with internet outages and have contacted the help desk due to the weather. The DON said it was important to notify the charge nurses of a resident having no bowel movement within ,d+[DATE] days and know the resident's bowel schedule because of the different complications that can occur such as what happened to Resident #1. The DON said with the nurse aides, they know their residents well and if they do not have something ordered for constipation, staff are expected to notify the physician to ensure efforts are made to ensure the residents avoids complications or deterioration in health. (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 11:08 AM, the HA said she had been employed at the facility for almost a year. The HA said the aides monitor bowel movements and that they have not provided training on bowel monitoring but that she has not returned to the facility since Resident #1 was sent out. The HA said Resident #1 was on the hall she last worked and the last time she saw her would be the prior Sunday before last, [DATE]. The HA said Resident #1 was talking to her like she always did and was not complaining. The HA said Resident #1 did not have a bowel movement with her for two weeks. The HA said she changed her at 8:00 PM, 12:00 AM, and 4:00 AM and would always ask for things. The HA said Resident #1 was never having any pain in her abdomen. The HA said she did not know that she should have notified someone about Resident #1 not having a bowel movement and said she was just being trained. The HA said nobody notified her that Resident #1 was not having a bowel movement. The HA said the computer system should have prompted a red flag and that made her think she was at least having a bowel movement during the day but come to find out it had been 2 weeks. The HA said she was not sure if Resident #1 was aware that she was not having a bowel movement. The HA said she acknowledged Resident #1 going over 4 days without a bowel movement should have been reported to avoid her being sent out to the hospital and that if they would have kept up with her bowel movement monitoring Resident #1 may still be alive today. The HA said she had not seen her eat food and that she would drink a shake and did not eat much since she has been there. During an interview on [DATE] at 12:21 PM, the Administrator said she received letter from an attorney the day Resident #1 expired on [DATE] with request to maintain all records possibly from RP D. The Administrator said it had been months since they talked to RP D. The Administrator said RP J asked the facility to comb her hair recently but that was her main concern and she informed her that she would get one of her staff down there to fix her hair. The Administrator said family for Resident #1 had a camera in her room to communicate with her and had a family friend visit that reported no concerns. The Administrator said she expected staff to report after three days of no bowel movement. The Administrator said for Resident #1 they had reviewed for weeks in morning meeting that her only intake was ensure and water and there was a concern with her not eating but not for her bowel movements. The administrator said the aides were responsible for monitoring bowel movements and reporting concerns and are making sure staff pulls the report every morning in meeting. The Administrator said Resident #1 had the ability to express what was going on with her and believed losing the internet due to weather was part of the problem for documenting and reporting. The Administrator said the facility lost power the weekend before she was sent to the hospital and on [DATE]st, 2024, that weekend it was down all weekend and was not notified until coming to work on Monday. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675976	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/12/2024
NAME OF PROVIDER OR SUPPLIER Winfield Rehab & Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 1108 E Loop 304 Crockett, TX 75835	
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 - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 1:00 PM, the ADON said she had been employed at the facility for 8 years. The ADON said she last saw Resident #1 on [DATE] and she was doing good. The ADON said she did not know when it was, but around last month Resident #1 was complaining about her side and the ADON listened to her bowel sounds at abdomen for movement. The ADON said Resident #1's family was on the camera and reported she was hurting so they offered her Tylenol and she refused. The ADON said her family wanted her to go out to the hospital and she refused to go and after the pain medication she did not complain anymore and had no tenderness to the area. The ADON said on that day, Resident #1 kept saying both sides were hurting and had a routine stool softener she would take but would not take the MiraLax. The ADON said she talked to CNA E the next day and reported she had a small bowel movement. The ADON said Resident #1 had not been eating for a while and ever since she had COVID-19 upon recovery she stopped eating food and would only eat a couple bites of food sometimes brought in from family. The ADON said the nurse aides were responsible for reporting if a resident had not had a bowel movement for over 3 days and said she thinks Resident #1's bowel movements were not reported due to a lack of communication and that they should have relayed that information during their shift report. The ADON said staff is expected to notify the nurse if a resident was not having a bowel movement in report and that it does prompt up on the electronic dashboard in their system if they had not had one for several days but with the weather causing internet failure staff may have not documented yet or seen the prompt. The ADON said paper charting was completed during internet outage. The ADON said the facility has provided training on bowel movement monitoring by conducting in-services with all staff. The ADON said they had reviewed this morning about pulling up reports on the computer to see if someone did not have a bowel movement for the last 3 days. The ADON said prior to Resident #1 being sent to the hospital they used to run the bowel movement sheet and go talk to that person or aide to see if they may have had one or was documentation accurate so they would go visit each person. The ADON said she has reviewed bowel movement reports and did not have any similar constipation concerns with any other residents. The ADON said CNA E was usually pretty good about reporting bowel movements and she may get busy but usually is good about reporting. The ADON said signs and symptoms of possible fecal impaction included nausea, abdomen hard or tender, and decreased appetite. The ADON said she had no changes other than Resident #1's side pain a couple of weeks ago and that was the last time she heard her complain and her family tried to send her out to the ER, and she refused to go. During a phone interview on [DATE] at 3:00 PM, the NP said she has been off for the last three weeks and visits the facility twice a month. The NP said if she had seen Resident #1 it would only be during one of those on-site visits and she could not recall when she last saw her. The NP said the nurses will tell her which residents have concerns when she is there. The NP said staff normally report residents not having any bowel movements and said she would assume they would report a resident not having one for over 3 days. The NP said if she was aware Resident #1 had not had a bowel movement for several days she would have assessed her medicines, prescribed stool softeners, and review medicine like MiraLax and most of the time there are already PRN orders in place to administer, and request to do an x-ray scan if medicine was not effective. The NP said she had no concerns with care and services provided by the facility and was not aware that Resident #1 had not had a bowel movement for that long. The NP said it would be important to report if a resident had not had a bowel movement for over 3 days because it could indicate a possible bowel blockage. The NP said staff they report concerns appropriately when she is at the facility. (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 3:11 PM, the hospital ICU Nurse said Resident #1 was admitted on [DATE] at 5:37 PM with a diagnosis of septic shock, respiratory failure, septic shock that was first unclear on etiology and including UTI, pneumonia, and then abdominal because she showed colitis on her imaging. The hospital ICU Nurse said on [DATE] a CAT scan revealed she had a fecal contained severe constipation and contained perforation along the rectum. The hospital ICU Nurse said x-rays were showing severe colonic distension and constipation and the outside hospital (hospital she was transferred from) showed stercoral colitis. Review of facility policy, titled Clinical Practice Guideline: Bowel Monitoring, review date [DATE], revealed the following: Anticipated Outcome The aim of this guideline is [to] provide guidance to avoid constipation or fecal incontinence in order to achieve evacuation of the bowel. Fundamental information A stooling frequency of less than 3 times a week may still be considered normal if not associated with abdominal discomfort in the absence of bowel sounds. A daily bowel movement is not necessary, but a resident that has not had a bowel movement for ,d+[DATE] days should be monitored closely for signs and symptoms of Constipation. Stool softeners, suppositories and enemas may be used to assist the resident with rectal evacuation. Process - o Bowel movements are monitored by nursing staff observation that a patient has had a bowel movement or a report from the patient that a bowel movement has occurred. - o If the patient has not had a bowel movement for ,d+[DATE] days monitor for signs and symptoms of constipation; abdominal distension, pain, nausea/vomiting, loss of appetite, decrease bowel sounds - o Notify the Physician of the abnormal symptoms - o Provide the patient with fluids and juices as indicated. - o Administer stool softener, suppositories, enemas and fibers as ordered. - o Continue to monitor the patient during 4 to 7 days for bowel movement, adverse signs and symptoms. - o Notify the physician if there is increased tenderness, rigidity, distinction, absence or decrease vowel sound for abnormal bowel movement e.g. blood or mucus in stool. - o Monitor [EHR] reports Documentation (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Progress Notes, Medication Administration Record Review of facility policy, titled Resident Rights, revised [DATE], revealed the following: .Policy Explanation and Compliance Guidelines: . 11. The facility will ensure that all staff members are educated on the rights of residents and the responsibility of the facility to properly care for its residents . Resident Rights . 2. Planning and Implementing Care . b . iv. The right to receive the services and/or items included in the plan of care . During an interview on [DATE] at 5:23 PM, the Administrator requested an IJ PNC and provided additional information to include a QAPI meeting and in-service documentation. Review of Performance Improvement Project Report, titled Bowel Movement Monitoring, start date of [DATE] revealed the following: .Goal: Establish a procedure for to avoid constipation or fecal impaction in order to achieve evacuation of the bowel that optimizes therapeutic benefits and minimizes associated risks . 4.) DON/Designee to pull no BM x 3 days report; resident is to be monitored for signs/symptoms of constipation and notify MD of any abnormal symptoms. 5.) Results of no BM x 3 days report will be discussed with admin/DON during morning clinical start up meeting. 6.) review findings monthly at QAPI meeting for three months to ensure compliance. During a phone interview on [DATE] at 9:24 AM, CNA K said she had been employed for one to two years at the facility and had received in-service training on bowel monitoring and notification of changes yesterday, [DATE], and the week prior. CNA K said that if a resident does not have a bowel movement for 3 to 4 days, she would notify her nurse. CNA K said she had no residents she had that were going that long without a bowel movement. During a phone interview on [DATE] at 9:31 AM, CNA L said she had been employed as an aide at the facility for over a year. CNA L said the timeframe she would report bowel concerns was 3 days of a resident not going to the bathroom. CNA L said there were in-services over bowel monitoring and notifying staff of changes last week. She said all of her residents were going to the bathroom within the timeframe Resident #1 was documented as not going to the bathroom and that she works with the same residents every time she works. (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An IJ PNC was determined on [DATE] at 11:06 AM. The administrator was provided with updated template on [DATE] at 11:06 AM. The surveyor confirmed PNC had been implemented sufficiently to remove the Immediate Jeopardy by: o Completion of Investigation Synopsis Timeline of Events o Like Resident: bowel assessment validation completed on [DATE] [TRUNCATED]		