

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676004	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/14/2025
NAME OF PROVIDER OR SUPPLIER The Hills Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 201 E Thompson St Decatur, TX 76234	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48236 Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs for 1 of 10 residents (Resident #1) reviewed for care plans. The facility failed to develop and implement a care plan for Resident #1 to address him being at risk for constipation which he was at increased risk for due to his diagnosis of cerebral palsy. This failure resulted in the facility staff not being aware of these risk factors for constipation and not implementing interventions to prevent the resident from having a fecal impaction of the rectum with associated stercoral colitis, which is a rare inflammatory colitis that occurs when impacted fecal material leads to distention of the colon and eventually hardened stool formation. An Immediate Jeopardy was identified on 03/13/25 at 10:00 AM. While the Immediate Jeopardy was removed on 03/14/25, the facility remained at the severity level of noncompliance that results in no more than minimal physical, mental and/or psychosocial discomfort to the resident and/or has the potential (not yet realized) to compromise the resident's ability to maintain and/or reach his or her highest practicable physical, mental and/or psychosocial well-being as defined by an accurate and comprehensive resident assessment, plan of care, and provision of service and a scope of pattern due to the facility continuing to monitor the implementation and effectiveness of their plan of removal. This failure placed residents at risk of serious harm or death. Findings included: Record review of Resident #1's Nursing Home Comprehensive Item Set MDS Record dated, 01/15/25, reflected an initial admitted [DATE] and readmitted [DATE]. Resident #1's diagnoses included: cerebral palsy (congenital disorder of movement, muscle tone, or posture), seizure disorder or epilepsy, sepsis (life-threatening complication of an infection), and dysphagia (difficulty swallowing foods or liquids, arising from the throat or esophagus, ranging from mild difficulty to complete and painful blockage). Resident #1's MDS also reflected that Resident #1's cognition was intact with a BIMS score of 15. Resident #1's MDS reflected that Resident #1 was dependent (helper does all the effort) on staff for toileting. Resident #1's MDS also reflected that Resident #1 was not on a bowel toileting program. Resident #1's MDS reflected that the resident was always incontinent of bowel. The MDS also reflected that Resident #1 showed no constipation present. (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 676004	Facility ID: 676004 If continuation sheet Page 1 of 29

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #1's undated Care Plan reflected that Resident #1 had not been placed at Risk of Constipation. Record review of Resident #1's undated Discontinued Orders reflected resident received Baclofen Oral Tablet 20 MG 1 tablet by mouth four times daily. Resident #1 was also ordered and received Clonazepam .5 MG tablet by mouth twice daily. Resident #1 received Probiotic Oral Capsule daily as well. Resident #1 had a PRN (as needed) order for Bisacodyl Rectal Suppository insert 10 mg rectally as needed for constipation. Resident #1's orders also reflected he received 2 Hydrocodone-Acetaminophen Oral Table 5-325 three times daily. Resident #1 received 1 Cyclobenzaprine HCl Oral Tablet 10 MG twice daily. Record review of Resident #1's undated MAR reflected that Resident #1 did not receive a dosage of his order for Bisacodyl Rectal Suppository for constipation as needed ordered by his primary care physician during the month of February 2025. Record review of Resident #1's Bowel Movement ADL 30-day documentation chart reflected no bowel movements between the days of 02/11/25 through 02/20/25. The ADL record reflected the resident had one bowel movement on 02/21/25 but had no other bowel movements before he was transferred to the hospital on 02/26/25 at 12:00AM. Therefore, the ADL record reflected the resident had one bowel movement from 02/11/25 until discharge on [DATE]. Record review of Resident #1's Progress Notes dated 02/26/25 at 6:47 PM reflected LVN A transferred Resident #1 to the hospital due to a change in condition and family request on 02/26/25 at 12:00 AM after Resident #1 spoke with his Responsible Party on 02/25/25. Record review of Resident #1's Progress Notes dated 02/28/25 at 10:32 AM reflected the DON was made aware of allegations of neglect. This Progress Note by the DON reflected Administrator, Medical Director, Area Director of Operations, and the Area DON were notified. Record review of Resident #1's Hospital Record dated 02/26/25 at 10:16 PM reflected, Prominent fecal impaction of the rectum with associated stercoral colitis. There is constipation, without bowel obstruction. Record review of Resident #1's Hospital Record dated 02/28/25 at 9:23 AM reflected, Severe Constipation: on 02/27 Disimpaction severe and Mag Citrate, Lactulose, and Go Lytely. Record review of Resident #1's Hospital Record dated 03/02/25 at 11:44 AM reflected Resident #1's diagnoses of Severe constipation with fecal impaction: Improving. S/P (Status Post Docusate) docusate, lactulose, soapsuds enema, manual disimpaction. Had watery stool. Record review of Resident #1's Hospital Record dated 03/03/25 at 9:20 AM reflected Resident #1's diagnosis of Severe constipation, fecal impaction. The same hospital notenotes also reflected, Noted stercoral colitis on CT, Initiate docusate, lactulose, Soapsuds enema x 2, and No BM despite manual disimpaction. Will obtain CT/AP with p.o. contrast (Computed tomography of Abdomen and pelvis with oral contrast). (continued on next page)		

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the National Library of Medicine at www.ncbi.nlm.nih.gov/books/NBK560608, Stercoral Colitis, dated 07/10/23, reflected: Stercoral colitis is a rare inflammatory colitis that occurs when impacted fecal material leads to distention of the colon and eventually fecaloma [hardened stool] formation Interview on 03/11/25 at 9:53 AM with the Administrator revealed that a family member put on social media that Resident #1 was being neglected in the areas of showering, oral care, and monitoring of bowel movements. The Administrator also revealed that the resident did not return to the facility after discharge from the hospital. The Administrator said that Resident #1 went to a sister facility for long-term care. The Administrator revealed he was not aware Resident #1 had gone 11 days with no bowel movements. The Administrator stated that on 02/28/25, he in-serviced all staff on abuse/neglect, patient rounding, resident rights, bowel and bladder documentation, bowel incontinence care, bath, tub/shower, bed bath complete, teeth care/oral hygiene, resident/resident incidents, Immediately in-service on the definition of Immediate, accurate documentation of refusals, and physician's orders. Interview on 03/11/25 at 1:46 PM with Resident #1's Responsible Party revealed that a family member placed a negative comment about the facility on social media the morning that the resident went out to the hospital. The Responsible Party stated that he saw Resident #1 on the morning of 02/25/25, and he could tell that something was wrong. The Responsible Party stated that he called the facility and requested that his family member be sent out to the hospital. The Responsible Party confirmed that the hospital did not do surgery on Resident #1, and Resident #1 was now at another facility. Interview on 03/12/25 at 11:18 AM with the Medical Director revealed that Resident #1 had risk factors for constipation due to his diagnosis of cerebral palsy, which was a neurological condition which led to his immobility. The Medical Director stated that he provided the facility with standing orders for the treatment of constipation if a resident did not have a bowel movement after three days. The Medical Director said that he expected the facility's nurses to notify him if his prescribed interventions did not work for residents. The Medical Director stated that he did not recall if he was notified of a change in condition for Resident #1. The Medical Director concluded by stating that he could not remember everything about every resident. Interview on 03/13/25 at 10:11 AM with MDS U revealed that she had been in training as the MDS Coordinator for two weeks, and weeks and had been in-serviced regarding care plans and the risk of constipation. MDS U stated that as the MDS Coordinator, she was trained to look at the resident's medications, diagnoses, the resident's hospital records, the physician's orders, and communication from the resident such as their last bowel movement to aide in developing the care plan and specifically the risk of constipation. The MDS Coordinator added that the admitting nurse conducted a head-to-toe assessment including listening to bowel sounds and palpating the resident's stomach to determine the resident's risk of constipation. MDS U also said that Resident #1 had a standing order for a medication to be given if he experienced constipation as well as a medication ordered to be administered if the resident was constipated. MDS U revealed that all residents' care plans had been updated to reflect their risk of constipation. The MDS Coordinator also stated that new risks were communicated to her to add to a residents' care plans in the daily clinical meetings and as needed due to residents' changes in condition to continue to daily develop the care plans. MDS U said that that it was important that all staff had access to residents' care plans so that they can provide the specific care needed to each resident. (continued on next page)		

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 03/13/25 at 11:30 AM, the Administrator was notified that an Immediate Jeopardy in the area of Comprehensive Resident Centered Care Plans. Interview on 03/13/25 at 6:41 PM with the Administrator revealed that upon admission the admitting nurse should complete a full assessment including bowel/bladder. The Administrator stated that the admitting nurse develops the care plan based on the risk of constipation due to diagnoses and medications and develop the goals and interventions. The Administrator revealed that if the resident was not assessed timely, then complications such as discomfort, loss of appetite, or potential infection could occur. Interview on 03/14/25 at 11:42 AM with the ADON revealed that Resident #1's care plan had now been updated to reflect the resident's risk of constipation. The ADON stated that upon admission, the charge nurse should complete a head-to-toe assessment and listen for bowel sounds. The ADON said that the admission assessment in addition to the resident's orders and medications would be used to determine if there was a risk of constipation. The ADON revealed that if there was a risk of constipation, the MDS coordinator would include it on the care plan as well as goals and interventions specific to each resident. The ADON stated that the care plan gave the staff the opportunity to view the residents' needs and changes as well as how to provide care to each resident. The ADON revealed that he and the DON monitored the care plans and verified residents' orders, medications, alerts, and necessary items involved in the care plans. The ADON stated that the care plans were reviewed quarterly in the care plan meetings and any changes that were needed could be made at that time or as needed prior to the care plan meeting by the MDS Coordinator. The ADON said that the interdisciplinary team (Administrator, the DON, the ADON, Social Worker, the Activities Director, the Therapy director, the Dietary manager) and the family as well as the resident attended the care plan meeting to review the risks (focus), goals, and interventions of residents. The ADON concluded by stating that the importance of timely documentation in care plans was to ensure continuity of care for residents. The DON was out due to illness during the days the surveyor was in the building 03/11/25-03/14/25. (continued on next page)		

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 03/13/25 at 2:30 PM with the Area DON revealed the facility began to in-service all staff on 03/13/25 after notification of the immediate jeopardy at 11:30 AM on 03/13/25. The Area DON stated that all staff were in-serviced on abuse and neglect by the ADON. Area DON also stated that all staff were in-serviced on documentation of bowel movements, reporting changes, and notifying the ADON and the DON of changes in bowel movements by the ADON. The Area DON revealed that she in-serviced the nursing staff on how to access clinical alerts in the facility's software. The Area DON also stated that the ADON in-serviced the nursing staff administering PRN (as needed) medication to residents with no bowel movement for three days. The Area DON said that the ADON in-serviced all nursing staff on bowel movement monitoring and dashboard alerts and monitoring. The Area DON stated that the ADON also in-serviced all nursing staff on recognizing a change of condition and the requirement to notify the resident's primary care physician. The Area DON revealed that she in-serviced the Administrator, the DON, Area Director of Operations, and the ADON on recognizing a change of condition and bowel movement changes. The Area DON revealed that the in-service was completed via a text service that went to all facility staff and copies were provided evidencing it. The Area DON also said that she and the ADON spoke with the staff about the in-service topics before they began their shifts in addition to the text that went out to all facility staff. The Area DON stated the DON or the ADON would review all new admissions in the stand-up meeting 5 times a week for six weeks and then as needed addressing alerts for no bowel movements and if the nurse accurately responded. The Area DON also revealed that the DON/and or the ADON would ask five nurses per week if anyone reported not having a bowel movement in the last three days and document the intervention and monitor for six weeks as needed. The Area DON stated that the DON/and or ADON would ask five CNAs per week if they reported a resident that did not have a bowel movement to their nurse and the nurse's response. Record review of in-services reflected: Abuse and Neglect completed on 02/28/25, Patient rounding completed on 02/28/25, Resident Rights completed on 02/28/25, Bowel and Bladder Documentation completed on 02/28/25, Bowel Incontinence Care completed on 02/28/25, Bath Tub/Shower completed on 02/28/25, Bed Bath Complete completed on 02/28/25, Teeth Care/Oral Hygiene completed on 02/28/25, Resident/Resident Incidents completed on 02/28/25, Immediate Notification completed on 02/28/25, Accurate Documentation of Refusals completed on 02/28/25, and Physician's Orders completed on 02/28/25. Record review of the facility's undated Comprehensive Care Planning Policy reflected: The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident right that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. Through the care planning process, facility staff will work with the resident and his/her representative, if applicable, to understand and meet the resident's preferences, choices and goals during their stay at the facility. The facility will establish, document and implement the care services to be provided to each resident to assist in attaining or maintaining his or her highest practicable quality of life. The comprehensive care plan will reflect interventions to enable each resident to meet his/her objectives. Interventions are the specific care and services that will be implemented. Record review of the facility's undated Physician's Orders policy reflected: To Monitor and ensure the accuracy and completeness of the medication orders, treatment orders, and ADL order for each resident. (continued on next page)		

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the facility's undated Documentation policy reflected: Documentation is the recording of all information, both objective and subjective, in the clinical record of an individual resident. It includes observations, investigations, and communications of the resident involving care and treatments. Record review of the facility's revised Abuse and Neglect Policy dated 9/9/24 reflected: The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat resident's medical symptoms. Residents should not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultant or volunteers, staff or other agencies serving the resident, family members or legal guardians, friends, or other individuals. The facility will provide and ensure the promotion and protection of resident rights. It is each individual's responsibility to recognize, report and promptly investigate actual or alleged abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property abuse and situations that may constitute abuse or neglect to any resident in the facility. .7. Neglect: is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. An Immediate Jeopardy was identified on 03/13/25 at 10:00 AM. The Administrator was informed of the Immediate Jeopardy in the areas of Quality of Care and Resident Care Plans. The Immediate Jeopardy template was provided to the Administrator via email on 03/13/25 at 11:30 AM. The plan of removal was accepted on 03/13/25 at 3:11 PM and included: Plan of Removal Action: 03/13/25 1. Resident #1 no longer resides in the facility as of 03/13/25. 2. All residents in the facility were assessed on 03/13/25 for risk of constipation or other bowel issues, comprehensive care plans updated to include interventions and monitoring by the DON and/or the ADON and/or the Regional Compliance Nurse. No additional residents were identified with no bowel movement within three days. 3. The Compliance Nurse in-serviced the Administrator, the DON, and ADON 1:1 on the following topics below on 03/13/25: a. All residents who are at risk of constipation will have an active care plan with interventions and monitoring. b. Upon admission all residents will be assessed by a nurse on risk of constipation, history of constipation/fecal impaction, or other bowel related issues. (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48236 Based on interviews and record reviews, the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices based on the comprehensive assessment of a resident for 1 of 10 residents (Resident #1) reviewed for quality of care. The facility failed ensure Resident #1, who was at increased risk for constipation due to having cerebral palsy, had measures in place to monitor his bowel activity and to ensure physician ordered interventions were implemented when the resident did not have a bowel movement within 72 hours. This failure resulted in the resident being diagnosed in the hospital with fecal impaction of the rectum with associated stercoral colitis, which is a rare inflammatory colitis that occurs when impacted fecal material leads to distention of the colon and eventually hardened stool formation. Prior to the hospitalization, the resident had only had one bowel movement between 02/11/25 and 02/26/25. An Immediate Jeopardy was identified on 03/13/25 at 10:00 AM. While the Immediate Jeopardy was removed on 03/14/25, the facility remained at the severity level of noncompliance that results in no more than minimal physical, mental and/or psychosocial discomfort to the resident and/or has the potential (not yet realized) to compromise the resident's ability to maintain and/or reach his or her highest practicable physical, mental and/or psychosocial well-being as defined by an accurate and comprehensive resident assessment, plan of care, and provision of service and a scope of pattern due to the facility continuing to monitor the implementation and effectiveness of their plan of removal. The failure placed residents at risk of serious harm or death. Findings included: Record review of Resident #1's Nursing Home Comprehensive Item Set MDS Record dated, 01/15/25, reflected an initial admitted [DATE] and readmitted [DATE]. Resident #1's diagnoses included: cerebral palsy (congenital disorder of movement, muscle tone, or posture), seizure disorder or epilepsy, sepsis (life-threatening complication of an infection), and dysphagia (difficulty swallowing foods or liquids, arising from the throat or esophagus, ranging from mild difficulty to complete and painful blockage). Resident #1's MDS also reflected that Resident #1's cognition was intact with a BIMS of 15. Resident #1's MDS reflected that Resident #1 was dependent (helper does all the effort) on staff for toileting. Resident #1's MDS also reflected that Resident #1 was not on a bowel toileting program. Resident #1's MDS reflected that the resident was always incontinent of bowel. The MDS also reflected that Resident #1 showed no constipation present. (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #1's undated Care Plan reflected that resident #1 was at risk for bowel incontinence. Resident #1's goal was to not have any complications relating to bowel incontinence. Resident #1's interventions included: apply barrier cream after every incontinent episode, check resident every two hours and assist with toileting as needed, provide peri care after each incontinent episode, report any skin change to the nurse immediately, see care plans on mobility, ADL, and cognitive deficit, Communication. Record review of Resident #1's undated Care Plan also reflected that resident #1 had an ADL Self Care Performance Deficit. Resident #1's goal was to maintain current level of function in bed mobility through the review date. Resident #1's interventions included: bathing-requires extensive assistance staff x 2 for assistance; bed mobility- requires extensive assistance staff x 2 for assistance; eating-requires staff x1; the resident requires a lift for all transfers; toilet use- requires extensive assistance staff x 2 for assistance; dressing-the resident requires (x2) staff participation to dress; the resident has contractures of the upper extremities. Record review of Resident #1's undated Discontinued Orders reflected resident received Baclofen Oral Tablet 20 MG 1 tablet by mouth four times daily. Resident #1 was also ordered and received Clonazepam .5 MG tablet by mouth twice daily. Resident #1 received Probiotic Oral Capsule daily as well. Resident #1 had a PRN (as needed) order for Bisacodyl Rectal Suppository insert 10 mg rectally as needed for constipation. Resident #1's orders also reflected he received 2 Hydrocodone-Acetaminophen Oral Table 5-325 three times daily. Resident #1 received 1 Cyclobenzaprine HCl Oral Tablet 10 MG twice daily. Record review of Resident #1's Progress Notes dated 02/26/25 at 6:47 PM reflected LVN A transferred Resident #1 to the hospital due to a change in condition and family request on 02/26/25 at 12:00 AM after Resident #1 spoke with his Responsible Party on 02/25/25. Record review of Resident #1's Progress Notes dated 02/28/25 at 10:32 AM reflected the DON was made aware of allegations of neglect. Progress Note by the DON reflected Administrator, Medical Director, Area Director of Operations, and Area DON notified. Record review of Resident #1's Bowel Movement ADL 30-day documentation chart reflected no bowel movements between the days of 02/11/25 through 02/20/25. The ADL record reflected the resident had one bowel movement on 02/21/25 but had no other bowel movements before he was transferred to the hospital on 02/26/25 at 12:00AM. Therefore, the ADL record reflected the resident had one bowel movement from 02/11/25 until discharge on [DATE]. Record review of Resident #1's undated MAR reflected that Resident #1 did not receive a dosage of his order for Bisacodyl Rectal Suppository for constipation as needed ordered by his primary care physician during the month of February 2025. Record review of Resident #1's Hospital Record dated 02/26/25 at 10:16 PM reflected, Prominent fecal impaction of the rectum with associated stercoral colitis (chronic constipation leading to stagnation of fecal matter). There is constipation, without bowel obstruction. Record review of Resident #1's Hospital Record dated 02/28/25 at 9:23 AM reflected, Severe Constipation: on 02/27 Disimpaction severe and Mag Citrate, Lactulose, and Go Lytely. (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #1's Hospital Record dated 03/02/25 at 11:44 AM reflected Resident #1's diagnoses of Severe constipation with fecal impaction: Improving. S/P (Status Post Docusate) docusate, lactulose, soapsuds enema, manual disimpaction. Had watery stool. Record review of Resident #1's Hospital Record dated 03/03/25 at 9:20 AM reflected Resident #1's diagnosis of Severe constipation, fecal impaction. The same hospital progress notes also reflected, Noted stercoral colitis on CT, Initiate docusate, lactulose, Soapsuds enema x 2, and No BM despite manual disimpaction. Will obtain CT/AP with p.o. contrast [Computed tomography of Abdomen and pelvis with oral contrast]. Record review of the National Library of Medicine at www.ncbi.nlm.nih.gov/books/NBK560608, Stercoral Colitis, dated 07/10/23, reflected: Stercoral colitis is a rare inflammatory colitis that occurs when impacted fecal material leads to distention of the colon and eventually fecaloma [hardened stool] formation Interview on 03/11/25 at 9:53 AM with the Administrator revealed that a family member put on social media that Resident #1 was being neglected in the areas of showering, oral care, and monitoring of bowel movements. The Administrator also revealed that the resident did not return to the facility after discharge from the hospital. The Administrator said that Resident #1 went to a sister facility for long-term care. The Administrator revealed he was not aware Resident #1 had gone 11 days with no bowel movements. The Administrator stated that on 02/28/25 he in-serviced all staff on abuse/neglect, patient rounding, resident rights, bowel and bladder documentation, bowel incontinence care, bath, tub/shower, bed bath complete, teeth care/oral hygiene, resident/resident incidents, Immediately in-service, accurate documentation of refusals, and physician's orders. Interview on 03/11/25 at 10:42 AM with CNA B revealed that she worked three days on and four days off. CNA B stated that she documented the residents' activities of daily living in the facility kiosk. CNA B stated that she did not recall if Resident #1 had a bowel movement in the date range of 02/11/25-02/21/25 on the shifts that she worked. CNA B said that because the software system was supposed to trigger a warning if a resident went 72 hours without a bowel movement, she thought that the resident had a bowel movement on another aide's shift. CNA B revealed that she did not recall the resident having a bowel movement in the days prior to his discharge from the facility. CNA B stated she did not recall the system flagging a warning for Resident #1. CNA B revealed that she did not notify the nurse because she did not see a warning on her computer screen, though the resident had not had a bowel movement on her shift. CNA B stated that the resident did not complain of abdominal pain or have nausea and/or vomiting. However, CNA B revealed that Resident #1 had decreased appetite and intake prior to discharge. CNA B said that Resident #1 could communicate that he was in pain. CNA B also said that Resident #1's stomach did not appear distended. CNA B revealed that the facility's policy was that if a resident went more than 72 hours without a bowel movement, the CNA was supposed to report it to the charge nurse. The CNA stated that she did not report this because she never saw the software flag that the resident had gone 72 hours without a bowel movement. CNA B revealed that if a resident did not have a bowel movement within 72 hours, she was supposed to notify the nurse so that an as needed medication could be administered to the resident for constipation to prevent an obstruction which could lead to weight loss. (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 03/11/25 at 11:02 AM with CNA C revealed that she was also his regular aide. CNA C stated that his bowel movements were not regular. CNA C stated that Resident #1 was alert and would communicate if he had a bowel movement and needed assistance. CNA C said that she told a nurse at the nurses' station that Resident #1 had not had a bowel movement in 72 hours. However, CNA C could not recall which nurse she told. CNA revealed that the software system was supposed to flag the CNAs and the nurses if the resident had not had a bowel movement within 72 hours. CNA C stated the facility's policy was to tell the charge nurse if a resident did not have a bowel movement in 72 hours to prevent the resident from getting constipated which could lead to sepsis and other negative outcomes. Interview on 03/11/25 at 11:17 AM with LVN A revealed that she was one of Resident #1's charge nurses. LVN A stated that she was not told that Resident #1 did not have a bowel movement from 02/11/25-02/21/25 by any of the aides that provided care for Resident #1. LVN A said that Resident #1 could communicate, and the resident did not complain of pain or discomfort to her during that time. LVN A also revealed that the facility software system was supposed to flag the aides and nurses as a pop-up if a resident had not had a bowel movement within 72 hours. LVN A stated she never saw Resident #1's electronic health record flag the warning of no bowel movement for 72 hours. LVN A revealed that during her nursing assessments, in that time period, Resident #1's stomach was not distended. LVN A stated that she did not recall reviewing Resident #1's bowel movements in the electronic health record though he was a high risk for constipation due to his diagnoses and medications. Electronic Health Record reflected LVN A sent the resident out to the hospital on 02/26/25 because the resident was not talking, and the family wanted the resident sent out. LVN A revealed the importance of regular bowel movements was to prevent a bowel obstruction. LVN A stated that if a resident was at risk for constipation, she would encourage fluids. LVN also revealed that residents had standing orders for an as needed medication for constipation to be provided to the resident if the resident had not had a bowel movement within 72 hours. LVN A stated that it was everyone's responsibility to follow up with the CNAs to ensure that residents had a bowel movement within 72 hours after an as needed medication for constipation was administered. Interview on 03/11/25 at 11:45 AM with RN D revealed that Resident #1 was at high risk for constipation complications. RN D also revealed that Resident #1 did not have a bowel movement for 72 hours. RN D stated that the facility software should flag the nurses and aides if no bowel movement in 72 hours was documented. RN D said that the aides were pretty good at telling the nurses if a resident had not had a bowel movement in 72 hours. RN D stated that the software had a specific place that a nurse could go to review the resident's bowel movement history. RN D said that when she completed her assessments on Resident #1 during her daily shifts, she did not observe abdominal firmness, abdominal tenderness, nor distention. RN D stated that Resident #1 could communicate if he was in pain during an assessment. RN D revealed that 72 hours or greater without a bowel movement, put a resident at risk for bowel obstruction. RN D also revealed that she depended on the aides to tell her if the resident went 72 hours or longer without a bowel movement. The RN said that after an as needed medication for constipation was provided to the resident, she relied on the resident and the aides to communicate to her if the interventions were working. RN D also said that, during her daily assessments, she used her observations and nursing skills to determine if the interventions worked. RN D stated that it was the nurses' responsibility to ensure that a resident had a bowel movement and follow up with an assessment after an intervention was utilized. (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 03/11/25 at 1:46 PM with Resident #1's Responsible Party revealed that a family member placed a negative comment about the facility on social media the morning that the resident went out to the hospital. The Responsible Party stated that he saw Resident #1 on the morning of 02/25/25, and he could tell that something was wrong. The Responsible Party stated that he called the facility and requested that his family member be sent out to the hospital. The Responsible Party confirmed that the hospital did not do surgery on Resident #1, and, Resident #1 was now at another facility. Interview on 03/11/25 at 4:14 PM with the ADON revealed that he was unaware Resident #1 had no bowel movement from 02/11/25 to 02/21/25. The ADON stated that his expectation was that the aides report to their charge nurses if a resident had an abnormal bowel movement. The ADON said that the nurses should receive an alert on their software if a resident has gone 72 hours or longer without a bowel movement. The ADON also revealed that residents have a standing order for a medication to be administered if a resident is constipated and it has been 72 hours since the resident's last bowel movement. The ADON said that nurses should look for signs of vomiting and distention as well as monitor for symptoms of constipation. The ADON revealed that constipation could lead to an obstruction which could further lead to other injuries such as a bowel perforation. Interview on 03/12/25 at 11:18 AM with the Medical Director revealed that Resident #1 had risk factors for constipation due to his diagnosis of cerebral palsy, which was a neurological condition which led to his immobility. The Medical Director stated that he provided the facility with standing orders for the treatment of constipation if a resident did not have a bowel movement after three days. The Medical Director said that he expected the facility's nurses to notify him if his prescribed interventions did not work for residents. The Medical Director stated that he did not recall if he was notified of a change in condition for Resident #1. The Medical Director concluded by stating that he could not remember everything about every resident. Interview on 03/12/25 at 1:25 PM with CNA E revealed that she provided care to Resident #1. CNA E stated that she could not recall if Resident #1 had a bowel movement from 02/11/25 to 02/21/25. CNA E said that the policy was to inform the nurse if a resident did not have a bowel movement within 72 hours. CNA E revealed her daily procedure when she worked was to review the resident's history. Then if the resident had missed a bowel movement within 48 hours and she arrived on the third day, she would report the abnormal bowel movement to the charge nurse verbally or write a note and hand it to them. CNA E stated that the importance of the policy was to ensure that a resident was provided their medication or treatment ordered by their physician for the constipation. CNA E confirmed that Resident #1 could communicate to her by using his tablet. CNA E said that Resident #1 did not complain pain. CNA E revealed that the resident's eating declined prior to discharge to the hospital. CNA E said that Resident #1 did not complain of vomiting, nausea, or stomach pain. CNA E stated that his stomach looked normal, without puffiness. (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 03/12/25 at 2:09 PM with CNA F revealed that Resident #1 was chronic for constipation. CNA F stated that Resident #1 had abnormal bowel movements, which was approximately once every two to four days. CNA F could not recall Resident #1's bowel movements for the month of February. CNA F stated that Resident #1 also had abnormal eating habits because he wanted to eat at night and not regular meals in the day. CNA F revealed that the resident did not complain of pain. CNA F stated that she did not observe distention of Resident #1's stomach. CNA F said that the documentation reviewed by her during the middle of shift depended on the individual she was working with. CNA F stated that she was not told that Resident #1 had not had a bowel movement in 72 hours when she last worked with the resident. CNA F said that she could not recall charting that the resident had no bowel movement during the time of 02/11/25 through 02/21/25 or if she had reported it to the nurse. CNA F stated that the standard protocol was that if a resident did not have a bowel movement within 72 hours, the nurse was supposed to be told by the aide. CNA F revealed that it was important to inform the nurse because the resident could be impacted or possibly have a bowel obstruction. Interview on 03/13/25 at 2:30 with Area DON revealed the facility began to in-service all staff on 03/13 after notification of the immediate jeopardy at 11:30 AM on 03/13/25. The Area DON stated that all staff were in-serviced on abuse and neglect by the ADON. The Area DON also stated that all staff were in-serviced on documentation of bowel movements, reporting changes, and notifying the ADON and DON of changes in bowel movements by the ADON. The Area DON revealed that she in-serviced the nursing staff on how to access clinical alerts in the facility software. The Area DON also stated that the ADON in-serviced the nursing staff administering PRN (as needed) medication to residents with no bowel movement for three days. The Area DON said that the ADON in-serviced all nursing staff on bowel movement monitoring and dashboard alerts and monitoring. The Area DON stated that the ADON also in-serviced all nursing staff on recognizing a change of condition and the requirement to notify the resident's primary care physician. The Area DON revealed that she in-serviced the Administrator, the DON, Area Director of Operations, and the ADON on recognizing a change of condition and bowel movement changes. The Area DON revealed that the in-service was completed via a text service that went to all facility staff and copies were provided evidencing it. The Area DON also said that she and the ADON spoke with the staff about the in-service topics before they began their shifts in addition to the text that went out to all facility staff. The Area DON stated the DON and/or the ADON will review all new admissions in the stand-up meeting 5 times a week for six weeks and then as needed addressing alerts for no bowel movements and if the nurse accurately responded. The Area DON also revealed that the DON and/or the ADON would ask five nurses per week if anyone reported not having a bowel movement in the last three days and document the intervention and monitor for six weeks as needed. The Area DON stated that the DON and/or the ADON would ask five CNAs per week if they reported a resident that did not have a bowel movement to their nurse and the nurse's response. The DON was out due to illness during the days the surveyor was in the building 03/11/25-03/14/25. Record review of the facility's undated Physician's Orders policy reflected: To Monitor and ensure the accuracy and completeness of the medication orders, treatment orders, and ADL order for each resident. Record review of the facility's undated Documentation policy reflected: Documentation is the recording of all information, both objective and subjective, in the clinical record of an individual resident. It includes observations, investigations, and communications of the resident involving care and treatments. (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the facility's Abuse and Neglect Policy dated 09/09/24 reflected: The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat resident's medical symptoms. Residents should not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultant or volunteers, staff or other agencies serving the resident, family members or legal guardians, friends, or other individuals. The facility will provide and ensure the promotion and protection of resident rights. It is each individual's responsibility to recognize, report and promptly investigate actual or alleged abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property abuse and situations that may constitute abuse or neglect to any resident in the facility. 7. Neglect: is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Record review of in-services reflected 32 staff attended the following in-services and all other staff were notified via cell phone text on the following in-services: Abuse/Neglect completed on 03/13/25, Documentation of Bowel Movements, Reporting Changes, Notify ADON/DON of Changes completed on 03/13/25, How to Access Clinical Alerts completed on 03/13/25, No Bowel Movement in 3 Days-Offer PRN (as needed) Intervention completed on 03/13/25, Bowel Movement and Monitoring/Dash Board Alerts and Monitoring completed 03/13/25, SBAR-Change of Condition/Notification to the Primary Care Physician completed 03/13/25, Change of Condition and Bowel Movements. Record review of in-services reflected 32 staff attended the following in-services and all other staff were notified via cell phone text on the following in-services: Abuse/Neglect completed on 02/28/25, Patient rounding completed on 02/28/25, Resident Rights completed on 02/28/25, Bowel and Bladder Documentation completed on 02/28/25, Bowel Incontinence Care completed on 02/28/25, Bath Tub/Shower completed on 02/28/25, Bed Bath Complete completed on 02/28/25, Teeth Care/Oral Hygiene completed on 02/28/25, Resident/Resident Incidents completed on 02/28/25, Immediate Notification completed on 02/28/25, Accurate Documentation of Refusals completed on 02/28/25, and Physician's Orders completed on 02/28/25. Record review of facility monitoring tool that reflected the DON and/or the ADON would review the 24-hour report and clinical alerts daily in stand-up meeting five times a week for five weeks, and then as needed completed 03/14/25 and reviewed 03/14/25. Record review of the facility monitoring tool that reflected the DON and/or the ADON would ask five nurses per week if anyone reported a resident not having a bowel movement in the last three days, the nurses' response, and monitoring to continue for six weeks and as needed completed 03/14/25 and reviewed 03/14/25. Record review of the facility monitoring tool that reflected the DON and/or the ADON would ask five CNAs per week if anyone reported a resident not having a bowel movement in the last three days, the nurses' response, and monitoring to continue for six weeks and as needed completed 03/14/25 and reviewed 03/14/25. (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An Immediate Jeopardy was identified on 03/13/25 at 10:00 AM. The Administrator was informed of the Immediate Jeopardy in the areas of Quality of Care. The Immediate Jeopardy template was provided to the Administrator via email on 03/13/25 at 11:30 AM. The plan of removal was accepted on 03/13/25 at 3:11 PM and included: Plan of Removal Action: 03/13/25 1. Resident #1 no longer resides at the facility as of 03/13/25. 2. The Compliance Nurse in-serviced the Administrator, the DON, and the ADON 1:1 on the following topics below on 03/13/25: a. The use of the Dashboard in the facility software, labeled clinical alerts for no bowel movements in the past 72 hours, Nurses will document Interventions in the facility software. b. Promptly and correctly assessing a resident when a change of condition has been identified or reported. Assessing a resident's change in condition using a SBAR (Situation, Background, Assessment, Recommendations tool so that all necessary information is communicated to the physician or nurse practitioner. c. Abuse and /Neglect Policy. d. Reporting changes of condition to the physician or nurse practitioner based on interact's Acute change in condition file cards, e. Residents who have not had a bowel movement within three days will be assessed for constipation and offered PRN interventions. If not successful, MD will be notified for additional instructions. Resident will be monitored each shift until success bowel movement is reported. f. Potential complications of Bowel constipation. g. All residents who are at risk of constipation will have an active care plan with interventions and monitoring. h. If the nurse does not assess timely, the DON is to be notified. i. Accurate and timely documentation in the facility software, including resident bowel movement. 3. The DON, the ADON, and Regional Compliance Nurse in-serviced the licensed Nurses on the following topics on 03/13/25: a. Abuse/Neglect Policy. (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	b. The use of the Dashboard in the facility software, labeled clinical alerts for no bowel movements in the past 72 hours, Nurses will document Interventions in the facility software. c. Promptly and correctly assessing a resident when a change of condition has been identified or reported. Assessing a resident's change in condition using a SBAR, so that all necessary information is communicated to the physician or nurse practitioner. d. Reporting changes of condition to the physician or nurse practitioner based on interact's Acute change in condition file cards. e. Residents who have not had a bowel movement within three days will be assessed for constipation and offered PRN interventions. If not successful, MD will be notified for additional instructions. Resident will be monitored each shift until success bowel movement is reported. f. Potential complications of Bowel constipation. g. All residents who are at risk of constipation will have an active care plan. 4. The DON, ADON, and Regional Compliance Nurse in-serviced the non-licensed staff on the following on 03/13/25: a. Abuse/Neglect Policy. b. Reporting changes in a resident's condition to a nurse immediately, including when a resident has not had a bowel c. If the nurse does not assess timely, the DON is to be notified. d. Accurate and timely documentation in the facility software, including resident bowel movements. 5. AD Hoc QAPI Contributors met and assessed all residents in the facility for the risk of constipation or other bowel movement issues, comprehensive care plans updated to include interventions and monitoring by the DON/ADON/Regional Compliance Nurse. No additional residents were identified with no Bowel movements within three days. Review of AD Hoc QAPI Completed on 03/13/25. 6. The QAPI committee will review findings and make changes as needed. Identified Residents at Risk: Only 1 resident was affected regarding this incident. The resident was treated with medication in the hospital. The resident did not require surgery. Systemic Changes: 1. Nursing Administration will monitor all residents at risk for bowel complications. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676004	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/14/2025
NAME OF PROVIDER OR SUPPLIER The Hills Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 201 E Thompson St Decatur, TX 76234	
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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	2. CNAs will monitor residents for no bowel movements and notify nurses and document it in the facility software. 3. Nurses will monitor the software dashboard for clinical alerts. 4. Nurses will contact the physician when a resident has a change in condition. 5. Nurses will provide a resident with an intervention medication if the resident has not had a bowel movement in 72 hours. Responsibility: It is the Administrator, or designee, and the Director of Nursing, or designee's responsibility to follow the actions and the systematic changes listed above. The Administrator, or designee, and the Director of Nursing, or designee, will report their findings of the above actions and systematic changes through their QAPI [Quality Assessment Performance Improvement] Process. Monitoring interviews for the Immediate Jeopardy were started on 03/13/25 at 3:39 PM and continued through 03/14/25 at 11:15 AM with 40 staff across all three shifts, including weekdays and weekends, including all departments. The staff were interviewed about and abuse/neglect, monitoring for risk of bowel complications, monitoring residents' bowel movements and notifying nurses and documenting it in the facility software, nursing monitoring the dashboard for clinical alerts, nurses contacting the physician when a resident has a change in condition, nurses providing a resident with an intervention medication if the resident has not had a bowel movement in 72 hours. The following staff's in-service logs were reviewed, and they were interviewed during the monitoring time frame. The were able to articulate what they were taught including the correct protocols and procedures related to documenting bowel movements, notifying nurse and nursing administration, administering intervention medication if a resident has not had a bowel movement for in 72 hours, the risk to bowel complications, and abuse/neglect: LVN A, CNA B, CNA C, RN D, CNA E, CNA F, CNA G, CNA H, CNA I, MA J, LVN K, CNA L, LVN M, LVN N, Hospitality Aide O, LVN P, CNA Q, CNA R CNA S, RN T, Administrator, and the ADON. An Immediate Jeopardy was identified on 03/13/25 at 10:00 AM. While the Immediate Jeopardy was removed on 03/14/25, the facility remained at the severity level of noncompliance that results in no more than minimal physical, mental and/or psychosocial discomfort to the resident and/or has the potential (not yet realized) to compromise the resident's ability to maintain and/or reach his or her highest practicable physical, mental and/or psychosocial well-being as defined by an accurate and comprehensive resident assessment, plan of care, and provision of service and a scope of pattern due to the facility continuing to monitor the implementation and effectiveness of their plan of removal.		

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48236 Based on interviews and record reviews, the facility failed to ensure that residents are free of any significant medication errors for 1 of 10 residents (Resident #1) reviewed for medications. The facility failed ensure Resident #1, who was at increased risk for constipation due to having cerebral palsy, was administered his physician-ordered Bisacodyl Rectal Suppository when he had only one bowel movement between 02/11/25 and 02/26/25. This failure resulted in the resident being diagnosed in the hospital with fecal impaction of the rectum with associated stercoral colitis, which is a rare inflammatory colitis that occurs when impacted fecal material leads to distention of the colon and eventually hardened stool formation. Prior to the hospitalization, the resident had only had one bowel movement between 02/11/25 and 02/26/25. An Immediate Jeopardy was identified on 03/13/25 at 10:00 AM. While the Immediate Jeopardy was removed on 03/14/25, the facility remained at the severity level of noncompliance that results in no more than minimal physical, mental and/or psychosocial discomfort to the resident and/or has the potential (not yet realized) to compromise the resident's ability to maintain and/or reach his or her highest practicable physical, mental and/or psychosocial well-being as defined by an accurate and comprehensive resident assessment, plan of care, and provision of service and a scope of pattern due to the facility continuing to monitor the implementation and effectiveness of their plan of removal. The failure placed residents at risk of serious harm or death. Findings included: Record review of Resident #1's Nursing Home Comprehensive Item Set MDS Record dated, 01/15/25, reflected an initial admitted [DATE] and readmitted [DATE]. Resident #1's diagnoses included: cerebral palsy (congenital disorder of movement, muscle tone, or posture), seizure disorder or epilepsy, sepsis (life-threatening complication of an infection), and dysphagia (difficulty swallowing foods or liquids, arising from the throat or esophagus, ranging from mild difficulty to complete and painful blockage). Resident #1's MDS also reflected that Resident #1's cognition was intact with a BIMS of 15. Resident #1's MDS reflected that Resident #1 was dependent (helper does all the effort) on staff for toileting. Resident #1's MDS also reflected that Resident #1 was not on a bowel toileting program. Resident #1's MDS reflected that the resident was always incontinent of bowel. The MDS also reflected that Resident #1 showed no constipation present. (continued on next page)		

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #1's undated Care Plan reflected that resident #1 was at risk for bowel incontinence. Resident #1's goal was to not have any complications relating to bowel incontinence. Resident #1's interventions included: apply barrier cream after every incontinent episode, check resident every two hours and assist with toileting as needed, provide peri care after each incontinent episode, report any skin change to the nurse immediately, see care plans on mobility, ADL, and cognitive deficit, Communication. Record review of Resident #1's undated Care Plan also reflected that resident #1 had an ADL Self Care Performance Deficit. Resident #1's goal was to maintain current level of function in bed mobility through the review date. Resident #1's interventions included: bathing-requires extensive assistance staff x 2 for assistance; bed mobility- requires extensive assistance staff x 2 for assistance; eating-requires staff x1; the resident requires a lift for all transfers; toilet use- requires extensive assistance staff x 2 for assistance; dressing-the resident requires (x2) staff participation to dress; the resident has contractures of the upper extremities. Record review of Resident #1's undated Discontinued Orders reflected resident received Baclofen Oral Tablet 20 mg 1 tablet by mouth four times daily. Resident #1 was also ordered and received Clonazepam .5 mg tablet by mouth twice daily. Resident #1 received Probiotic Oral Capsule daily as well. Resident #1 had a PRN (as needed) order for Bisacodyl Rectal Suppository insert 10 mg rectally as needed for constipation. Resident #1's orders also reflected he received 2 Hydrocodone-Acetaminophen Oral Table 5-325 three times daily. Resident #1 received 1 Cyclobenzaprine HCl Oral Tablet 10 mg twice daily. Record review of Resident #1's Progress Notes dated 02/26/25 at 6:47 PM reflected LVN A transferred Resident #1 to the hospital due to a change in condition and family request on 02/26/25 at 12:00 AM after Resident #1 spoke with his Responsible Party on 02/25/25. Record review of Resident #1's Progress Notes dated 02/28/25 at 10:32 AM reflected the DON was made aware of allegations of neglect. Progress Note by the DON reflected Administrator, Medical Director, Area Director of Operations, and Area DON notified. Record review of Resident #1's Bowel Movement ADL 30-day documentation chart reflected no bowel movements between the days of 02/11/25 through 02/20/25. The ADL record reflected the resident had one bowel movement on 02/21/25 but had no other bowel movements before he was transferred to the hospital on 02/26/25 at 12:00AM. Therefore, the ADL record reflected the resident had one bowel movement from 02/11/25 until discharge on [DATE]. Record review of Resident #1's undated MAR reflected that Resident #1 did not receive a dosage of his order for Bisacodyl Rectal Suppository for constipation as needed ordered by his primary care physician during the month of February 2025. Record review of Resident #1's Hospital Record dated 02/26/25 at 10:16 PM reflected, Prominent fecal impaction of the rectum with associated stercoral colitis (chronic constipation leading to stagnation of fecal matter). There is constipation, without bowel obstruction. Record review of Resident #1's Hospital Record dated 02/28/25 at 9:23 AM reflected, Severe Constipation: on 02/27 Disimpaction severe and Mag Citrate, Lactulose, and Go Lytely. (continued on next page)		

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #1's Hospital Record dated 03/02/25 at 11:44 AM reflected Resident #1's diagnoses of Severe constipation with fecal impaction: Improving. S/P docusate, lactulose, soapsuds enema, manual disimpaction. Had watery stool. Record review of Resident #1's Hospital Record dated 03/03/25 at 9:20 AM reflected Resident #1's diagnosis of Severe constipation, fecal impaction. The same hospital progress notes also reflected, Noted stercoral colitis on CT, Initiate docusate, lactulose, Soapsuds enema x 2, and No BM despite manual disimpaction. Will obtain CT/AP with p.o. contrast [Computed tomography of Abdomen and pelvis with oral contrast]. Record review of the National Library of Medicine at www.ncbi.nlm.nih.gov/books/NBK560608, Stercoral Colitis, dated 07/10/23, reflected: Stercoral colitis is a rare inflammatory colitis that occurs when impacted fecal material leads to distention of the colon and eventually fecaloma [hardened stool] formation Interview on 03/11/25 at 9:53 AM with the Administrator revealed that a family member put on social media that Resident #1 was being neglected in the areas of showering, oral care, and monitoring of bowel movements. The Administrator also revealed that the resident did not return to the facility after discharge from the hospital. The Administrator said that Resident #1 went to a sister facility for long-term care. The Administrator revealed he was not aware Resident #1 had gone 11 days with no bowel movements. The Administrator stated that on 02/28/25 he in-serviced all staff on abuse/neglect, patient rounding, resident rights, bowel and bladder documentation, bowel incontinence care, bath, tub/shower, bed bath complete, teeth care/oral hygiene, resident/resident incidents, Immediately in-service, accurate documentation of refusals, and physician's orders. Interview on 03/11/25 at 10:42 AM with CNA B revealed that she worked three days on and four days off. CNA B stated that she documented the residents' activities of daily living in the facility kiosk. CNA B stated that she did not recall if Resident #1 had a bowel movement in the date range of 02/11/25-02/21/25 on the shifts that she worked. CNA B said that because the software system was supposed to trigger a warning if a resident went 72 hours without a bowel movement, she thought that the resident had a bowel movement on another aide's shift. CNA B revealed that she did not recall the resident having a bowel movement in the days prior to his discharge from the facility. CNA B stated she did not recall the system flagging a warning for Resident #1. CNA B revealed that she did not notify the nurse because she did not see a warning on her computer screen, though the resident had not had a bowel movement on her shift. CNA B stated that the resident did not complain of abdominal pain or have nausea and/or vomiting. However, CNA B revealed that Resident #1 had decreased appetite and intake prior to discharge. CNA B said that Resident #1 could communicate that he was in pain. CNA B also said that Resident #1's stomach did not appear distended. CNA B revealed that the facility's policy was that if a resident went more than 72 hours without a bowel movement, the CNA was supposed to report it to the charge nurse. The CNA stated that she did not report this because she never saw the software flag that the resident had gone 72 hours without a bowel movement. CNA B revealed that if a resident did not have a bowel movement within 72 hours, she was supposed to notify the nurse so that an as needed medication could be administered to the resident for constipation to prevent an obstruction which could lead to weight loss. (continued on next page)		

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 03/11/25 at 11:02 AM with CNA C revealed that she was also his regular aide. CNA C stated that his bowel movements were not regular. CNA C stated that Resident #1 was alert and would communicate if he had a bowel movement and needed assistance. CNA C said that she told a nurse at the nurses' station that Resident #1 had not had a bowel movement in 72 hours. However, CNA C could not recall which nurse she told. CNA revealed that the software system was supposed to flag the CNAs and the nurses if the resident had not had a bowel movement within 72 hours. CNA C stated the facility's policy was to tell the charge nurse if a resident did not have a bowel movement in 72 hours to prevent the resident from getting constipated which could lead to sepsis and other negative outcomes. Interview on 03/11/25 at 11:17 AM with LVN A revealed that she was one of Resident #1's charge nurses. LVN A stated that she was not told that Resident #1 did not have a bowel movement from 02/11/25-02/21/25 by any of the aides that provided care for Resident #1. LVN A said that Resident #1 could communicate, and the resident did not complain of pain or discomfort to her during that time. LVN A also revealed that the facility software system was supposed to flag the aides and nurses as a pop-up if a resident had not had a bowel movement within 72 hours. LVN A stated she never saw Resident #1's electronic health record flag the warning of no bowel movement for 72 hours. LVN A revealed that during her nursing assessments, in that time period, Resident #1's stomach was not distended. LVN A stated that she did not recall reviewing Resident #1's bowel movements in the electronic health record though he was a high risk for constipation due to his diagnoses and medications. Electronic Health Record reflected LVN A sent the resident out to the hospital on 02/26/25 because the resident was not talking, and the family wanted the resident sent out. LVN A revealed the importance of regular bowel movements was to prevent a bowel obstruction. LVN A stated that if a resident was at risk for constipation, she would encourage fluids. LVN also revealed that residents had standing orders for an as needed medication for constipation to be provided to the resident if the resident had not had a bowel movement within 72 hours. LVN A stated that it was everyone's responsibility to follow up with the CNAs to ensure that residents had a bowel movement within 72 hours after an as needed medication for constipation was administered. Interview on 03/11/25 at 11:45 AM with RN D revealed that Resident #1 was at high risk for constipation complications. RN D also revealed that Resident #1 did not have a bowel movement for 72 hours. RN D stated that the facility software should flag the nurses and aides if no bowel movement in 72 hours was documented. RN D said that the aides were pretty good at telling the nurses if a resident had not had a bowel movement in 72 hours. RN D stated that the software had a specific place that a nurse could go to review the resident's bowel movement history. RN D said that when she completed her assessments on Resident #1 during her daily shifts, she did not observe abdominal firmness, abdominal tenderness, nor distention. RN D stated that Resident #1 could communicate if he was in pain during an assessment. RN D revealed that 72 hours or greater without a bowel movement, put a resident at risk for bowel obstruction. RN D also revealed that she depended on the aides to tell her if the resident went 72 hours or longer without a bowel movement. The RN said that after an as needed medication for constipation was provided to the resident, she relied on the resident and the aides to communicate to her if the interventions were working. RN D also said that, during her daily assessments, she used her observations and nursing skills to determine if the interventions worked. RN D stated that it was the nurses' responsibility to ensure that a resident had a bowel movement and follow up with an assessment after an intervention was utilized. (continued on next page)		

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 03/11/25 at 1:46 PM with Resident #1's Responsible Party revealed that a family member placed a negative comment about the facility on social media the morning that the resident went out to the hospital. The Responsible Party stated that he saw Resident #1 on the morning of 02/25/25, and he could tell that something was wrong. The Responsible Party stated that he called the facility and requested that his family member be sent out to the hospital. The Responsible Party confirmed that the hospital did not do surgery on Resident #1, and, Resident #1 was now at another facility. Interview on 03/11/25 at 4:14 PM with the ADON revealed that he was unaware Resident #1 had no bowel movement from 02/11/25 to 02/21/25. The ADON stated that his expectation was that the aides report to their charge nurses if a resident had an abnormal bowel movement. The ADON said that the nurses should receive an alert on their software if a resident has gone 72 hours or longer without a bowel movement. The ADON also revealed that residents have a standing order for a medication to be administered if a resident is constipated and it has been 72 hours since the resident's last bowel movement. The ADON said that nurses should look for signs of vomiting and distention as well as monitor for symptoms of constipation. The ADON revealed that constipation could lead to an obstruction which could further lead to other injuries such as a bowel perforation. Interview on 03/12/25 at 11:18 AM with the Medical Director revealed that Resident #1 had risk factors for constipation due to his diagnosis of cerebral palsy, which was a neurological condition which led to his immobility. The Medical Director stated that he provided the facility with standing orders for the treatment of constipation if a resident did not have a bowel movement after three days. The Medical Director said that he expected the facility's nurses to notify him if his prescribed interventions did not work for residents. The Medical Director stated that he did not recall if he was notified of a change in condition for Resident #1. The Medical Director concluded by stating that he could not remember everything about every resident. Interview on 03/12/25 at 1:25 PM with CNA E revealed that she provided care to Resident #1. CNA E stated that she could not recall if Resident #1 had a bowel movement from 02/11/25 to 02/21/25. CNA E said that the policy was to inform the nurse if a resident did not have a bowel movement within 72 hours. CNA E revealed her daily procedure when she worked was to review the resident's history. Then if the resident had missed a bowel movement within 48 hours and she arrived on the third day, she would report the abnormal bowel movement to the charge nurse verbally or write a note and hand it to them. CNA E stated that the importance of the policy was to ensure that a resident was provided their medication or treatment ordered by their physician for the constipation. CNA E confirmed that Resident #1 could communicate to her by using his tablet. CNA E said that Resident #1 did not complain pain. CNA E revealed that the resident's eating declined prior to discharge to the hospital. CNA E said that Resident #1 did not complain of vomiting, nausea, or stomach pain. CNA E stated that his stomach looked normal, without puffiness. (continued on next page)		

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 03/12/25 at 2:09 PM with CNA F revealed that Resident #1 was chronic for constipation. CNA F stated that Resident #1 had abnormal bowel movements, which was approximately once every two to four days. CNA F could not recall Resident #1's bowel movements for the month of February. CNA F stated that Resident #1 also had abnormal eating habits because he wanted to eat at night and not regular meals in the day. CNA F revealed that the resident did not complain of pain. CNA F stated that she did not observe distention of Resident #1's stomach. CNA F said that the documentation reviewed by her during the middle of shift depended on the individual she was working with. CNA F stated that she was not told that Resident #1 had not had a bowel movement in 72 hours when she last worked with the resident. CNA F said that she could not recall charting that the resident had no bowel movement during the time of 02/11/25 through 02/21/25 or if she had reported it to the nurse. CNA F stated that the standard protocol was that if a resident did not have a bowel movement within 72 hours, the nurse was supposed to be told by the aide. CNA F revealed that it was important to inform the nurse because the resident could be impacted or possibly have a bowel obstruction. Interview on 03/13/25 at 2:30 with Area DON revealed the facility began to in-service all staff on 03/13 after notification of the immediate jeopardy at 11:30 AM on 03/13/25. The Area DON stated that all staff were in-serviced on abuse and neglect by the ADON. The Area DON also stated that all staff were in-serviced on documentation of bowel movements, reporting changes, and notifying the ADON and DON of changes in bowel movements by the ADON. The Area DON revealed that she in-serviced the nursing staff on how to access clinical alerts in the facility software. The Area DON also stated that the ADON in-serviced the nursing staff administering PRN (as needed) medication to residents with no bowel movement for three days. The Area DON said that the ADON in-serviced all nursing staff on bowel movement monitoring and dashboard alerts and monitoring. The Area DON stated that the ADON also in-serviced all nursing staff on recognizing a change of condition and the requirement to notify the resident's primary care physician. The Area DON revealed that she in-serviced the Administrator, the DON, Area Director of Operations, and the ADON on recognizing a change of condition and bowel movement changes. The Area DON revealed that the in-service was completed via a text service that went to all facility staff and copies were provided evidencing it. The Area DON also said that she and the ADON spoke with the staff about the in-service topics before they began their shifts in addition to the text that went out to all facility staff. The Area DON stated the DON and/or the ADON will review all new admissions in the stand-up meeting 5 times a week for six weeks and then as needed addressing alerts for no bowel movements and if the nurse accurately responded. The Area DON also revealed that the DON and/or the ADON would ask five nurses per week if anyone reported not having a bowel movement in the last three days and document the intervention and monitor for six weeks as needed. The Area DON stated that the DON and/or the ADON would ask five CNAs per week if they reported a resident that did not have a bowel movement to their nurse and the nurse's response. The DON was out due to illness during the days the surveyor was in the building 03/11/25-03/14/25. Record review of the facility's undated Physician's Orders policy reflected: To Monitor and ensure the accuracy and completeness of the medication orders, treatment orders, and ADL order for each resident. Record review of the facility's undated Documentation policy reflected: Documentation is the recording of all information, both objective and subjective, in the clinical record of an individual resident. It includes observations, investigations, and communications of the resident involving care and treatments. (continued on next page)		

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the facility's Abuse and Neglect Policy dated 09/09/24 reflected: The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat resident's medical symptoms. Residents should not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultant or volunteers, staff or other agencies serving the resident, family members or legal guardians, friends, or other individuals. The facility will provide and ensure the promotion and protection of resident rights. It is each individual's responsibility to recognize, report and promptly investigate actual or alleged abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property abuse and situations that may constitute abuse or neglect to any resident in the facility. 7. Neglect: is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Record review of in-services reflected 32 staff attended the following in-services and all other staff were notified via cell phone text on the following in-services: Abuse/Neglect completed on 03/13/25, Documentation of Bowel Movements, Reporting Changes, Notify ADON/DON of Changes completed on 03/13/25, How to Access Clinical Alerts completed on 03/13/25, No Bowel Movement in 3 Days-Offer PRN (as needed) Intervention completed on 03/13/25, Bowel Movement and Monitoring/Dash Board Alerts and Monitoring completed 03/13/25, SBAR-Change of Condition/Notification to the Primary Care Physician completed 03/13/25, Change of Condition and Bowel Movements. Record review of in-services reflected 32 staff attended the following in-services and all other staff were notified via cell phone text on the following in-services:: Abuse/Neglect completed on 02/28/25, Patient rounding completed on 02/28/25, Resident Rights completed on 02/28/25, Bowel and Bladder Documentation completed on 02/28/25, Bowel Incontinence Care completed on 02/28/25, Bath Tub/Shower completed on 02/28/25, Bed Bath Complete completed on 02/28/25, Teeth Care/Oral Hygiene completed on 02/28/25, Resident/Resident Incidents completed on 02/28/25, Immediate Notification completed on 02/28/25, Accurate Documentation of Refusals completed on 02/28/25, and Physician's Orders completed on 02/28/25. Record review of facility monitoring tool that reflected the DON and/or the ADON would review the 24-hour report and clinical alerts daily in stand-up meeting five times a week for five weeks, and then as needed completed 03/14/25 and reviewed 03/14/25. Record review of the facility monitoring tool that reflected the DON and/or the ADON would ask five nurses per week if anyone reported a resident not having a bowel movement in the last three days, the nurses' response, and monitoring to continue for six weeks and as needed completed 03/14/25 and reviewed 03/14/25. Record review of the facility monitoring tool that reflected the DON and/or the ADON would ask five CNAs per week if anyone reported a resident not having a bowel movement in the last three days, the nurses' response, and monitoring to continue for six weeks and as needed completed 03/14/25 and reviewed 03/14/25. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676004	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/14/2025
NAME OF PROVIDER OR SUPPLIER The Hills Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 201 E Thompson St Decatur, TX 76234	
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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An Immediate Jeopardy was identified on 03/13/25 at 10:00 AM. The Administrator was informed of the Immediate Jeopardy in the areas of Quality of Care. The Immediate Jeopardy template was provided to the Administrator via email on 03/13/25 at 11:30 AM. The plan of removal was accepted on 03/13/25 at 3:11 PM and included: Plan of Removal Action: 03/13/25 1. Resident #1 no longer resides at the facility as of 03/13/25. 2. The Compliance Nurse in-serviced the Administrator, the DON, and the ADON 1:1 on the following topics below on 03/13/25: a. The use of the Dashboard in the facility software, labeled clinical alerts for no bowel movements in the past 72 hours, Nurses will document Interventions in the facility software. b. Promptly and correctly assessing a resident when a change of condition has been identified or reported. Assessing a resident's change in condition using a SBAR (Situation, Background, Assessment, Recommendations) tool so that all necessary information is communicated to the physician or nurse practitioner. c. Abuse and /Neglect Policy. d. Reporting changes of condition to the physician or nurse practitioner based on interact's Acute change in condition file cards, e. Residents who have not had a bowel movement within three days will be assessed for constipation and offered PRN interventions. If not successful, MD will be notified for additional instructions. Resident will be monitored each shift until success bowel movement is reported. f. Potential complications of Bowel constipation. g. All residents who are at risk of constipation will have an active care plan with interventions and monitoring. h. If the nurse does not assess timely, the DON is to be notified. i. Accurate and timely documentation in the facility software, including resident bowel movement. 3. The DON, the ADON, and Regional Compliance Nurse in-serviced the licensed Nurses on the following topics on 03/13/25: a. Abuse/Neglect Policy. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER The Hills Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 201 E Thompson St Decatur, TX 76234	
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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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	b. The use of the Dashboard in the facility software, labeled clinical alerts for no bowel movements in the past 72 hours, Nurses will document Interventions in the facility software. c. Promptly and correctly assessing a resident when a change of condition has been identified or reported. Assessing a resident's change in condition using a SBAR, so that all necessary information is communicated to the physician or nurse practitioner. d. Reporting changes of condition to the physician or nurse practitioner based on interact's Acute change in condition file cards. e. Residents who have not had a bowel movement within three days will be assessed for constipation and offered PRN interventions. If not successful, MD will be notified for additional instructions. Resident will be monitored each shift until success bowel movement is reported. f. Potential complications of Bowel constipation. g. All residents who are at risk of constipation will have an active care plan. 4. The DON, ADON, and Regional Compliance Nurse in-serviced the non-licensed staff on the following on 03/13/25: a. Abuse/Neglect Policy. b. Reporting changes in a resident's condition to a nurse immediately, including when a resident has not had a bowel c. If the nurse does not assess timely, the DON is to be notified. d. Accurate and timely documentation in the facility software, including resident bowel movements. 5. AD Hoc QAPI Contributors met and assessed all residents in the facility for the risk of constipation or other bowel movement issues, comprehensive care plans updated to include interventions and monitoring by the DON/ADON/Regional Compliance Nurse. No additional residents were identified with no Bowel movements within three days. Review of AD Hoc QAPI Completed on 03/13/25. 6. The QAPI committee will review findings and make changes as needed. Identified Residents at Risk: Only 1 resident was affected regarding this incident. The resident was treated with medication in the hospital. The resident did not require surgery. Systemic Changes: 1. Nursing Administration will monitor all residents at risk for bowel complications. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER The Hills Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 201 E Thompson St Decatur, TX 76234	
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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	2. CNAs will monitor residents for no bowel movements and notify nurses and document it in the facility software. 3. Nurses will monitor the software dashboard for clinical alerts. 4. Nurses will contact the physician when a resident has a change in condition. 5. Nurses will provide a resident with an intervention medication if the resident has not had a bowel movement in 72 hours. Responsibility: It is the Administrator, or designee, and the Director of Nursing, or designee's responsibility to follow the actions and the systematic changes listed above. The Administrator, or designee, and the Director of Nursing, or designee, will report their findings of the above actions and systematic changes through their QAPI [Quality Assessment Performance Improvement] Process. Monitoring interviews for the Immediate Jeopardy were started on 03/13/25 at 3:39 PM and continued through 03/14/25 at 11:15 AM with 40 staff across all three shifts, including weekdays and weekends, including all departments. The staff were interviewed about and abuse/neglect, monitoring for risk of bowel complications, monitoring residents' bowel movements and notifying nurses and documenting it in the facility software, nursing monitoring the dashboard for clinical alerts, nurses contacting the physician when a resident has a change in condition, nurses providing a resident with an intervention medication if the resident has not had a bowel movement in 72 hours. The following staff's in-service logs were reviewed, and they were interviewed during the monitoring time frame. The were able to articulate what they were taught including the correct protocols and procedures related to documenting bowel movements, notifying nurse and nursing administration, administering intervention medication if a resident has not had a bowel movement for in 72 hours, the risk to bowel complications, and abuse/neglect: LVN A, CNA B, CNA C, RN D, CNA E, CNA F, CNA G, CNA H, CNA I, MA J, LVN K, CNA L, LVN M, LVN N, Hospitality Aide O, LVN P, CNA Q, CNA R CNA S, RN T, Administrator, and the ADON. An Immediate Jeopardy was identified on 03/13/25 at 10:00 AM. While the Immediate Jeopardy was removed on 03/14/25, the facility remained at the severity level of noncompliance that results in no more than minimal physical, mental and/or psychosocial discomfort to the resident and/or has the potential (not yet realized) to compromise the resident's ability to maintain and/or reach his or her highest practicable physical, mental and/or psychosocial well-being as defined by an accurate and comprehensive resident assessment, plan of care, and provision of service and a scope of pattern due to the facility continuing to monitor the implementation and effectiveness of their plan of removal.		