STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676412	A. Building B. Wing	04/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fall Creek Rehabilitation and Healthcare Center	14949 Mesa Dr Humble, TX 77396

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to treat each resident with respect and dignity and provide care in a manner that promoted maintenance or enhancement of his or her quality of life for 3 of 8 residents (Resident #1, Resident #2 and Resident #3) reviewed for resident rights. 1. The facility failed to ensure Resident #1's ileostomy (a surgical technique that uses small incisions and specialized instruments, including a laparoscope (a thin tube with a camera), to examine and treat conditions within the abdomen) bag was empty timely to avoid leakage. 2. The facility failed to ensure Resident #1 was cleaned immediately after his ileostomy bag leaked. 3. The facility failed to ensure that Licensed Vocational Nurse (LVN) A and certified nursing assistant (CNA) C maintained professionalism by speaking to and around Resident #1 with dignity and respect while providing ileostomy care. 4. The facility failed to ensure LVN A, LVN E, and LVN F were properly trained to maintain Resident #1's ileostomy system. 5. The facility failed to ensure that Resident #1's physician was informed immediately and expressed the immediacy of the Resident #1's change of condition. 6. The facility failed to ensure that Resident #1 was promptly/properly cleaned and free from soiled clothing and linin before sending the resident to the hospital. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #1's Medical Doctor (MD) A's Encounter Notes Date of Service: 12/14/2024 8:06 p.m., reflected, HISTORY OF PRESENTING ILLNESS. The Resident #1 was a pleasant [AGE] year-old male patient, past medical history of schizophrenia, hyperlipidemia, heavy tobacco abuse for many years, comes to the hospital for evaluation of abdominal distention, discomfort and progressively increasing weight loss. Resident currently was with a nasogastric intubation (NG) tube in place gives limited information, information is obtained from Family #2. Per Family #2, Resident #1 had been noted to start losing weight at least since July of this year when he was noted to start losing weight on a psychiatry evaluation. Resident was noted to still have appetite close to normal but then. About mid-October he has been noted to have markedly decreased appetite and poor intake, followed by some on and off episodes of nausea and abdominal discomfort after eating small portions of solids or liquids. Resident had a quick and rapid decline in weight loss, calculated to be of a total of 50 pounds since July, but most of it noted since early to mid-October. Resident was admitted to hospital and found to have evidence of a high-grade small bowel obstruction (SBO) that was treated conservatively and resolved. Computer tomography (CT) scans reports did not show any significant or acute issue noted. Resident was told that he had a liver and gluteal masses that needed biopsy as there was a high suspicion of neoplasm apparently. Resident presented to radiology yesterday but was told after ultrasounds were done that there was no evidence of any mass in the liver nor in the gluteal region. During this time, resident had persisted with markedly decreased p.a. intake, and on the last few days has been noted to have no BMs and progressively increasing abdominal distention and discomfort and occasional episodes of vomiting reason for which she presented to the ER and subsequently admitted after being found to have a skin high-grade SBO with no transition point. Record review of Resident #1's Progress Notes dated 01/29/2025 at 09:38 p.m., created by LVN F reflected Resident #1 arrived via stretcher Family #2 at bedside. Resident alert and oriented times 3 out of 4, denies any complaints of (c/o) at present. Orders verified with Medical Director (MD) on call. Vitals stable, afebrile (the absence of fever). Total assist with Activities of daily living (ADLs). Able to use urinal, ileostomy to right upper quad (RUQ) intact with staples in place. Oriented to call light system, bed in low position, water within reach. Record review of Resident #1's Progress Notes dated 01/30/2025 at 09:35 p.m., created by LVN F reflected Resident #1 alert, stable, oriented times 3 and able to make needs known. Snacks given, and fluids encouraged. Total assist with ADLs. Ileostomy bag draining liquid stools with frequent changes. Denies any c/o at present time. Safety and comfort measures in place. Record review of Resident #1's Active Orders reflected, Order Summary: Order Date and Order Start Date of: 01/31/2025: Ileostomy right, lower, quadrant (RLQ) every shift. Colostomy/Urostomy/Ileostomy Care each and every shift (Qshift) and PRN. Order Date and Order Start Date of: 01/31/2025: Ileostomy to RLQ every shift every 3 day(s). Change ileostomy bag and wafer every 3 days. Record review of Resident #1's Progress Notes dated 01/31/2025 at 07:09 p.m. created by LVN C reflected, Note Text: Resident has ileostomy in place, site around ileostomy was excoriated and weeping clear serous drainage, attempted several methods to attach ostomy bag unsuccessfully, tried ostomy paste, skin prep, and ostomy powder, ostomy site left open to air with ABD pad in place to allow site to heal and minimize drainage, resident resting in bed currently laying on his left, side of ostomy site, ostomy bag in place attached onto ostomy ring. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #1's Progress Notes dated 01/31/2025 at 10:44 p.m., created by LVN H reflected, Ostomy site malfunction, and reinforced . No complaints of pain, no visible signs of distress visualized. Record review of Resident #1's Active Orders reflected, Order Summary: Order Date and Order Start Date of: 02/01/2025: Send Resident to emergency room (ER). Record review of Resident #1's Progress Notes dated 02/01/2025 at 05:53 a.m. created by LVN E, reflected, resident AAO . ostomy site malfunction, and reinforced . No complaints of pain, no visible signs of distress visualized. Record review of Resident #1's Progress Notes dated 02/01/2025 at 02:04 p.m., created by LVN B reflected, Resident left to go to hospital by way of (via) stretcher with ambulance to be transferred to ER. Alert and able to make needs known dry and clean gown, Family #2 at his side, with no concerns. Record review of Resident #1's Situation, Background, Assessment, and Recommendation (Sbar) dated 02/01/2025 at 08:38 a.m. completed by LVN B. Section S reflected: The change in condition, symptoms, N&V, ABD pain, and BM, started on 02/01/2025. 3. Since started, gotten worse. 4. Things that make the condition worse are: nothing. 5. Things that make the condition or symptom better are: none. 6. This condition, symptom, or sign has occurred before: No. 7. Treatment for the last episode: None. B. Background. Resident Description: Reported to Medical Doctor (MD) B on call. Record review of EMT transport record dated 02/01/2025, reflected. Call to dispatch from NF on 02/01/2025 at 09:13:57 a.m. Call assigned at 09:16:10 a.m. to EMT. Time EMT enroute to NF, 09:35:51 a.m. EMT arrived at NF, 09:54:50 a.m. Time EMT departed from NF, 10:38:16 a.m. and arrived at the ER at 11:12:02 a.m. Record review of Resident's #1's provider report dated 02/10/2025 reflected, on 02/10/2025 at 10:45 a.m. NF learned that on 02/01/2025 at 10:06 a.m. that Family #2 had concerns related to sending Resident #1 transport to hospital with vomit and bowel movement (BM) on him. LVN B, CNA B, and CNA D, listed as witnesses. On 02/01/2025 at 08:15 a.m., resident assessed by LVN B. Results of the assessment: Resident #1 has ileostomy. Experiencing N&V and ABD pain, and BM from rectum. Resident sent to the hospital. Level of cognition: BIMS score of 13. Diagnosis: pertinent medical diagnosis: acute respiratory failure with hypoxia (insufficient oxygen intake); nutritional marasmus (sever form of malnutrition); unspecified severe protein-calorie malnutrition; Crohn's disease of both small and large intestine with intestinal obstruction; other schizophrenia; muscle weakness (generalized); dysphagia, unspecified; unsteadiness on feet; other symbolic dysfunctions; anemia, unspecified; other hyperlipidemia; nicotine dependence, unspecified, uncomplicated; and colostomy status. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 02/15/2025 at 01:10 p.m., Family #1 stated Resident #1 admitted to the NF on 01/29/2025 just after visiting hours (8:00 p.m.). Family #1 stated that Family #2 arrived just before the resident and was informed that even though resident had not arrived yet, Family #2 would have to leave at 8:00 p.m. He stated that Family #2 had to inform the NF that she would not depart until she was assured that the resident had arrived and was settled in his room. He stated the NF acted negative towards the resident and Family #2 on the onset by leaving the resident in the room upon admission without introducing themselves or checking on the resident for nearly 30-minutes. He stated the following evening 01/30/2025, Family #2 informed him that after visiting the resident that the staff had difficulties keeping up with the emptying of the resident's ileotomy bag as it had begun leaking out from being full. He stated that Family #2 told him that she had to ask staff to come change the bag and they had difficulty finding someone who could/would change it, and the staff who came had come unprepared to change it. He stated he learned that day, the staff had emptied the resident's ileotomy bag 8-times that day. He stated on 01/31/2025, Family #2 arrived in the evening again to find that the resident's ileotomy bag was full, and it had leaked out onto the resident and his bedding, He stated that Family #2 had to find a staff again to inform them to come empty the full ileotomy bag. He stated Family #2 again learned that the staff had changed his bag multiple times that day and was informed by that staff that the next shift would come on and change the bag. He stated on the morning of 02/01/2025, he learned that the resident had been sitting up in the bed with vomit, BM all over his body from his ileotomy bag bursting, BM from the resident's rectum on him and the bedding for 1.5 hours before emergency medical technicians (EMT) arrived and another 20 to 30 minutes while staff cleaned the resident before he was able to transport to the ER. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 02/15/2025 at 01:28 p.m. Family #2 stated that Resident #1 discharged from the hospital to the NF on 01/29/2025 at 08:05 p.m. She stated once the resident arrived and placed in the bed, she waited for 15 or more minutes for someone to come into the room when LVN A came in and said, Oh God who is this we have to deal with now. She stated that LVN A did not know she was in the room at first because she was standing in a far corner of the room. She stated once LVN A saw her, LVN A straightened up her demeaner and Family #2 noticed that the resident's ileotomy bag was full and pointed out that it needed to be emptied. She stated that LVN A informed CNA C to go get a new bag and the CNA C debated in front of her with LVN A about who was going to empty the bag. Family #2 stated she turned to CNA C and stated, How you going to tell the nurse what she going to do? CNA C then began acting scared to touch the resident's ileotomy bag. She stated that she began assisting CNA C. She stated then CNA C then began yelling she needed her wipes. She stated the wipes were outside in the hall on a cart, so she went to the cart grabbed the wipes for CNA C and guided her on how to clean the resident. She stated that at one point, CNA C's glasses began to fall off and CNA C became upset all over again about having to change the ileotomy bag. She stated on 01/30/2025 at 04:15 p.m., and LVN A stated the resident's ileotomy bag would not remain in place and leaked from the resident's stoma onto the resident and his bedding and stated that the resident had been messing with the adhesive causing bowel to leak. She stated she asked the resident, but he denied removing or loosen the adhesive tape. She stated that after the resident was cleaned up, LVN A told him how to lay on the opposite side of the stoma to prevent any leakage. She stated on 01/30/2025, 01/31/2025, and 02/01/20205 she witnessed the resident's ostomy bag full and leaking and had to inform staff that the bag needed to be emptied. She stated on 01/31/2025 she called the ADM and left a message for a return call to voice concerns. She stated later that afternoon, she arrived at the NF and walked past the ADM's office and seen her inside saying, Why did we accept this man if we cannot meet his needs and now Family #2 is calling and complaining. She stated on 02/01/2025 at 08:53 a.m., she received a call from LVN B that the resident had been vomiting after feeling nauseous and that they were sending the resident to the ER. She stated she arrived at the NF at 10:00 a.m. She stated that 2-EMTs were waiting in the hall outside of the resident's room. She stated that when the resident arrived at the ER, they had taken cultures and learned that his blood pressure (bp) was 73/51, he was dehydrated, his white blood count was up, and the 2.5 days the resident had been at the NF the acid from ileotomy leakage had broken down his skin on his stomach, that he was septic, and could have died. Interview on 02/15/2025 at 02:36 p.m., the ADM stated that she had first became aware that Resident #1 had issues with his Ileostomy bag on 01/31/2025. She stated that she called Family #2 who began expressing unpleasant nursing professionalism by LVN A. She stated she apologized to Family #2 and stated she would address the issue. She stated she called LVN C to the resident's room and learned that wafer would not remain attached to the resident's skin and BM was leaking from the resident's stoma. She stated on 02/01/2025, she learned the resident was sent to the ER for complications with the ileostomy bag. Remaining in place. She stated on 02/10/2025, Family #1 came to the NF and she learned that the resident was sent to the hospital from the NF covered in his own vomit and feces, explaining he had photographs he was going to send to her, that were not received. She stated that she informed DON A and the began an investigation and planned to call back Family #1 on 02/17/2025 with their findings. She stated through their investigation, she learned that the resident had been vomiting, and had BMs from his rectum despite having an ileostomy. She stated that DON A spoke to LVN A who admitted that she had been frustrated while providing care to Resident #1 and had not been her most professional self. She stated that LVN A had been required to complete additional training courses on customer service and received an in-service counseling on customer service. She stated after the resident's discharge to the hospital she had made attempts to contact Family #1 and Family #2 with no avail and had not heard back on his status. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 02/15/2025 at 04:55 p.m., LVN B stated that she had not been familiar with Resident #1 until 02/01/2025. She stated she started her shift at 06:00 a.m. and learned that the resident was removing his ileotomy bag and that the resident may have caused blockage damage because the ileotomy had the inability to drain properly. She stated she went into the resident's room about 08:45 a.m. and used her stethoscope to listen for BMs in the resident's abdomen and had heard none. She stated the resident's ileotomy bag had been empty and she had not known what happened. She stated that the resident had not complained of any pain but stated that he had felt nauseous. She gave the resident some nausea medication. She stated thereafter, a CNA who she could not recall brought in the resident's breakfast tray and he began projectile vomiting. She stated at about 09:00 a.m. and called Family #2 to inform Family #2 Resident would be sent to the ER. She stated CNA B and CNA C had come into the room and cleaned up and prepare the resident for transport out to the ER. She stated she had not returned to the resident's room because she had called the EMT, hospital, and prepared his discharged paperwork for the discharge to send him out to the hospital. She stated she informed the EMT of the resident's history and resident left to the ER. Interview on 02/15/2025 at 06:35 p.m., Family #2 stated that that she had taken photographs on 02/01/2025 of Resident #1 lying in the NF's bed covered in vomit and BM and had sent the photographs through text message to this surveyor. In an observation/interview on 02/15/2025 at 07:06 p.m., Resident #1 was seen at the hospital and appeared to be weak, frail, speaking slowly and lethargically. Resident #1 stated the staff at the nursing facility (NF) had not treated him well. He stated that he had sat in his bed with a leaking ileotomy bag for long periods of time every day he had been at the NF. He stated that LVN A and CNA B acted like changing his colostomy bag and cleaning the spilled bm had been nasty. He stated he had pushed the call button on several unknown specific dates and times, and no one would come right away. He stated when LVN A would come, she would say, I am not going to clean up that mess and accused him of taking off his ileotomy bag causing it to leak, which he stated he had not. Interview on 04/02/2025 at 10:52 a.m. LVN C stated that he was on shift 01/30/2025 and 01/31/2025 from 6 a.m. to 6 p.m. and responsible for the nursing and ileostomy care for Resident #1. He stated that he had complications adhering the wafer around the resident's stoma site the entire shift each day. He stated he had changed the ileotomy system 6-7 times during those shifts. He stated because the system would not remain in place, the ileostomy leaked liquid onto the resident and his beading, requiring constant cleaning of the stoma area he stated he had left system off to allow the area to dry and laid towels and clean briefs to collect any liquid from the moisture. He stated he informed DON A and LVN F of the issues, and his implementation of the towels laid to collect any leakage. He stated on 01/31/2025 he contacted the resident's nurse practitioner (NP) making her aware that the ileostomy system would not remain in place and his towel laying interventions, which NP agreed with. He stated that evening he informed, Family #2 that the towels were laid to absorb moisture. He stated that he received ostomy training upon hire and routinely. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 04/02/2025 at 12:18 p.m., LVN E stated that on 01/31/2025 she had made a call to Family #2 for an unrelated request related to Resident #1 when she learned that there were customer services concerns with LVN A's care for the resident. She stated that Family #2 told her on 01/30/2025 that LVN A was overwhelmed after having to change the resident multiple times during her visit with the resident. She stated on 01/31/2025, she interviewed LVN A who stated she had become overwhelmed after having changed the resident 8-times on 01/30/2025 and 7-times on 01/31/2025, and suspected the resident was removing the tape from around his surgical site. She stated once the tape was removed the stoma area had become moist from the leaking and difficult for LVN A to keep the wafer securely taped down. She stated she learned that LVN A told her that Family #2 wanted her to stop whatever she was doing to come attend to the resident no matter what assistance she was providing to other residents. She stated she reported what Family #2 and LVN A told her to the ADM and Assistant Director of Nursing (ADON) and the ADON gave LVN A an in-service on customer service. She stated LVN A had been a sweet, personal, and typically had not been aggressive at all. Interview on 04/02/2025 at 12:25 p.m., NP stated she was over Resident #1's care and on 01/30/2025 met with the resident about pulling on his ileostomy bag. She stated she reminded the resident to be leaving his stoma area covered to avoid leakage, and burns to the skin. She made sure to inform that NF staff to ensure the bag stayed intact. She stated she spoke to the resident who seemed upset he had to deal with the ileostomy in general, and while he appeared to calm and ileostomy was intact, he did not appear to be receptive to the idea the care required, of which she understood as it took time for a patient to get used to. She stated it had been her expectations that the staff monitor, keeping the resident's skin clean and dry, and replace the ileostomy system immediately after it came off to keep the skin from infections. She stated on 01/31/2025 received notice that the Resident's ostomy bags were no longer sticking and that the staff would be sending the resident to the hospital. She stated she was not aware that staff had laid towels and briefs to collect leakage from the resident ileostomy bag and would not recommend as an intervention. Interview on 04/02/2025 at 12:49 p.m., ADON stated she provided LVN A in-service training on customer service, resident rights, customer service presentation, colostomy/ileostomy as instructed by DON A on 02/10/2025. She stated that she did not provide any direct care to Resident #1. She stated it had been her expectations that ileostomy care would be comprised of monitoring, changing as ordered and prn, notify physicians if staff were not able to keep the ileostomy system intact and they were not able to control the ileostomy output. She stated she was not aware that staff were using towels and briefs to capture waste from resident's ileostomy site and would not consider that an effective intervention. She stated that she, the DON and CN were responsible for training ostomy care. Interview on 04/02/2025 at 01:23 p.m., DON B stated that she began working at the NF on 03/31/2025, but since arriving, she had performed several in-services on customer services. She stated she had not personally made herself familiar with Resident #1 but had reviewed the NF provider investigation. She stated it would have been her expectations that the resident's physician had been notified. She stated that she learned that LVN A was overwhelmed on 01/30/2025, because another resident on the floor had passed away, and it was her understanding that LVN A had come off rude while being overwhelmed. She stated that LVN A resigned thereafter. (continued on next page)

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	676412	A. Building B. Wing	04/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fall Creek Rehabilitation and Healthcare Center	14949 Mesa Dr Humble, TX 77396

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 04/02/2025 at 02:04 p.m., DON A stated she was the previous DON at the time Resident #1 was admitted to the facility. She stated he had only been at the facility a day to 2 when he was sent out to the hospital with issue with his colostomy/ileostomy site. She stated she received a text on the morning of 02/01/2025 from LVN B that the resident was vomiting and had a BM from his rectum and that they were sending him out because of that. She stated she was also informed that area around the resident's stoma was irritated from changing his bag often. She stated that it was her expectations that the nursing staff perform the interventions necessary for colostomy/ileotomy residents by protecting the skin from infections and notify physicians of changes in condition. She stated she was not made aware that staff had used towels or briefs to collect moisture from the leaking stoma. Interview on 04/02/2025 at 02:40 p.m., CNA C stated that on 01/31/2025 she worked 02:00 p.m. to 10:00 p. m. She stated when she came on shift, she learned that the previous shift had been having difficulties keeping Resident #1's ileotomy bag attached. She stated she entered the resident's room when she came on shift and saw that the ileotomy bag was full and leaking bowel liquid from the stoma site. She stated that LVN A had been the day shift nurse on shift. She stated when she entered the resident's room LVN A had been trying to figure out how to keep the wafer attached around the stoma to prevent the liquid from leaking from the site. She stated no matter what amount of paste or tape LVN A had used, she could not keep the system in place. She stated as such, they were constantly gowning up PPE to clean the resident and change his bedding. She stated that LVN A had laid towels beside the resident to help captured so of the leakage and she explained to Family #2 why the towels were there. She stated she remembered at some point, Family #2 asked to speak to the charge nurse and LVN F came on shift at 06:00 p.m. and spoke to Family #2. She stated she had not witnessed LVN A express frustration in front of Family #2 nor had she, and she was not aware of Family #2 had complaints. She stated she believed that the resident had unattached the ileotomy tubing, that she had not witnessed. She had not witnessed resident being withheld of food or liquids. Interview on 04/02/2025 at 03:14 p.m., ADM stated she learned of Resident #1 ileostomy issues on 01/31/2025 when she received a text message from DON A that the resident had BMs from his rectum, which had been abnormal. She stated that evening she phoned Family #2 while at the NF and learned LVN A's professionalism and beside manners was in question relating to her care for Resident #1. She stated she assured Family #2 that she would address LVN A and while they spoke, Family #2 yelled out, Oh my God, get down here right now. She stated that she grabbed LVN C who was the charge nurse on the resident's hall and entered Resident #1's room. She stated when she entered the resident's room, she saw fluid coming out of the resident's ileostomy site that had been leaking onto the resident and his bedding. She stated that LVN C began to explain what all he had done to try and keep the site from leaking. She stated he told them that he had been into the resident's room [ROOM NUMBER]-different times that shift trying to keep the ileotomy bag attached to the ileostomy site, but it would not adhere to the resident's skin. She stated on 02/01/2025 she learned from LVN E that the resident was sent out to the ER. On 02/10/2025, Family #1 came to the NF and she learned that Resident #1 was sent to the hospital on [DATE] covered in vomit and BM. She stated that CN and her assured Family #1 that they would investigate the situation and reached back to him on 02/17/2025. She stated that LVN A admitted that she was tired of going in Resident #1's room dealing with the le[TRUNCATED]

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** Based on observations, interviews, and record review, the facility failed to immediately inform and consult with the resident's physician when there was a need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment) ensure the severity of changes in condition were reported to physician for resident (Resident #1) who required colostomy, urostomy, or ileostomy for 1 of 4 residents reviewed for change in condition in that: 1. The facility failed to when notify the NP of the severity of the change in condition and the difficulties the nursing staff were having keeping Resident #1's ileostomy system secure and in place. 2. The facility failed to obtain a new physician order due to resident's change in condition causing skin breakdown. Resident #1 discharged to the hospital and was diagnosed with a sepsis bacterial infection and an AKI. An IJ was identified on [DATE]. The IJ template was provided to the facility on [DATE] at 5:48 p.m. While the IJ was removed on [DATE] at 10:50 a.m., the facility remained out of compliance at a scope of a pattern with a potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems. The facility failure to when notifying and consulting with the physician the severity of the change and lack of improvement in a condition resulted in a delay of appropriate medical treatment and a worsening of a resident's condition resulting in Resident #1 requiring hospitalization. This failure had the potential to affect other residents not requiring ostomy care who may experience a significant change in condition. Findings included: Record review of Resident #1's Facesheet dated [DATE] reflected that resident was a [AGE] year-old male who admitted to the facility on [DATE] and discharged on [DATE] with diagnosis but were not limited to unspecified severe protein-calorie malnutrition, Crohn's disease of both small and large intestine with intestinal obstruction; unsteadiness on feet; and anemia. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #1's Medical Doctor (MD) A's Encounter Notes Date of Service: [DATE] 8:06 p.m. , reflected, HISTORY OF PRESENTING ILLNESS. The Resident #1 was a pleasant [AGE] year-old male patient, past medical history of schizophrenia, hyperlipidemia, heavy tobacco abuse for many years, comes to the hospital for evaluation of abdominal distention, discomfort and progressively increasing weight loss. Resident currently was with a NG tube in place gives limited information, information is obtained from Family #2. Per Family #2, Resident #1 had been noted to start losing weight at least since July of this year when he was noted to start losing weight on a psychiatry evaluation. Resident was noted to still have appetite close to normal but then. About mid-October he has been noted to have markedly decreased appetite and poor intake, followed by some on and off episodes of nausea and abdominal discomfort after eating small portions of solids or liquids. Resident had a quick and rapid decline in weight loss, calculated to be of a total of 50 pounds since July, but most of it noted since early to mid-October. Resident was admitted to hospital and found to have evidence of a high-grade SBO that was treated conservatively and resolved. Computer tomography (CT) scans reports did not show any significant or acute issue noted. Resident was told that he had a liver and gluteal masses that needed biopsy as there was a high suspicion of neoplasm apparently. Resident presented to radiology yesterday but was told after ultrasounds were done that there was no evidence of any mass in the liver nor in the gluteal region. During this time, resident had persisted with markedly decreased p.a. intake, and on the last few days has been noted to have no BMs and progressively increasing abdominal distention and discomfort and occasional episodes of vomiting reason for which she presented to the ER and subsequently admitted after being found to have a skin high-grade SBO with no transition point. Record review of Resident #1's hospital record dated [DATE] reflected, that resident had an ileostomy laparoscopic procedure occurred on [DATE]: resulting in an exploratory laparotomy, ileostomy creation and mucus fistula. Record review of Resident #1's Progress Notes dated [DATE] at 09:38 p.m., created by LVN F reflected, Resident #1 arrived via stretcher Family #2 at bedside. Resident alert and oriented times 3 out of 4, denies any c/o at present. Orders verified with MD on call. Vitals stable, afebrile. Total assist with Activities of daily living (ADLs). Able to use urinal, ileostomy to RUQ intact with staples in place. Oriented to call light system, bed in low position, water within reach. Record review of Resident #1's Progress Notes dated [DATE] at 09:35 p.m., created by LVN F reflected, Resident #1 alert, stable and oriented x3. Able to make needs known. Snacks given, and fluids encouraged. Total assist with ADLs. ileostomy bag draining liquid stools with frequent changes. Denies any c/o at present time. Safety and comfort measures in place. Record review of Resident #1's Baseline Care Plan dated [DATE], reflected under section D. Disease/Illness Management: wound and in the other section: Ileostomy. Record review of Resident #1's BIMS dated [DATE], reflected that the resident had a score of 13 out of 15 indicating that the resident was cognitively intake. Record review of Resident #1's Active Order Summary: Order Date/ Start Date of: [DATE]: Ileostomy right, lower, quadrant (RLQ) every shift. Colostomy/Urostomy/Ileostomy Care Qshift and PRN. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #1's Active Order Summary: Order Date/ Start Date of: Order Date/Start Date of: [DATE]: Ileostomy to RLQ every shift every 3 day(s). Change ileostomy bag and wafer every 3 days. Record review of Resident #1's Progress Notes dated [DATE] at 07:09 p.m. created by LVN C reflected, Note Text: Resident has ileostomy in place, site around ileostomy is excoriated and weeping clear serous drainage, this nurse attempted several methods to attach ostomy bag unsuccessfully, nurse tried ostomy paste, skin prep and ostomy powder, ostomy site left open to air with ABD pad in place to allow site to heal and minimize drainage, resident resting in bed currently laying on his left, side, ostomy bag in place attached onto ostomy ring, will continue to monitor site and provide appropriate treatment. Record review of Resident #1's Progress Notes dated [DATE] at 10:44 p.m., created by LVN H reflected, Ostomy site malfunction, and reinforced . No complaints of pain, no visible signs of distress visualized. Record review of Resident #1's Progress Notes dated [DATE] at 05:53 a.m. created by LVN E, Late Entry. Note Text: Resident AAO and able to make needs known. Ostomy site malfunction, and reinforced. Staples to ABD area covered with DCD . No complaints of pain, no visible signs of distress visualized. Continues with therapy to improve strength and endurance. Record review of Resident #1's Progress Notes dated [DATE] at 08:38 a.m. created by LVN B reflected, situation: I am calling about the following condition, signs, symptoms: N&V and ABD pain, and BM from rectum. This started on [DATE]. Since this started has it gotten worse. The following makes this condition WORSE: Nothing. The following make this condition Better: none. This condition, symptom, or sign has not occurred before. Treatment for the last episode (if applicable) is None. Background: The resident is in this NF for Post-Acute Care. The primary diagnosis - ileostomy and pertinent history: Last international normalized ratio (INR) (test to determine risk of clots in blood) result was on [DATE]. Record review of Resident #1's dated [DATE] at 08:38 a.m. completed by LVN B. Section S reflected: Situation: 1. The change in condition, symptoms, or signs I am calling about is/are: N&V ABD pain and BM from rectum. 2. This started on [DATE]. 3. Since this started it has gotten Worse. 4. Things that make the condition worse are: nothing. 5. Things that make the condition or symptom better are: none. 6. This condition, symptom, or sign has occurred before: No. 7. Treatment for the last episode: None. B. Background. Resident Description: The resident as at this NF for Post Acute Care. B. Primary Diagnosis: Ileostomy. Vital Signs: i. Most Recent Blood Pressure: 150/89. Dated: [DATE] 8:42 a.m. 4. GI/Abdomen 4b. Nausea 4c. Vomiting 4e. Decreased Appetite 4f. Abdominal Pain 4i. Decreased Bowel Sounds. 4j. Date of last BM [DATE]. A. Assessment Registered Nurse (RN) or Appearance Licensed Practical Nurse (LPN). LPN: Resident appears (e.g. short of breath, in pain, more confused): possible obstruction. Date and time: [DATE] 08:16 a.m. 4a. Reported to Medical Doctor (MD) B on call. Record review of EMT transport record dated [DATE] reflected, that EMT transport serviced received a call from the NF at 09:13:57 a.m. to transport Resident #1 to ER. Dispatch assigned an EMT to NF at 09:16:10 a. m., EMT enroute to NF at 09:35:51 a.m., EMT arrived at NF at 09:54:50 a.m., EMT departed from NF with resident at 10:38:16 a.m., and arrived at the ER with resident at 11:12:02 a.m. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #1's Active Order Summary: Order Date/ Start Date of: Order Date/Order Start Date of: [DATE]: Send Resident to ER. Record review of Resident #1's Progress Notes dated [DATE] at 02:04 p.m., created by LVN B reflected, Late Entry: Note Text: Resident left to go to hospital by way of (via) stretcher with ambulance to be transferred to ER. Alert and able to make needs known dry and clean gown on with Family #2 at his side with no concerns before leaving to go to the ER. Record review of Resident #1's Encounter Note signed by MD C [DATE] 02:32 p.m. Date of service: [DATE]. Transition of Care: Transition occurred. Electronic Summary of Care not incorporated. Manual reconciliation performed. Details: This is a copy of a signed encounter note documented in GEHRIMED. History and Physical History . Newly diagnosed Crohn's disease. Past Surgical History: Ex lap with ileostomy creation and mucous fistula repair . Chief Complaint / Nature of Presenting Problem: Evaluate after hospital stay for SBO, new diagnosis of cancer and Crohn's disease. History Of Present Illness: [AGE] year-old man with past medical history of schizophrenia presented to hospital with weight loss and abdominal pain, diagnosed with small bowel obstruction requiring NG tube due to malignant obstructing mass with widespread peritoneal disease. On [DATE] he had a cardiac arrest due to Co2 narcosis and septic shock status post CPR. Extubated 2 days later. Required TPN. He underwent ex lap, peritoneal biopsy, ileostomy creation and mucous fistula creation on [DATE]. So far biopsy is showing adenocarcinoma. Once stable discharged to NF for further rehabilitation. Resident was seen lying in bed, states his appetite was good, denies abdominal pain. Ostomy output is good. States he was able to ambulate with a walker and therapy today. Review Of Systems General: No complaint of malaise, fatigue, or change in appetite . Small bowel obstruction. Status post ileostomy, monitor ostomy output: Physical debility Consult physical therapy (PT)/occupational therapy (OT). Crohn disease. New diagnosis, established with GI for treatment . Ileostomy care. Severe protein-calorie malnutrition. Low weight with 50-pound weight loss in the last 6 months, registered dietitian, appetite was good. Adenocarcinoma. Presumed GI primary, follow-up oncology. Record review of Resident #1's Encounter Note signed dated by NP: [DATE] 7:41 p.m. Date of service: [DATE]. Visit Type: Day 2 admission Visit . Details: This is a copy of a signed encounter note documented evaluate recent admission from hospital, pain, debility. History Of Present Illness: [AGE] year-old man with past medical history of schizophrenia presented to hospital with weight loss and abdominal pain, diagnosed with small bowel obstruction requiring NG tube due to malignant obstructing mass with widespread peritoneal disease. On [DATE] he had a cardiac arrest due to carbon dioxide (Co2) narcosis and septic shock status post Cardiopulmonary Resuscitation (CPR). Extubated 2 days later. Required total parenteral nutrition (TPN). He underwent ex lap, peritoneal biopsy, ileostomy creation and mucous fistula creation on [DATE]. So far biopsy is showing adenocarcinoma (cancer that affects glands and glandular tissues). Once stable discharged to nursing facility (NF) for further rehabilitation. He is seen lying in bed, states his appetite is good, denies abdominal pain. Ostomy output is good. [DATE] patient seen in bed resting pain waxes and wane manage on tramadol. Record review of Resident's #1's provider report dated [DATE] reflected, on [DATE] at 10:45 a.m., NF learned that on [DATE] at 10:06 a.m., that Family #1 had concerns with Resident #1 discharge to ER with vomit and BM on him. Noted staff (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	LVN B, CNA B, and CNA D as witnesses. Resident assessment on [DATE] at 08:15 a.m., completed by LVN B. Results: Resident #1 had ileostomy, experienced N&V, ABD pain, and rectum BMs. Resident sent to the ER. Level of cognition: BIMS score of 13. Diagnosis: pertinent medical diagnosis: acute respiratory failure with hypoxia; nutritional marasmus; unspecified severe protein-calorie malnutrition; Crohn's disease of both small and large intestine with intestinal obstruction; other schizophrenia; muscle weakness (generalized); dysphagia, unspecified; unsteadiness on feet; other symbolic dysfunctions; anemia, unspecified; other hyperlipidemia; nicotine dependence, unspecified, uncomplicated; and colostomy status. Interview on [DATE] at 11:27 a.m., Hospital Case Manager Nurse (HCMN) stated that Resident #1 admitted to the hospital ER from the NF on [DATE], after the NF had not taken care of the ileostomy bag and it had exploded BM waste had gotten into the midline incision and caused sepsis. She stated she had been provided with photographs of the resident's condition at the NF showing the resident covered in BM and vomit when he discharged from the NF to the ER. Interview on [DATE] at 01:10 p.m., Family #1 stated that Resident #1 received poor care at the NF on the onset of his care. He stated on [DATE], the NF staff had difficulties keeping up with the emptying of the Resident #1's ileotomy bag and he had begun leaking from being over full. He stated he learned that staff were not prepared to change ileostomy bags and seemed disturbed by having to empty the bag 8-times a day. He stated he learned that on [DATE] that Family #2 had to find a staff to empty the ileostomy bag that was full and leaking. He stated Family #2 learned that the staff had changed resident's ostomy bag multiple times that shift. He stated on the morning of [DATE], Family #2 arrived to find that the resident's ileotomy bag again full and leaking and unattached to the resident. He stated that the resident had been sitting up in the bed vomiting and having BMs all over himself after his ileotomy bag burst. He stated that the resident was left to set in his vomit and BM for 1.5 hours before EMT arrived. He stated once EMT arrived, the resident had to wait another 20 to 30 minutes while staff tried to clean him for the transport to the ER. (continued on next page)

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She stated LVN A stated that the stoma would then leak bowel on to the bed from the ileotomy tubing. She stated at 06:16 p.m. she smelled bowel and pulled back the resident's sheet and the resident and his bed was covered in bowel and his ileotomy bag was full. She stated the top of the adhesive around the stoma had loosed and bowel had been seeping from the bottom area of the stoma. She stated she alerted the staff and LVN A came into the room, seen the bowel on the bed and stated she was not going to clean up the resident again. She stated that LVN A recommended to her that she should find another facility that could better meet the resident's needs. She stated she asked LVN A to speak to her supervisor and LVN A told her to go to the front desk and ask for them. She stated at the front desk, the staff told her to go to the nurse's station. She stated at the nurse's station the staff whose names she had not learned, looked without speaking when she voiced her concerns about LVN A's comments. She stated the staff passed her a form and told her to write down her concerns and told that the nightshift nurse should be coming in at 7:00 p.m. She stated that she took the form and waited back with the resident in his room, but no one came to clean or check on the resident. She stated from 06:15 p.m. to 07:15 p.m. the resident continued to sit in his own bowel uncleaned. She stated at 07:15 p.m. went back to the nurse's station to see who was coming to clean the resident. She stated again the nurses looked at her with no response. She stated that LVN A was called to the nurse's station. She stated that LVN A came and stated that she did not know who was going to clean the resident, and stated she was not going to do it. She stated she went back to the resident's room and around 8:00 p.m. LVN F came down and changed the resident. She stated she could see that the resident's stoma was bleeding, bowel was leaking from his rectum, and his skin broken down around the stoma. She stated LVN F told her that the skin breakdown was because the resident's bowel was leaking on him all day and all night. She stated LVN F taped the wafer around the resident's stoma and stated that should help and laid towels down near the stoma area to collect any bowel leakage and moisture. She stated on [DATE] she overheard the ADM saying, Why did we accept this man if we cannot meet his needs and now Family #2 is calling and complaining. She stated she went to the resident's room when the ADM called her phone. She stated that the ADM began apologizing, saying, Please allow us opportunity to serve him. She stated as she was speaking to the ADM, she smelled the foul smell of bowel, pulled back the resident's covers and saw that he was laying in bowel, and he did not have an ileotomy bag attached to him. She stated she began crying and told the ADM what she had seen and told the ADM she needed to come down to the resident's room immediately. She stated that the ADM entered the resident's room and seen the resident laying in his bowel with no ileotomy bag attached. She stated that the ADM called LVN C to the room and LVN C began immediately explaining that he had difficulties keeping the resident's ileotomy bag secured around the resident's stoma. She stated that she could see the breakdown around the resident's stoma had gotten worse. She stated that LVN C stated he had left off the ileotomy wafer so that the resident's stoma and skin could air out due to the skin break down. She stated that LVN C began cleaning up the resident and changed his bedding and reattached the ileotomy bag. She stated on [DATE] at 08:53 a.m., she received a call from LVN B that the resident had been vomiting after feeling nauseous and would be sent to the ER. She stated she arrived at the NF at 10:00 a.m., to find 2-EMT waiting in the hall of resident's room. She stated that she was horrified seeing that the resident was lying in a bed of his own vomit and feces and with his ileotomy bag full and the tubing leaking BM. She stated that the scene was so horrific no one would believe her if she told them, so she took photographs. She stated that the resident loved to eat and seen over to the side that he had a fresh breakfast tray that had not been touched or eaten from. She stated that breakfast was served at the NF at 7:00 a.m. She stated the resident told her he had vomited 3-times. She stated he sounded weak. She stated then CNA B and CNA C came into the room and began cleaning up to be sent to the ER. She

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on [DATE] at 02:36 p.m., the ADM stated that she had first became aware that Resident #1 had issues with his Ileostomy bag on [DATE]. She stated that she called Family #2 who began expressing unpleasant nursing professionalism by LVN A. She stated she apologized to Family #2 and stated she would address the issue. She stated while they were speaking on the phone Family #2 began screaming and told her to come to the resident's room. She stated she was not aware that Family #2 was in the NH. She stated when she entered the resident's room, she could see that the resident was laying in his bed full of bowel that leaked from his ileotomy site and tubing. She stated she called LVN C to the room who had been on shift 12-hours who was about to come off shift and explained that they were having difficulties, keeping the wafer attached to the resident's skin and it had been making a mess during the whole shift and he had been doing what he could to keep the wafer attached. She stated that LVN C told her that he had been in and out of the resident's room [ROOM NUMBER]-different times trying to keep the wafer attached to the skin. She stated on [DATE], she received a text from LVN B that resident was going to the hospital for nausea and vomiting due to problems with his ileotomy bag. She stated on [DATE], Family #1 came to the NF and she learned that the resident was sent to the hospital from the NF covered in his own vomit and feces, explaining he had photographs he was going to send to her, that were not received. She stated that she informed DON A and the began an investigation and planned to call back Family #1 on [DATE] with their findings. She stated through their investigation, she learned that the resident had been vomiting, and had BMs from his rectum despite having an ileostomy. She stated that DON A spoke to LVN A who admitted that she had been frustrated while providing care to Resident #1 and had not been her most professional self. She stated that LVN A had been required to complete additional training courses on customer service and received an in-service counseling on customer service. She stated after the resident's discharge to the hospital she had made attempts to contact Family #1 and Family #2 with no avail and had not heard back on his status. She stated it had been her expectation that the nursing staff had contacted the NP. She stated that it had been the DON's responsible to ensure that the nursing staff were trained on ostomy care. Interview on [DATE] at 04:55 p.m., LVN B stated that she cared for Resident #1 on [DATE], when she that the resident was removing his ileotomy bag and that the resident may have caused blockage damage because the ileotomy had the inability to drain properly. She stated on or about 08:45 a.m. and used her stethoscope to listen for BMs in the resident's abdomen and had heard none and seen that his ileotomy bag had been empty. She stated thereafter, he began projectile vomiting. She stated she left the room and about 09:00 a.m., called Family #2 and informed her that resident would be sent to the ER. She stated CNA B and CNA C come in and cleaned up and prepare the resident for the ER. She stated the that the brown duo dermo tape used to tape down the wafer and protect the skin around the stoma would not stick to the resident's skin because there was a lot of drainage from his ileotomy bag leaving the resident's skin moist. She stated she had not returned to the resident's room because she had called the EMT, hospital, and prepared his discharged paperwork for the discharge to send him out to the hospital. She stated CNA B and CNA C were had still been cleaning the resident when EMT arrived. She stated she informed the EMT of the resident's history. She stated once the resident discharged , she learned from CNA B that he had BMs through his rectum, not through his ileotomy, so she called back the hospital and informed them. Interview on [DATE] at 06:35 p.m., Family #2 stated that that she had taken photographs on [DATE] of Resident #1 lying in the NF's bed covered in vomit and BM and had sent the photographs through text message to this surveyor. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an observation/interview while at the hospital on [DATE] at 07:06 p.m., Resident #1 was a thin male who appeared weak and frail and spoke slowly and appeared to be lethargic. He stated that he was admitted from the ER to the hospital and was doing much better than when he was at the NF of which he stated he had not wanted to return. He stated that they NF staff had not treated him well. He stated he had pushed the call button, and staff LVN A would say, I am not going to clean up that mess. He stated that he had sat in his bed with a leaking ileotomy bag for a long time every day he had been at the NF and it messed him and his bed. He stated in the late evening of [DATE], he had begun feeling nauseous. He stated on the early morning of [DATE], before breakfast, he vomited, 3-times. He stated that LVN A accused him of taking off his ileotomy bag, but he denied doing so. He stated he had not felt safe when he was at the facility. He stated that LVN C and LVN F were the only staff that helped clean him up, otherwise CNA B and LVN A kept acting like he was nasty and had not wanted to clean him up. Interview on [DATE] at 10:52 a.m. LVN C stated that he was on shift [DATE] from 6 a.m. to 6 p.m. and responsible for the nursing and ileostomy care for Resident #1 who he indicated had a cognitive rating of 3-4 out of 4, 4-being cognitively intact. He stated that he had complications adhering the wafer around the resident's stoma site his entire shift. He stated he had changed the ileotomy system 6-7 times because the wafer would not stay attached to the resident's skin. He stated the ileostomy leaked so quickly filling the ileotomy bag faster than normal causing a lot of liquid to excavate/come out from site and tubing, which further lead to more escalation from the stoma site. He stated he tried to reinforce the wafer with tape and strummer paste (adhesive paste). He stated the paste would be successful for a moment, but soon as the resident moved it would come off. He stated that he had interventions in place keep the wafer in place: strong adhesive, cleaned the area, and gave the skin around the stoma time to breathe and dry before applying a new wafer. He stated basically, every time the resident ate, liquid had swished out and pushed the wafer and bag off the resident. He stated the way the resident would favor laying on the right-side, same side as the stoma made it easier for the liquid bowel to [NAME] out. He stated that that he never had a patient like Resident #1 where the liquid would come gushing out from the stoma site and fill up the ileotomy bags so quickly. He stated he informed DON A and LVN F of the issues he had adhered the wafer to the resident. He stated he implemented a new intervention by laying towels and clean briefs on the bed near the stoma site to absorb some of the moisture. He stated on [DATE] he worked 6 a.m. to 6 p.m. and after experiencing a second day of issues with the resident's leaking stoma, contacted the resident's nurse practitioner (NP) making her aware of his new intervention to allow the site to dry and laying towels to absorb any leakage of which NP agreed with. He stated he had noted in progress notes the resident's condition but had not noted that he had contacted the NP. When asked why, he stated he had no answer. He stated he asked the resident to be as still as possible to assist with keeping the wafer in place, but soon as the resident would fall asleep, he would involuntarily move, and the wafer would come off. He stated on the evening of [DATE], Family #2 was at bedside and witnessed the stoma area drying and the towels absorbing the moisture with concerns. He stated some of the feces was on the towel that had leaked from the uncovered stoma. He stated he explained to Family #2 that the laid towels were an intervention placed to absorb any moister from the leaking stoma, and that the stoma was uncovered to allow it to dry from leaking. He stated Family #2 stated she understood and had no concerns. He stated after that shift he had not seen the resident again. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on [DATE] at 11:00 a.m., CNA D stated that on the morning of [DATE] CNA B approached to assist with cleaning Resident #1 for transport to the ER. She stated when she entered the resident's room, she saw a very thin man lying in bed vomiting, bowel drainage from his uncovered stoma, bowel draining from his ileotomy bag, and having a BM from his rectum. She stated that majority of the bowel drainage came from the ileotomy bag tubing. She stated that Family #2 and 2-EMTs were at bedside. She stated that the resident was covered in vomit and bowel. She stated that her and CNA B began removing the resident's soiled brief and soiled gown, and placed a new brief on the resident when he began to have another full BM. She stated the resident had not made any needs or concerns known nor appeared to be in pain or distress. She stated the resident was pretty quiet, was very cooperative, alert and somewhat oriented. She stated that there was no NF nurse in the room. She stated as CNA B picked up the resident's colostomy tubing, one of the EMTs stated to just leave the resident that way. She stated to the EMT that she should have gotten a nurse to reattach the ileotomy bag and the EMT stated no to leave it that way for the ER physicians to properly diagnosis the resident's condition. She stated then the EMTs transported the resident out of the NH. Interview on [DATE] at 11:17 a.m. CNA B stated on [DATE] she worked 6:00 a.m. to 2:00 p.m. and her first interaction with the Resident #1 had been sometime after 8:00 a.m. when she entered his room. She stated resident, lying in bed with his ileostomy site exposed, covered in vomit, and his ileotomy tubing leaking BM. She stated asked CNA D to come assist cleaning up the resident to send him to the ER. She stated once the resident was clean and in a new gown, she handed a sheet to 1 of 2 EMTs to cover the resident and they wheeled him out of the room on a stretcher. She stated that the resident's stoma site was exposed and not covered, and no nurse had come into the room while they cleaned up the resident. Interview on [DATE] at 11:37 a.m., LVN A stated that she no longer worked for the NF and had worked for them as a PRN nurse. She stated she recalled Resident #1 but could not recall speaking to or having interactions with or around Family #2 about the resident. She stated that she cared for the resident during two of her consecutive 12-hour shifts. Her and the CNA C worked the hall had to go to his room on[TRUNCATED]

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F 0691 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure that residents who required colostomy, urostomy, or ileostomy services received such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences for 1 of 4 residents (Resident #1) reviewed for ostomy care in that: 1. The facility failed to ensure Resident #1's ileostomy (a surgical procedure that creates an opening in the abdomen, called a stoma, to divert waste from the small intestine), wafer (the piece of the pouching system that sticks to your body and holds your pouch in place and should help protect the skin around your stoma from damage) and bag were in place. 2. The facility failed to empty Resident's #1's ileostomy bag timely and remain free from leakage. Resident #1 discharged to the hospital and was diagnosed with a sepsis bacterial infection and an AKI. An IJ was identified on [DATE]. The IJ template was provided to the facility on [DATE] at 05:48 p.m. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of a pattern with a potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems. This failure resulted in Resident #1 requiring hospitalization. It also placed other residents with ileostomy and colostomy status at risk of skin breakdowns, pain, infections, hospitalization, and decreased quality of life. Findings included: Record review of Resident #1's Facesheet dated [DATE] reflected that resident was a [AGE] year old male who admitted to the facility on [DATE] and discharged on [DATE] with diagnosis that included acute respiratory failure with hypoxia (lungs fail to adequately oxygenate the blood and/or remove carbon dioxide); nutritional marasmus (a severe form of protein-energy malnutrition characterized by extreme weight loss, muscle wasting, and depletion of body fat); unspecified severe protein-calorie malnutrition, Crohn's disease of both small and large intestine with intestinal obstruction; other schizophrenia (mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions, often including hallucinations, delusions, and disorganized thinking); muscle weakness (generalized); dysphagia (difficulty swallowing); unsteadiness on feet; anemia (a condition where your blood doesn't have enough healthy red blood cells to carry sufficient oxygen to your body's tissues, leading to symptoms like fatigue, weakness, and shortness of breath). (continued on next page)

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F 0691 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #1's Medical Doctor (MD) A's Encounter Notes Date of Service: [DATE] 8:06 p.m. , reflected, HISTORY OF PRESENTING ILLNESS. The Resident #1 was a pleasant [AGE] year-old male patient, past medical history of schizophrenia, hyperlipidemia, heavy tobacco abuse for many years, comes to the hospital for evaluation of abdominal distention, discomfort and progressively increasing weight loss. Resident currently was with a NG tube in place gives limited information, information is obtained from Family #2. Per Family #2, Resident #1 had been noted to start losing weight at least since July of this year when he was noted to start losing weight on a psychiatry evaluation. Resident was noted to still have appetite close to normal but then. About mid-October he has been noted to have markedly decreased appetite and poor intake, followed by some on and off episodes of nausea and abdominal discomfort after eating small portions of solids or liquids. Resident had a quick and rapid decline in weight loss, calculated to be of a total of 50 pounds since July, but most of it noted since early to mid-October. Resident was admitted to hospital and found to have evidence of a high-grade SBO that was treated conservatively and resolved. Computer tomography (CT) scans reports did not show any significant or acute issue noted. Resident was told that he had a liver and gluteal masses that needed biopsy as there was a high suspicion of neoplasm apparently. Resident presented to radiology yesterday but was told after ultrasounds were done that there was no evidence of any mass in the liver nor in the gluteal region. During this time, resident had persisted with markedly decreased p.a. intake, and on the last few days has been noted to have no BMs and progressively increasing abdominal distention and discomfort and occasional episodes of vomiting reason for which she presented to the ER and subsequently admitted after being found to have a skin high-grade SBO with no transition point. Record review of Resident #1's hospital record dated [DATE] reflected, that resident had an ileostomy laparoscopic procedure on [DATE]: exploratory laparotomy, ileostomy creation and mucus fistula. Record review of Resident #1's Baseline Care Plan dated [DATE], reflected under section D. Disease/Illness Management: Psychiatric Illness, Psychiatric Medication, and Wound and in the other section Ileostomy. Record review of Resident #1's BIMS dated [DATE], reflected that the resident had a score of 13 out of 15 indicating that the resident was cognitively intake. Record review of NF's grievance dated [DATE] reflected, a delay in care of Resident #1's ileostomy bag, had poor customer service care provided by LVN A. An investigation stated by DON A. Resolution: Resident #1 pulled on his ileostomy bag and required excessive bag changes. LVN A became frustrated with Resident #1's behavior. An 1:1 customer service in-service and assigned a customer service course training was provided to LVN A. Record review of Resident #1's Progress Notes dated [DATE] at 09:38 p.m., created by LVN F reflected, Resident #1 arrived via stretcher Family #2 at bedside. Resident alert and oriented times ¾, Denies any c/o at present. Orders verified with MD on call. Vitals stable, afebrile. Total assist with Activities of daily living (ADLs). Able to use urinal, ileostomy to RUQ intact with staples in place. Oriented to call light system, bed in low position, water within reach. Record review of Resident #1's Progress Notes dated [DATE] at 09:35 p.m., created by LVN F reflected, Resident #1 alert, stable and oriented times 3. Able to make needs known. Snacks given, and fluids encouraged. Total assist with ADLs, ileostomy bag draining liquid stools with frequent changes. Denies any c/o at present time. Safety and comfort measures in place. (continued on next page)

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F 0691 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of facility's grievance dated [DATE] reflected, Family #1 reported delay in changing Resident #1's ileostomy bag and LVN A had poor customer service. Dated/Follow-up Investigation. Person assigned to investigation DON A. Resolution: Resident #1 pulled on his ileostomy bag and required excessive bag changes. LVN A became frustrated with Resident #1's behavior. LVN A given 1-on-1 customer service and assigned a course training on customer service. LVN A will change bag as needed. Record review of Resident #1's Progress Notes dated [DATE] at 07:09 p.m. created by LVN C reflected, Note Text: Resident has ileostomy in place, site around ileostomy is excoriated and weeping clear serous drainage, this nurse attempted several methods to attach ostomy bag unsuccessfully, nurse tried ostomy paste, skin prep and ostomy powder, ostomy site left open to air with ABD pad in place to allow site to heal and minimize drainage, resident resting in bed currently laying on his left, side, ostomy bag in place attached onto ostomy ring, will continue to monitor site and provide appropriate treatment. Record review of Resident #1's Progress Notes dated [DATE] at 10:44 p.m., created by LVN H reflected, Ostomy site malfunction, and reinforced . No complaints of pain, no visible signs of distress visualized. Record review of Resident #1's Active Orders Order Summary: Order Date/Order Start Date of: [DATE]: Ileostomy right, lower, quadrant (RLQ) every shift. Colostomy/Urostomy/Ileostomy Care each and Qshift and PRN. Record review of Resident #1's Active Orders Order Summary: Order Date/Order Start Date of: [DATE]: Ileostomy to RLQ every shift every 3 day(s). Change ileostomy bag and wafer every 3 days. Record review of Resident #1's Progress Notes dated [DATE] at 05:53 a.m. created by LVN E, Late Entry. Note Text: Resident AAO and able to make needs known. Ostomy site malfunction, and reinforced. Staples to ABD area covered with DCD . No complaints of pain, no visible signs of distress visualized. Continues with therapy to improve strength and endurance. Record review of Resident #1's Progress Notes dated [DATE] at 08:38 a.m. created by LVN B reflected, situation: I am calling about the following condition, signs, symptoms: N&V, ABD pain, and BM from rectum. This started on [DATE]. Since this started has it gotten worse. The following makes this condition WORSE: Nothing. The following make this condition Better: none. This condition, symptom, or sign has not occurred before. Treatment for the last episode (if applicable) is None. Background: The resident is in this NF for Post-Acute Care. The primary diagnosis - ileostomy and pertinent history: Last INR result was on [DATE]. Record review of 1 of 24 photographs taken of Resident #1 on [DATE] at or around 08:38 a.m. dressed in a brief and hospital gown, lying in bed covered in vomit and BM. The resident's face was not show and was shown from the midsection of his torso to his thighs. Towels and briefs covered in vomit and BM were observed lying near the resident. The resident's ileostomy bag/tubing not shown in photographs. Record review of Resident #1's Active Orders Order Summary: Order Date/Order Start Date of: [DATE]: Send Resident to ER. (continued on next page)

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F 0691 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #1's Situation, Sbar dated [DATE] at 08:38 a.m. completed by LVN B. Section S reflected: Situation: 1. The change in condition, symptoms, or signs I am calling about is/are: N&V ABD pain and BM from rectum. 2. This started on [DATE]. 3. Since this started it has gotten Worse. 4. Things that make the condition worse are: nothing. 5. Things that make the condition or symptom better are: none. 6. This condition, symptom, or sign has occurred before: No. 7. Treatment for the last episode: None. B. Background. Resident Description: The resident as at this NF for Post Acute Care. B. Primary Diagnosis: Ileostomy. Vital Signs: i. Most Recent Blood Pressure: 150/89. Dated: [DATE] 8:42 a.m. 4. GI/Abdomen 4b. Nausea 4c. Vomiting 4e. Decreased Appetite 4f. Abdominal Pain 4i. Decreased Bowel Sounds. 4j. Date of last BM [DATE]. A. Assessment Registered Nurse (RN) or Appearance Licensed Practical Nurse (LPN). LPN: Resident appears (e.g. short of breath, in pain, more confused): possible obstruction. Date and time: [DATE] 08:16 a.m. 4a. Reported to Medical Doctor (MD) B on call. Record review of EMT transport record dated [DATE], call received from NF at 9:13:57 a.m. Time call assigned for EMT dispatch to NF, 09:16:10 a.m. Time EMT enroute to NF, 09:35:51 a.m. Time EMT arrived at NF scene, 09:54:50 a.m. Time EMT departed from NF scene, 10:38:16 a.m. and arrived at the ER, 11:12:02 a.m. Record review of Resident #1's Progress Notes dated [DATE] at 02:04 p.m., created by LVN B reflected, Late Entry: Note Text: Resident left to go to hospital by way of (via) stretcher with ambulance to be transferred to ER. Alert and able to make needs known dry and clean gown on with Family #2 at his side. Family #1 or Resident had no concerns before leaving to go to the ER. Record review of ER hospital/physician progress note pg. 142. dated [DATE], reflected, principal problem: AKI. Record review of Resident #1's Encounter Note signed by MD C [DATE] 02:32 p.m. Date of service: [DATE]. Transition of Care: Transition occurred. Electronic Summary of Care not incorporated. Manual reconciliation performed. Details: This is a copy of a signed encounter note documented in GEHRIMED. History and Physical History . Newly diagnosed Crohn's disease. Past Surgical History: Ex lap with ileostomy creation and mucous fistula repair . Chief Complaint / Nature of Presenting Problem: Evaluate after hospital stay for SBO, new diagnosis of cancer and Crohn's disease. History Of Present Illness: [AGE] year-old man with past medical history of schizophrenia presented to hospital with weight loss and abdominal pain, diagnosed with small bowel obstruction requiring NG tube due to malignant obstructing mass with widespread peritoneal disease. On [DATE] he had a cardiac arrest due to Co2 narcosis and septic shock status post CPR. Extubated 2 days later. Required TPN. He underwent ex lap, peritoneal biopsy, ileostomy creation and mucous fistula creation on [DATE]. So far biopsy is showing adenocarcinoma. Once stable discharged to NF for further rehabilitation. Resident was seen lying in bed, states his appetite was good, denies abdominal pain. Ostomy output is good. States he was able to ambulate with a walker and therapy today. Review Of Systems General: No complaint of malaise, fatigue, or change in appetite . Small bowel obstruction. Status post ileostomy, monitor ostomy output : Physical debility Consult PT/OT). Crohn disease. New diagnosis, established with GI for treatment . Ileostomy care. Severe protein-calorie malnutrition. Low weight with 50-pound weight loss in the last 6 months, registered dietitian, appetite was good. Adenocarcinoma. Presumed GI primary, follow-up oncology. (continued on next page)

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F 0691 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #1's Encounter Note signed dated by NP: [DATE] 7:41 p.m. Date of service: [DATE]. Visit Type: Day 2 admission Visit . Details: This is a copy of a signed encounter note documented evaluate recent admission from hospital, pain, debility. History Of Present Illness: [AGE] year-old man with past medical history of schizophrenia presented to hospital with weight loss and abdominal pain, diagnosed with small bowel obstruction requiring NG tube due to malignant obstructing mass with widespread peritoneal disease. On [DATE] he had a cardiac arrest due to carbon dioxide (Co2) narcosis and septic shock status post Cardiopulmonary Resuscitation (CPR). Extubated 2 days later. Required total parenteral nutrition (TPN). He underwent ex lap, peritoneal biopsy, ileostomy creation and mucous fistula creation on [DATE]. So far biopsy is showing adenocarcinoma (cancer that affects glands and glandular tissues). Once stable discharged to nursing facility (NF) for further rehabilitation. He is seen lying in bed, states his appetite is good, denies abdominal pain. Ostomy output is good. [DATE] patient seen in bed resting pain waxes and wane manage on tramadol. Record review of ER hospital/physician progress note pg. 57. dated [DATE] created by MD A reflected, Assessment/Plan: severe sepsis, suspected due to abdominal wall cellulitis. Computer tomography (CT) abdomen showed no acute pathology. Continue broad spectrum intravenous therapy (IV) antibiotic. Continue IVF support, prn pressors. Monitor hemodynamics (blood flow and it's force) closely. AKI metabolic acidosis (excess acid in the body) and hyperkalemia (high potassium that can contribute to stroke and/or death). Suspect due to high ostomy (upper intestine BMs) output and poor P.O. (process of rehydrating someone by giving them fluids to drink) hydration that is administered per os (by mouth). Record review of hospital/Nephrology progress note pg. 64, dated [DATE], created by MD A reflected, Assessment, Plan and Recommendations: 1. AKI due to volume depletion, hypotension, and likely sepsis. Baseline low creatinine (indicate that the kidneys are not functioning properly or that there is a decrease in muscle mass) is likely underestimating degree of underlying kidney dysfunction. Cystatin C 1.05 milligram/litter renal function improved status post in vitro fertilization (IVF) resuscitation (the patient's kidneys are likely functioning better). Monitor close off IVF. 2. Acidosis, metabolic due to AKI and GI outputs. Persists despite alkali therapy in MVF (associated with an improvement in kidney function, which may afford a long-term benefit in slowing the progression chronic kidney disfunction). Give additional 2 amp sodium bicarbonate. 3. Hyponatremia. Due to high antidiuretic hormone (a chemical produced in the brain that causes the kidneys to release less water, decreasing the amount of urine produced) state in settling of volume depletion. Worsening with isotonic IVF. Give 2 amp sodium bicarbonate today repeat sodium this afternoon. Is sodium remains low will trial slightly hypertonic IVF. Avoid hypotonic IVF's. 4. Sepsis, likely. Concern for underling intra-abdominal process and wound infection due to likely fecal contamination. Agree with broad spectrum antimicrobials dose for renal function. Record review of Physical Therapy (PT) Wound Care (WOC) evaluation pg. 10-11, dated [DATE], created by PT. Principal problem: AKI active problems: SBO. Acidosis (high levels of acid in the body, disrupting the bloods normal acidity/power of hydrogen (pH) balance) . hyponatremia (abnormally low sodium levels in the blood: Symptoms causing sudden or gradual nausea, headaches, confusion, and fatigue). Procedure ileostomy, laparoscopic [DATE]. WOC therapy diagnosis: patient with decreased skin integrity associated with pressure wound. Course of events during hospitalization: presented from NF due to abdominal pain, nausea, and vomiting . (continued on next page)

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	676412	A. Building B. Wing	04/13/2025

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F 0691 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of hospital WOC evaluation initial assessment pg. 4, dated [DATE], created by Certified Wound, Ostomy, and Continence Nurse (CWON). Diagnosis presents with nausea vomiting abdominal pain. History of obstructive colon mass and peritoneal met with recent high-grade SBO and ostomy creatin chronic disease and schizophrenia was recently admitted here for SBO. He was discharged to NF on 0,[DATE]. In ER he was hypotensive with new AKI hyperkalemia acidosis and white blood cell (hemoglobin) of 24.000 grams per deciliter (g/dL), (elevated, normal range generally for men 13.8-17.2 g/dL, higher indicates infection) . General information: Patient lying in bed awake and oriented (AO) times 3, subject slash patient comments: I want to drink coffee. Does the patient have any pain: No. Mental Status: Follows commands. Mobility transfer: Maximize Assistant 25%. Preventative measures: Support surface. Atmosphere airfare, air mattress on tube feeds, oral diet, position to left/right with wedge pillow support. Patient visited at bedside for established ileostomy care patient was well known from previous admission. Nurse reports thought ileostomy site was leaking but at the first time I visit in the morning the pouch was intact the high output pouching system was connected to a drain bag boots, brown output noted . Record review of hospital/physician progress note pg. 164, dated [DATE], created by MD B. Percepts suspicious, suspect due to abnormal wall cellulitis (aggressive intra-abdominal inflammation) from inadequate maintenance of ostomy. CT abdomen showed no acute pathology. Blood cultures remained negative. Completed 7 days of antibiotics course. AKI metabolic acidosis and hyperkalemia, state and improved. Suspect due to high ostomy output and poor po hydration. Status post IVF. Record review of in-service dated [DATE] titled Customer Service signed acknowledgement of education by LVN A, CNA B, LVN C and DON A and presented by ADON. Record review of in-service dated [DATE] titled Ostomy Care signed acknowledgement of education by LVN A, LVN C, CNA B, and DON A and presented by ADON. Record review of Resident's #1's provider report dated [DATE] reflected, incident details. ` o Date/Time you first learned of incident: [DATE] at 10:45 a.m. o Date/Time the incident occurred: [DATE] at 10:06 a.m. NF o Brief narrative summary of the reportable incident: Family #2 concerns related to sending Resident #1 to the hospital with vomit and bowel movement (BM) on him. o Witnesses name and title: LVN B, CNA B, and CNA D (continued on next page)

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F 0691 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	o The date and time of the assessment: [DATE] at 08:15 a.m. o Name and title of person who completed assessment: LVN B o Results of the assessment: Resident #1 has ileostomy. Experiencing N&V, ABD pain, and BM from rectum. Resident sent to the hospital. o Level of cognition: BIMS score of 13. Diagnosis: pertinent medical diagnosis: acute respiratory failure with hypoxia; nutritional marasmus; unspecified severe protein-calorie malnutrition; Crohn's disease of both small and large intestine with intestinal obstruction; other schizophrenia; muscle weakness (generalized); dysphagia, unspecified; unsteadiness on feet; other symbolic dysfunctions; anemia, unspecified; other hyperlipidemia; nicotine dependence, unspecified, uncomplicated; and colostomy status. Interview on [DATE] at 11:27 a.m., HCMN stated on [DATE], the resident arrived at the ER after the NF failed to provide appropriate care resulting in the resident's ileostomy bag exploding and BM seeped into his midline incision causing sepsis. She stated that she felt like the resident was not able to advocate for himself, and being a nurse for a long time, found the resident's case complex, alarming, and after view photographs provided by Family #2 of the resident covered in BM and vomit when he discharged from the NF to the ER, required follow up. Interview on [DATE] at 01:10 p.m., Family #1 stated on the evening of [DATE], [DATE] and [DATE], that the NF staff had difficulties keeping up with the emptying of the resident's ileotomy bag resulting in excessive leakage. He stated on the morning of [DATE], he learned that Family #2 had arriving at the NF to find that the resident had been sitting up in the bed with vomit and BM all over him as his ileotomy bag had burst from being to full. He stated that the resident had sat in his bowel for 1.5 hours before the EMT arrived to transport the resident to the ER and EMT had to wait 20 to 30 minutes at bedside for the staff to clean the resident of the vomit and BM before transporting him to the ER. (continued on next page)

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F 0691 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on [DATE] at 01:28 p.m. Family #2 stated on [DATE], [DATE], and [DATE], Resident #1's ileostomy bag had overfilled and not remained secured in place causing BM to leak all over the resident, and his bed. She stated on [DATE], she asked to speak to LVN A's supervisor with no avail after LVN A refused to change the resident. LVN F came down and changed the resident. She stated she could see that the resident's stoma was bleeding, bowel was leaking from his rectum, and his skin broken down around the stoma. She stated on [DATE] and [DATE], resident laid in his bed without his ostomy system intake and towels and briefs laid beside him to collect the leakage. She stated on [DATE] at 08:53 a.m., she learned that resident had been vomiting and nauseas and was being sent to the ER. She stated she arrived at the NF at 10:00 a.m., 2-EMTs were waiting in the hall outside of the resident's room, and the resident in a bed of his own vomit, and feces. She stated that breakfast was served at the NF at 7:00 a.m. The resident stated that he had vomited 3-times, she stated he sounded weak. She stated then CNA B and CNA C came into the room and stated that they were going to clean him up before sending him out to the hospital. She stated that the resident then stated that he needed to have a BM. She stated that CNA B told him to go head and the resident had BM on the bed. She stated then LVN B came in and began removing what tape that was attached to the resident's stomach, when one of the EMTs said, Stop, leave him that way the ER physicians could see his condition, and then LVN B left the resident's room and had not returned. She stated then the EMTs placed the resident on their stretcher and transported him out of the facility. She stated once at the ER the resident was admitted with a BP of 73/51, dehydration, a high white blood count, skin breakdown around his stomach, and a new sepsis diagnosis. She stated that the resident could have died. Interview on [DATE] at 02:36 p.m., the ADM stated Resident #1 had issues with his Ileostomy bag on [DATE] and LVN C to assisted and explained to Family #2 the difficulties of keeping the ostomy system attached to the resident's skin. She stated that LVN C told her that he had been in and out of the resident's room [ROOM NUMBER]-different times trying to keep the wafer attached to the skin. She stated on [DATE], she received a text from LVN B that resident was going to the ER for nausea and vomiting for issues relating to his ileotomy bag. She stated that DON A spoke to LVN A who admitted that she had been frustrated while providing care to Resident #1 and had not been her most professional self. She stated that LVN A had been required to complete additional training courses on customer service and received an in-service counseling on customer service. Interview on [DATE] at 04:55 p.m., LVN B stated on [DATE], she learned that the Resident #1 may have had blockage damage because the site had the inability to drain properly. She stated that the resident had been removing the ostomy system. She stated she used a stethoscope to listen for bowel sounds in the resident's abdomen finding none. She stated the resident's ileotomy bag was empty. She stated that the resident had not complained of any pain but stated that he had felt nauseous. She gave the resident some prn emodin D. She stated thereafter, the resident began projectile vomiting and she tried to ask the resident questions about his condition, with responses. She stated she left the room and about 09:00 a.m., Family #2 about preparations to send the resident to the ER. She stated CNA B and CNA C had come into the room and began cleaned up the resident and she attempted to use brown duo dermo tape to tape down the wafer the resident's stoma site, but resident's skin was moist from site drainage. She called EMT, the hospital and prepared the resident's discharged paperwork. She stated CNA B and CNA C had still been cleaning the resident when EMT arrived. She stated she informed the EMT of the resident's medical history. (continued on next page)

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F 0691 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on [DATE] at 06:35 p.m., Family #2 stated that that she had taken photographs on [DATE] of Resident #1 lying in the NF's bed covered in vomit and BM and had sent the photographs through text message. She stated that the resident told her in the early morning hours of [DATE] he had BMs from his rectum and his ileotomy bag had filled up quickly. She stated that the resident told her that the staff had come into the room [ROOM NUMBER]-times to change him and each time they would complaint and go back and forth about who was going to change him. She stated that he told her he had begun vomiting at 07:30 a.m. and told her that CNA B had come to clean him up 2-hours later. She stated throughout his stay at the facility, he had been hungry, and the staff had begun cutting his portions down so he would fill up his ileotomy bag slower. She stated when the resident arrived at the ER on [DATE], she learned that the resident could have intermitted BMs. In an observation/interview while at the hospital on [DATE] at 07:06 p.m., Resident #1 stated while at the NF LVN A would say, I am not going to clean up that mess and accused him of taking off his ileotomy bag. He stated that CNA B and LVN A kept acting like he was nasty when they had cleaned him up. He stated he sat in his mess for a long time. He stated that he felt better being at the hospital and the staff at the hospital were able to keep his ileotomy bag attached. He stated that he could not provide any exact dates or times but stated everyday his bag leaked on to the bed and onto his stomach. He stated in the late evening of [DATE], he had begun feeling nauseous and on the morning of [DATE], he vomited, 3-times and the NF sent him to the ER. (continued on next page)

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