STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235197	A. BUILDING _____ B. WING _____	08/14/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HILLSDALE CO MEDICAL CARE FACI	140 W MECHANIC ST HILLSDALE, MI 49242

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 0552 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that residents are fully informed and understand their health status, care and treatments.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake MI 306 and MI 141. Based on interview and record reviews, the facility failed to inform the Resident Representative and the physician of the serious nature of the resident's condition for one of three reviewed for notification (Resident #2), resulting in a lack of information to make decisions regarding his care. Findings include: Resident #2 (R2) no longer resided at the facilty at the time of the Survey - he expired at the facility on [DATE]. According to the Significant Change Minimum Data Set (MDS), dated [DATE], Resident #2 (R2) was severely, cognitively impaired, needed extensive assistance of two or more staff with bed mobility, had one unstageable Stage I pressure ulcer over a bony prominence and one skin tear, and [DIAGNOSES REDACTED]. and told me I need to get a lawyer. Another lady gave me the run-around. I argued with her until she sent him to the hospital. I went to the hospital In a telephone interview, on [DATE] at 2:02 PM, R2's Responsible Party/Power of Attorney/Son FF reported, I wasn't told nothing. One day a woman called and said he had a little bit of swelling in his testicle. Son FF said he did not remember her name. Son FF said she told him an antibiotic was started antibiotics x 2 days ago and a CT scan (imaging report) to look for cyst; that came back negative. I got a call one-two weeks later saying the treatment was not working and his perineum had a cut between his scrotum and anus. They said it was not that bad. They called me ,[DATE] days later and said it was turning black and wanted to have a wound specialist look at it. It was a Friday and they said the specialist wouldn't be available for another week. I said, 'I don't want to take a chance to wait I want a real doctor to look at him.' A nurse came in balling and talked with the surgeon. He told me he should have been sent here much sooner, said this is much worse than it needs to be. He had a perforation in his colon, bile leaking into his scrotum and body. I watched as my Dad was screaming in pain while the doctor was trying to put his insides back into his body. They said they didn't know how it happened . Review of R2's Nursing Progress Notes, dated [DATE] at 1:11 PM, . scrotum appears more swollen than yesterday . Review of R2's Nursing Progress Notes, dated [DATE] at 2:16 PM, revealed resident was found on his bedside mat but there was no documentation that Son FF or a physician was notified of the fall. Nursing Progress Notes also revealed there was documented communication between the facility and Son FF on [DATE] at 10:37 AM but not again until [DATE] at 10:36 AM. According to an anonymous Complaint, filed [DATE], Resident was made to walk many times around unit to 'calm him down'. He was made to drink 4 glasses of prune juice, 2 doses of milk of magnesium, and then was given 2 enemas back to back, while being held down by staff. The resident has severe anal bruising, enlarged scrotum, and rectal bleeding. This was reported to higher ups next day and was blown off. They did get a CT scan do to bleeding but telling staff it showed a cyst and that's why the bleeding. According to a Witness Statement, dated [DATE] (not timed), CNA (Certified Nursing Assistant) GG documented, . I understood that it was requested of me to provide a statement regarding my experiences from the weekend of working [DATE] - [DATE] . On Saturday, [DATE] . was informed, in report, that (R2) was given a suppository on the prior shift . on this day showed no unusual behaviors . (no) signs of needing to use the toilet .did not any of his usual signs of needing to have a bowel movement . At approximately 13:30 (1:30 PM) . (R2) had yet to have a bowel movement. The charge nurse determined that, at this point, an enema would be required . The charge nurse and a fell ow CNA administered the enema . (R2) had not had a bowel movement upon first shift departure . On Sunday, [DATE], I reported to work at 2:00 AM . (The CNA that gave me report said) (R2) hadn't had a solid bowel movement .the movement that he had was extremely 'watery' . There were no unusual occurrences on this shift . (R2) showed no signs of needing to have a bowel movement. He did regularly urinate . On [DATE], I arrived to work at 2:00 AM . (CNA T) appeared extremely upset. (CNA T) said that she would explain when she came back (from break) . (at 2:00 AM), the charge nurse (L) was sitting behind the desk. I noticed that (R2) was in bed, which was unusual for him . (CNA T) report that (R2) was given two enemas within half an hour, milk of magnesia (MOM) and approximately seven glasses of prune juice. She state (sic) that he had one solid formed stool and some loose stool. She also state he appeared to be passing blood . stated that she reported this to the nurse .(R2) was showing signs of discomfort. MULTIPLE, FREQUENT attempts throughout the next ,[DATE] hours, by both us CNAs were made to reposition (R2) and make him comfortable . 5:10 (AM) I undid (R2's) brief so that we could begin washing him. (R2) was extremely agitated . Once resident was on his side, there was a clear view of his peri-rectal area. There was evidence of blood near his rectum. There was blood in his brief. His scrotum was abnormally swollen. I immediately went to get the charge nurse . The charge nurse came in . stated that she didn't see any 'active' bleeding, so there wasn't much that she could do. We tried to point out that the size of his scrotum was not normal. We tried to point out that he was painful. We were told again that she couldn't do anything . We left him without a brief for his comfort. Several blue pads were laid under him. As he was gently rolled, fresh blood spots were noted on the clean blue pads. I immediately went to the charge nurse and informed her that there was active bleeding. She stated that it was 20 (minutes) till 6:00, 'I am not going to do anything. I will let the day shift nurse know and she can do it' . We then followed facility policy. If we feel that there is any type of abuse, we are to notify administration immediately. We called (DON B) at the end of our shift . According to a Witness Statement, dated [DATE] (not timed), [DATE] (8:10 PM) pm shift: I (CNA G) witnessed an unsettling enema procedure performed by my floor nurse in Snap Dragon Valley (Alley), (RN J). (RN J) asked (CNA H) and myself to assist her in an enema orchestrated on an Alzheimer patient (R2) The nurse instructed me to hold the residents' legs and instructed (CNA H) to hold his arms and torso . the nurse then proceeded to jam the tip into the resident's rectum. The resident instantly started to shout, scream and cry. I felt really upset but continued to do what I was instructed because I trusted my nurse and figured the patient was having a behavior with the discomfort of the enema. We then cleaned up the resident and put a clean brief on him. Moments later I assisted (CNA W) in the bathroom as she helped toilet (R2) and we discovered blood in the brief and blood coming out of (R2's) rectum. I went to (RN J) and instantly reported the blood. She said that's normal and it could be because he's so impacted. Several minutes later we (CNA H and I) were asked to do another enema with the nurse. This time it was very unsettling as I watched the nurse now lubricate her gloves and shove her fingers inside the rectum to help 'break up the compacted stool'. (R2) screamed and cried and shouted, 'please make it stop . oh, fuc* I'm going to die, get out of there' and much more as tears fell from his eyes. Stool and blood was on the glove once the nurse pulled her hand out. The next enema was given, and the resident was washed up and changed into a new brief and pants. (RN J) then instructed to walk (R2) around to move his bowels. I walked him around the rest of the shift and he was so tired he was falling asleep and then told the nurse I felt he was unsafe to continue to walk around and I was told to keep him moving . (R2) showed signs of pain and discomfort and couldn't even sit down. I feel the need to report this . Review of R2's Nursing Progress Notes and the facility's investigation into allegations of abuse revealed no documentation that Son FF nor R2's physician (Medical Director R) not been notified of the allegations of abuse. In an interview, on [DATE] at 10:54 AM, third shift House Supervisor/Registered Nurse/RN J reported, It came up on the computer that (R2) was due (for an enema)

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235197	A. BUILDING _____ B. WING _____	08/14/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HILLSDALE CO MEDICAL CARE FACI	140 W MECHANIC ST HILLSDALE, MI 49242

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 0552 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) and it said how many shifts and that is what I went by. No, I was not told he was on bowel protocol by (Licensed Practical Nurse/LPN O) or that she gave a suppository (earlier that day). (Former Quality Assurance CC) would not have found it because she didn't work weekends. I can't tell what the system does. We learned to use the computer to decide two years ago when we learned how to use the EMR (electronic medical record). (Resident #3) was on bowel program Friday. Regarding R2, RN J said, I was trying to get him to go (have a bowel movement), so I gave him prune juice and MOM (milk of magnesia laxative) and he was straining so hard his face was red. Yes, I gave him prune juice 60 cc and 15 cc of MOM mixed together. Later, I tried 60 cc prune juice. I did not call the doctor; I just used my nursing judgement. I pulled up the aides' tasks and he was 4 days, rolling into 5 days with no bowel movement. If you assume he had a BM (bowel movement) on the shift that no one charted, he was on the 9th day on second shift. If he did have a BM on the day it wasn't charted, then it would only have been the 5th shift . (R2) kicked out at me when I gave the first enema. (R2) walked into the general area and screamed, 'I got to[***]' He had ,[DATE] pea sized pellets in the toilet. I don't know how you count that as a BM. He laid back down, that's when I gave him, about 40 minutes later prune juice and MOM. He came back out yelling that he had to[***] In the bathroom yelling and not cooperative at all, straining and red face, I felt like I needed to check him, first one he didn't cooperate at all, I checked him and there was hard stool and rectal vault was full. I felt we needed to give him an enema. (R2) took of it and squirmed a lot, so I stopped. They walked him in the merry walker . (CNA G) walked him. He was up at 10:00 PM and I gave report to (RN/Registered Nurse L). (RN L) said nothing about the bowel protocol. At 10:00 PM, I was supervisor and went to the COVID unit and counted off. Around 11:00 PM, (R2) was still walking around with (CNA T). No one said anything about his condition not being okay. I called each unit and spoke with (RN L) and she said (R2) was sleeping and he had no BM. As I was getting ready to leave 6:15 AM (LPN/Licensed Practical Nurse K) called and spoke with (Unit Manager/RN AA) and said there was a lot of bruising and (Unit Manager AA) said she would go look at it and I should go home. Ultrasound showed a cyst at the head of the epididymis. On Tuesday, I went to see what was going on. (RN II) was his nurse Monday night. There was a long bruise. I measured it 13.5 cm long. (Wound Nurse/ RN Q) documented everything before I did. I was just floored as to where this bruise came from. Hospital report - I was shocked - perforation, abscess. I did not speak with (Medical Director R) about it. (Medical Director R) was on vacation for two weeks. I don't know why (Physician Assistant Y) wasn't called in. (Unit Manager/RN EE) is the Unit Manager. Perforation is a potential with enemas or suppositories. I spoke with (Director of Nursing/DON B) about that on [DATE]. If a resident resists an enema . I stopped. (CNA H's) hands, (CNA G) supported his back and held is legs up. (R2's) rectal vault full of stool . didn't come out for us . he must of had a BM on the next shift. He was lying on his left side in bed, I checked him with one finger. He yelled. I then attempted another enema. I didn't even think about notifying the doctor. I did not receive discipline and was only educated on enemas. No, I was not suspended. We need to look at the bowel protocol no one mentioned the problem until you brought it to my attention. RN J reported she did not call a physician regarding R2 to get an order to administer repeated enemas, give prune juice with unscheduled MOM, or perform digital removal of stool. Review of R2's Bowel Elimination Record (documented by CNAs) revealed the 2:00 PM - 10:00 PM shift on [DATE] was blank, indicating that R2's bowel elimination had not been documented on that shift and therefore, it could not be determined whether he had had a BM during that timeframe. If R2 had a BM on that shift, it would mean, according to the Bowel Protocol, it should not have been initiated/medication should not have been administered on [DATE] at all. RN J reported she did not call Son FF or a physician to get an order to administer repeated enemas, give prune juice with mixed with unscheduled MOM, to perform digital removal of stool or about the presence of blood. Review R2's Emergency Report, dated [DATE] at 2:12 PM, revealed, Chief Complaint: LESION and (Patient with open wound to perineum and scrotal [DIAGNOSES REDACTED] and swelling. Sent from nursing home for evaluation of three week old wound having already completed two courses of antibiotics.) This started about 3 weeks ago and is still present and worsening. It was abrupt in onset and has been constant. Patient reported suffered skin tear as initial wound . Review of R2's hospital Imaging report, dated [DATE] at 6:20 PM, revealed, . [MEDICAL CONDITION] changes about the rectum. Fecal like material tracking from the rectum into the perirectal/perianal region and perineum, where there is overlying ulcer. This extends caudally along with gas and fluid into the scrotal sac. Subjacent soft tissue [MEDICAL CONDITION] . Recommend clinical correlation for necrotizing . During a telephone interview on [DATE] at 1:05 PM, Medical Director (MD) R, I remember a discussion about swelling and bleeding. True did not write a note until he came back from the hospital. Medical Director R stated he had not examined R2 before he was discharged to the hospital and if he had known the seriousness of the situation, he had a Physician Assistant and an associate, Who I could have called but I felt I understood it. In retrospect it was worse than I knew. I did see pictures. Yes, family wanted him to be sent out. I thought about colonoscopy. Family did not want that. They focused on comfort. Later, they wanted him checked out and we said sure, send him to the ER (emergency room) that's when CT (imaging) showed infection and perforation. There was no instrumentation to know where the perforation was. I think I heard about his scrotum and ordered an ultrasound. I put him on antibiotics for potential epididymitis. The ultrasound was vague. Yes, the perforation explains it all (the scrotal swelling, necrotic tissue, bruising, bleeding, pain). I know he got some enemas. I believe the son knows about the perforation. I did not specifically, did not talk to him.
F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake MI 306 and MI 141. Based on interview and record reviews, the facility failed to update a care plan with accurate information for one of three residents (Resident #2), resulting in the potential for lack of appropriate care. Findings include: According to the Significant Change Minimum Data Set (MDS), dated [DATE], Resident #2 (R2) was severely, cognitively impaired, needed extensive assistance of two or more staff with bed mobility, had one unstageable Stage I pressure ulcer over a bony prominence and one skin tear, and [DIAGNOSES REDACTED]., winces, wrinkled forehead, furrowed brow, clenched teeth or jaw), protective body movements or postures (bracing, guarding, rubbing or massaging a body part/area, clutching or holding a body part during movement). According to R2's previous MDS, dated [DATE], he had no indications of pain. Review of R2's Care Plans revealed he had a plan of care for: Symptoms of Infection: Epididymitis initiated 7/13/20 and it remained a Problem until it was canceled on 8/06/20 even though (according to the Medication Administration Record/MAR) treatment for [REDACTED]. There were no interventions on the care plan except Alert Charting. During a telephone interview on 8/13/20 at 1:05 PM, Medical Director (MD) R reported he initially treated R2 for Epididymitis because his scrotum was swollen and said, I remember a discussion about swelling and bleeding . I put him on antibiotics for potential epididymitis. The ultrasound was vague. Medical Director R stated he had not examined R2 before he was discharged to the hospital and if he had known the seriousness of the situation, he had a Physician Assistant and an associate, Who I could have called but I felt I understood it. In retrospect it was worse than I knew . we said sure, send him to the ER (emergency room) that's when CT (imaging) showed infection and perforation . Yes, the perforation explains it all (the scrotal swelling, necrotic tissue, bruising, bleeding, pain) . According to a hospital History and Physical, dated 7/23/20, R2's #1 [DIAGNOSES REDACTED]. These [DIAGNOSES REDACTED].
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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** This citation pertains to Intake MI 306 and MI 141. Based on interview and record reviews, the facility failed to develop and implement comprehensive care plans with measurable objectives and timeframe's to meet the resident's medical, nursing needs for one of three residents (Resident #2), resulting in the potential for lack of appropriate care. Findings include: According to the Significant Change Minimum Data Set (MDS), dated [DATE], Resident #2 (R2) was severely, cognitively impaired, needed extensive assistance of two or more staff with bed mobility, had one unstageable Stage I pressure ulcer over a bony prominence and one skin tear, and [DIAGNOSES REDACTED]., winces, wrinkled forehead, furrowed brow, clenched teeth or jaw), protective body movements or postures (bracing, guarding, rubbing or massaging a body part/area, clutching or holding a body part during movement). According to R2's previous MDS, dated [DATE], he had no indications of pain. According to R2's previous MDS, dated [DATE], he was occasionally incontinent of bowel, had no indications of pain or [MEDICAL CONDITION]. Review of R2's MDS dated [DATE] revealed no [MEDICAL CONDITION]. R2's MDS, dated [DATE] revealed Death in facility. According to an anonymous Complaint, filed 7/15/20, Resident was made to walk many times around unit to 'calm him down'. He was made to drink 4 glasses of prune juice, 2 doses of milk of magnesium, and then was given 2 enemas back to back, while being held down by staff. The resident has severe anal bruising, enlarged scrotum, and rectal bleeding.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235197	A. BUILDING _____ B. WING _____	08/14/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HILLSDALE CO MEDICAL CARE FACI	140 W MECHANIC ST HILLSDALE, MI 49242

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 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) This was reported to higher ups next day and was blown off. They did get a CT scan do to bleeding but telling staff it showed a cyst and that's why the bleeding. In a Witness Statement, dated 7/16/20, RN (Registered Nurse) L documented, On the night of 7-12-20 I was told in shift change report that (R2) was on bowel program et (and) had received 2 enemas . also 2 things of prune juice . and that due to the resident having 2 enemas, resident was noted to have some bleeding . Staff reported et (sic) some blood noted. Staff noted resident did not strain to have BM . noted et (sic) reported with AM care the open area on resident L (left) inner buttock cheek near rectum. Area around rectum was dark purple et (sic) the scrotum was grossly enlarged . Review of R2's Medication Administration Record [REDACTED]. Give 1 capsule by mouth in the morning related to constipation (start date 5/08/20 - end date 7/28/20). Polyethylene [MEDICATION NAME] Powder (also known as [MEDICATION NAME]) give 17 gram by mouth in the morning for constipation (start date 4/30/20 - end date 7/28/20). Senna-[MEDICATION NAME] Sodium Tablet 8/6-50 mg. Give 1 tablet by mouth at bedtime for constipation (start date 4/28/20 - 7/28/20). Bowel Program per facility protocol every 8 hours as needed for Constipation: no bowel movement on the 7th shift Give 30 ml of Milk of Magnesium; no bowel movement on the 8th shift Give [MEDICATION NAME] suppository; no bowel movement on the 9th shift Give [MEDICATION NAME] enema. If no bowel movement on the 10th shift contact physician (start date 4/29/20 - end date 8/02/20). In it's entirety, the facility Bowel Program, dated 2/28/19, read as follows: Policy Statement: Nursing department will pursue and provide such care as will refresh and provide comfort to the resident and assure that elimination is occurring appropriately Purpose: To aid in evaluation of resident's bowel habits, to establish regular routines, and to decrease or prevent the incidence of constipation. Forms used: Bowel program is monitored in PCC (Point Click Care Electronic Medical Record); Procedure: Residents are assessed upon admission by nursing department in regard to the resident's bowel pattern and bowel regularity. All CNA's (Certified Nursing Assistants) must address bowel movements in PCC. Alerts will be sent to the nurse in appropriate time frames rt (sic). If no BM (bowel movement) in six shifts, beginning on the seventh shift, the nurse will give 30 cc's of MOM (Milk of Magnesia) p.o. (orally). If no results, at the beginning of the eight shift, a [MEDICATION NAME] suppository is given rectally. If no results, at the beginning of the ninth shift, give [MEDICATION NAME] Enema. If no results are recorded, consult physician. *May given 30cc's MOM with physician's orders [REDACTED]. Through interview and record review during the Survey, it was confirmed CNAs and licensed nursing staff did not administer the bowel protocol as ordered or per the facility to R2 on 7/11/20. Although R2 had a Care Plan with the problem area: The resident has potential nutritional problem d/t (due to) anxiety and agitation issues: DX (diagnoses): Dementia, Acute [MEDICATION NAME] (urinary tract infection), DM2 (insulin dependent diabetes), Hallucinations, Constipation, [MEDICAL CONDITION], Fluctuating intake at time low . Weight trend down d/t Dementia with behavioral issues (initiated 11/08/19), all of the interventions in that plan of care were related to diet. R2 did not have a plan of care for bowel function/dysfunction. Review of R2's Care Plans revealed the only plan of care related to pain was Alteration in Comfort related to end of life issues, was not initiated until 7/25/20 although he (According to the Medication Administration Record) had been receiving [MEDICATION NAME] 650 mg two times a day for pain (start date 5/01/20) and began exhibiting severe pain on 7/12/20 and [MEDICATION NAME] skin patches were administered continuously beginning on 7/15/20. [MEDICATION NAME] skin patches are very strong narcotic (opioid) painkillers that may cause death from overdose. The [MEDICATION NAME] skin patch should always be prescribed at the lowest dose needed for pain relief. [MEDICATION NAME] skin patches should not be used to treat short-term pain, pain that is not constant, or for pain after an operation. <www.medicalnewstoday.com/articles/ 6> Nursing Progress Notes, dated 7/14/20 at 3:51 AM, revealed, (R2's) scrotum is enlarged. A small amount of bright red blood from his rectum. He is biting his gums probably from pain . Nursing Progress Notes, dated 7/14/20 at 10:37 AM, revealed, .new orders for [MEDICATION NAME] (strong narcotic) patch and treatment orders . to skin tear near rectum . R2's Medication Administration Records revealed he wore a 72 hour [MEDICATION NAME] Patch 12 MCG/HR patch every day between 7/14/20 - 8/04/20.
F 0684 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake MI 306 and MI 141. Based on interview and record review, the facility failed to identify and provide care in accordance with professional standards of practice that were patient centered, in accordance with the residents' preferences, and goals for care for one of three reviewed for Quality of Care (Resident #2), resulting in (using the reasonable person standard) prolonged physical, mental, and psychosocial suffering and death. Findings include: According to an anonymous Complaint, filed 7/15/20, Resident was made to walk many times around unit to 'calm him down'. He was made to drink 4 glasses of prune juice, 2 doses of milk of magnesium, and then was given 2 enemas back to back, while being held down by staff. The resident has severe anal bruising, enlarged scrotum, and rectal bleeding. This was reported to higher ups next day and was blown off. They did get a CT scan do to bleeding but telling staff it showed a cyst and that's why the bleeding. According to the Significant Change Minimum Data Set (MDS), dated [DATE], Resident #2 (R2) was severely, cognitively impaired, needed extensive assistance of two or more staff with bed mobility, was always incontinent of bowel, had one unstageable Stage I pressure ulcer over a bony prominence and one skin tear, and [DIAGNOSES REDACTED]., winces, wrinkled forehead, furrowed brow, clenched teeth or jaw), protective body movements or postures (bracing, guarding, rubbing or massaging a body part/area, clutching or holding a body part during movement). According to R2's previous MDS, dated [DATE], he was occassionally incontinent of bowel, had no indications of pain or [MEDICAL CONDITION]. Review of R2's MDS dated [DATE] revealed no [MEDICAL CONDITION]. R2's MDS, dated [DATE] revealed Death in facility. Review of R2's Certificate of Death revealed the cause of his death was Perianal (in or in the tissues near the anus) abcess (full of puss). According to a hospital History and Physical, dated 7/23/20, R2's #1 [DIAGNOSES REDACTED]. Nursing Progress Notes, dated 7/14/20 at 3:51 AM, revealed, (R2's) scrotum is enlarged. A small amount of bright red blood from his rectum. He is biting his gums probably from pain . Nursing Progress Notes, dated 7/14/20 at 10:37 AM, revealed, .new orders for [MEDICATION NAME] and treatment orders . to skin tear near rectum . R2's Medication Administration Records revealed he wore a 72 hour [MEDICATION NAME] Patch 12 MCG/HR patch every day between 7/14/20 - 8/04/20. R2's Medication Administration Records revealed he received [MEDICATION NAME] almost every two hours beginning 7/27/20. Review of R2's Wound Records revealed no mention of a skin tear. Review of R2's Wound Records, dated 7/20/20 at 9:37 AM, revealed, Wound measurements 1. Area 21.4 cm2; 2. Length 7.3 cm; 3. Width 4.2 cm; 4. Depth 0.1 cm; 5. Undermining Not applicable; 6. Tunneling Not applicable. Weekly assessment completed to what originated as a bruise at the rectum. Wound is now with thick slough, with dark/black edges. Wound has a foul odor. Difficult to keep a dressing in place d/t (due to) the location and d/t (R2) stools often and is (incontinent) . Review of R2's Wound Records, dated 7/23/20 at 10:50 AM, revealed, Wound measurements 1. Area 26.3 cm2; 2. Length 8.1 cm; Width 4.1 cm; 4. Depth 0.2 cm; Undermining Not applicable; 6. Tunneling 0.7 cm. Assessment of wound, changed since last assessment. Wound bed it black necrotic tissue. The edges are pink. Tunneling noted at about 9:00: 0. cm and at about 11:00 0.5 cm. Periwound is dark pink in color . Wound with foul odor. (R2) moved slightly with signs of discomfort with light palpation . On 7/31/20 R2's wound was labeled pressure . unstageable with slough or eschar . in-house acquired. CNA (Certified Nurse Aide) H worked Snap Dragon Alley on 7/12/20 between 2:00 PM - 10:00 PM. CNA G worked Snap Dragon Alley on 7/12/20 between 2:00 PM - 10:00 PM. CNA W worked Snap Dragon Alley on 7/12/20 - 7/13/20 between 2:00 PM - 2:00 AM. CNA T worked Snap Dragon Alley on 7/12/20 - 7/13/20 between 10:00 PM - 6:00 AM. CNA GG worked Snap Dragon Alley on 7/13/20 between 2:00 AM - 6:00 AM. LPN (Licensed Practical Nurse) O worked Snap Dragon Alley on 7/12/20 between 6:00 AM - 2:00 PM. LPN DD worked Snap Dragon Alley on 7/12/20 between 2:00 PM - 6:00 PM. RN (Registered Nurse) J (the third shift supervisor) worked Snap Dragon Alley as a charge nurse on 7/12/20 between 6:00 PM - 10:00 PM. RN L worked Snap Dragon Alley 7/12/2 - 7/13/20 between 10:00 PM - 6:00 AM According to a Witness Statement, dated 7/14/20 (not timed), I (CNA G) witnessed an unsettling enema procedure performed by my floor nurse in Snap Dragon Valley, (RN J). (RN J) asked (CNA H) and myself to assist her in an enema orchestrated on an Alzheimer patient (R2) The nurse instructed me to hold the residents' legs and instructed (CNA H) to hold his arms and torso . the nurse then proceeded to jam the tip into the resident's rectum. The resident instantly started to shout, scream and cry. I felt really upset but continued to do what I was instructed because I trusted my nurse and figured the patient was having a behavior with the discomfort of the enema. We then cleaned up the resident and put a clean brief on him. Moments later I assisted (CNA W) in the bathroom as she helped toilet (R2) and we discovered blood in the brief and blood coming out of (R2's) rectum. I went to (RN J) and instantly reported the blood. She said that's normal and it could be because he's so impacted. Several minutes later we (CNA H and I) were asked to do another enema with the nurse. This time it was very unsettling as I watched the nurse now

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235197	A. BUILDING _____ B. WING _____	08/14/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HILLSDALE CO MEDICAL CARE FACI	140 W MECHANIC ST HILLSDALE, MI 49242

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0684 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 3) lubricate her gloves and shove her fingers inside the rectum to help 'break up the compacted stool'. (R2) screamed and cried and shouted, 'please make it stop . oh, fuc* I'm going to die, get out of there' and much more as tears fell from his eyes. Stool and blood was on the glove once the nurse pulled her hand out. The next enema was given, and the resident was washed up and changed into a new brief and pants. (RN J) then instructed to walk (R2) around to move his bowels. I walked him around the rest of the shift and he was so tired he was falling asleep and then told the nurse I felt he was unsafe to continue to walk around and I was told to keep him moving . (R2) showed signs of pain and discomfort and couldn't even sit down . According to a Witness Statement, (not dated/timed), CNA H documented, On Sunday, 7/12/20, I worked with (CNA G) and (RN J) was the nurse. (R2) received an enema on first shift around (1:30 PM) according to one of the CNAs. We toileted (R2) at about (2:15 PM) with no stool produced. Later that night, (CNA G) and I helped hold (R2) for another enema. While I'm unsure whether he was clenching, impacted, etc., perhaps a combination of the two, the enema was not fully instilled. (R2) gripped me hard and would not let go but appeared more pained than angry. He screamed profanities and screamed for help and we did our best to comfort him. Later, he received about 3 ounces prune juice w/MOM (with Milk of Magnesia) and 4 ounces plain prune juice and we pushed water. (RN J) attempted digital stimulation using the first three fingers and thumb of her hand with little success, though he began passing trace amounts of liquid stool A second enemas was delivered successfully, although after the dig with an unlubricated glove, there was significant bleeding and pain. In an interview, on 8/12/20 at 2:19 PM, CNA H reported, They told me (R2) received an enema around 1:30 PM on first shift (R2's Medication Administration Record [REDACTED]. We moved his bed his bed out from the wall I held his hands and upper body and (CNA G) held his legs. (R2) was holding me more than I was holding him; he seemed scared. We tried to talk to him . (RN J) pulled the enema out of his rectum, only about 1/3 had been given. I saw her. She started and looked the same for the insertion but when he got upset, she used more force on it for a minute or two minutes, doing a twisting-pushing motion. At first (R2) just acted normal shouting profanities and cussing us out. Towards the end, he was calling for his mother and screaming, 'Oh help me, oh god, it hurts, Mom help me.' Afterwards, he could not get up out of bed by himself. He did not want to get out of bed at all which was very unusual for him. We could not sit him at the side of the bed because he would scream in pain that his bottom hurt. Me and (CNA G) got him to roll over to lean on one side, placed his feet on the floor and arm under arm walked him to the bathroom to see if he would produce stool. There was frank bleeding, bright red, soaked into the brief enough to change the brief two or three times before the next enema. I heard (CAN G) tell (RN J), '(R2) is bleeding and it's kind of a lot.' (RN J) said that's normal and never went in to check him. Maybe 30-40 minutes later (RN J) called us in to help her again and we did the same thing as before. This time, (R2) was shaking and went, 'Oh God, not again!' The enema was more successfully installed but as soon as she removed it dribbled out and was mostly clear. Then a little stool brown and chunky stool on the tip of the enema. (RN J) tried digital stimulation - used four fingers without lubrication and he screamed in pain and said, 'NO, get it out!' There were small crumbles of BM (bowel movement) on the glove. No results on my shift. On third shift, I heard he produced a medium stool. She didn't order us to hold him down but (CNA G) really had to hold his leg so he couldn't bring his leg back to make the nurse stop. A little blood on the glove, but when we put his brief on there was stark red blood on the brief a few ounces. There was blood in the toilet. The water was tinged red. 30 minutes later, (RN/Registered Nurse F) said we had to get him up and walk him around. We walked him. He had a funny look in his eyes, he was shaking, unstable, drifting back and forth and leaning back and forth. He seemed too tired and shaken to be walking. (CNA G) told (RN F) and she said, 'Keep walking him.' RN J told CNA W) to get water and force fluids. She said, 'Pump him full of fluids and keep him walking'. Total walking was from 8:30 PM - 10:00 PM and (RN J) wanted him to keep walking. (RN J) was upset with (CNA T) and me for laying him down. He just couldn't keep doing it anymore. It just didn't feel right. I told her I understand why you want him to keep walking, but this doesn't seem safe and she got hostile. She said in a nasty tone, Well nurse Megan, if you know everything, you just do it. I asked her a lot of questions that night. Is he supposed to be bleeding that much? She said, 'He's fine'. I believe he has a right to refuse and during the first enema he made it very clear he didn't want interventions to be applied, and we kept going. He drank prune juice cup full, 4 ounces, then half of the second one mixed with MOM. I think (RN J) was physically rougher than she should have been.; she had blinders on to get him to have stool and did everything she could to make that happen without considering his safety or comfort or his right to refuse. DON (Director of Nursing B) called me into her office on Wednesday (7/15/20) and said it was an epididymal cyst that ruptured. No thorough investigation. (DON B) kind of said, 'I don't know what really happened so we kept him here longer than we should have. We brought him back here to die.' She contacted his son and said, 'If he were my Dad, I would make him a DNR (do not resuscitate). I wasn't educated at all, but she told me, 'We don't do digital stimulation here' . I don't know if physical trauma can cause epididymal cyst to rupture. I was not told anything further. DON (B) showed me the picture the wound nurse took three 3 days after the incident. It may have been there that night, but he was up walking the rest of the night and we didn't bother looking at his bottom. This may be an administrative thing that issues or mistakes that nurses have made get covered up and glossed over. In a telephone interview, on 8/12/20 at 10:00 PM, CNA T stated, (CNA W) I took (R2) to the restroom around 11:15. (R2) had blood in the toilet, brief and on his legs. It was dripping down his legs and, on the floor, - droplets falling. Told (RN L) as soon as we came out of his room. (RN L) told us she was told there would be blood and not to worry about it. Same amount in the next two briefs. Every couple of hours. Second time around 1:00 AM and (CNA W) left at 2:00 AM and (CNA GG) came in at 2:00 AM. The next brief change was around 5:00 AM; at that time, it was the same as before. Then we washed him, and we made (RN L) go in and look because she wouldn't look before. She was playing Candy Crush on her phone and she usually leave doesn't leave the nurses' station. We asked (RN L) to give (R2) pain medication a few different times through the night, then at 5:00 AM we said, 'At least give him Tylenol', and she said he didn't have an order and we needed to wait until the first shift nurse came in. You could tell he was painful when I came in. He wouldn't sit down, and his bottom was painful when he sat down on the bed. He could only lay on his right side. He would holler and push away if we tried to prop him on his left side. It was unusual for him. I was extremely pissed-off that she wouldn't get him some pain medication. At 6:00 AM, in the parking lot we called (DON B) about what had happened. We told her what we had walked into at 10:00 PM and that he had been bleeding all night, that he was in pain and wasn't given anything all night . I believe it was done when (RN F) was with him. (RN L) - I believe she didn't do anything to help him all night; (CNA GG) and I said, 'You need to get up and go look at him.' I have concerns about her. She doesn't give pain meds when they are needed . They think someone didn't chart a BM . they were discussing that at report. If we forget to chart, you can go back in and chart. No one has ever called to ask if I missed charting. (Quality Assurance CC) used to check the books to make sure they were filled in, but I don't know of anyone checking now. According to a Witness Statement, dated 7/13/20 (not timed), CNA (Certified Nursing Assistant) GG documented, On Saturday, July 11, 2020 . was informed, in report, that (R2) was given a suppository on the prior shift . on this day showed no unusual behaviors . (no) signs of needing to use the toilet .did not any of his usual signs of needing to have a bowel movement . At approximately 13:30 (1:30 PM) . (R2) had yet to have a bowel movement. The charge nurse determined that, at this point, an enema would be required . The charge nurse and a fell ow CNA administered the enema . (R2) had not had a bowel movement upon first shift departure . On Sunday, July 12, 2020, I reported to work at 2:00 AM . (The CNA that gave me report said) (R2) hadn't had a solid bowel movement .the movement that he had was extremely 'watery' . There were no unusual occurrences on this shift . (R2) showed no signs of needing to have a bowel movement. He did regularly urinate . On July 13, 2020, I arrived to work at 2:00 AM . (CNA T) appeared extremely upset. (CNA T) said that she would explain when she came back (from break) . (at 2:00 AM), the charge nurse (L) was sitting behind the desk. I noticed that (R2) was in bed, which was unusual for him . (CNA T) report that (R2) was given two enemas within half an hour, milk of magnesia and approximately seven glasses of prune juice. She state (sic) that he had one solid formed stool and some loose stool. She also state he appeared to be passing blood . stated that she reported this to the nurse .(R2) was showing signs of discomfort. MULTIPLE, FREQUENT attempts throughout the next 2-3 hours, by both us CNAs were made to reposition (R2) and make him comfortable . 5:10 (AM) I undid (R2's) brief so that we could begin washing him. (R2) was extremely agitated . Once resident was on his side, there was a clear view of his peri-rectal area. There was evidence of blood near his rectum. There was blood in his brief. His scrotum was abnormally swollen. I immediately went to get the charge nurse . The charge nurse came in . stated that she didn't see any 'active' bleeding, so there wasn't much that she could do. We tried to point out that the size of his scrotum was not normal. We tried to point out that he was painful. We were told again that she couldn't do anything . We left him without a brief for his comfort. Several blue pads were laid under him. As he was gently rolled, fresh blood spots were noted on the clean blue pads. I immediately went to the charge nurse and informed her that there was active bleeding. She stated that it was 20 (minutes) till 6:00, 'I am not going to do anything. I will let the day shift nurse know and she can do it' . In a telephone interview, on 8/13/20 11:50

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235197	A. BUILDING _____ B. WING _____	08/14/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HILLSDALE CO MEDICAL CARE FACI	140 W MECHANIC ST HILLSDALE, MI 49242

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0684 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 4) AM, CNA GG reported, (R2) tended to have days and nights backwards. He is usually up at 2:00 AM. (On 7/13/20) prior to 5:10 AM, when we rolled him he seemed uncomfortable and agitated when we changed him. Between 2:00 AM - 5:00 AM, (RN L) was gone for an hour for lunch . We asked her to come at 5:10 AM when we saw there was potentially an issue . There was no active bleeding when the nurse was in there but when we rolled him there was blood on the pad and we told her at 5:40 AM. (RN L) told me she wasn't going to do anything even though I told her there was active bleeding. I feel we pointed out that something was wrong, we tried to get help for our resident and felt we were not listened to. Our job is to notice behavior changes, and physical changes and we were disregarded. We told (RN L), something is wrong. In an interview, on 8/13/20 at 10:54 AM, third shift House Supervisor/Registered Nurse/RN J reported, It came up on the computer that (R2) was due (for an enema) and it said how many shifts and that is what I went by. No, I was not told he was on bowel protocol by (Licensed Practical Nurse/LPN DD) or that she gave a suppository (earlier that day). (Former Quality Assurance CC) would not have found it because she didn't work weekends. I can't tell what the system does. We learned to use the computer to decide two years ago when we learned how to use the EMR (electronic medical record). (Resident #3) was on bowel program Friday (7/10/20/Review of R2's Medication Administration Record [REDACTED]. Regarding R2, RN J said, I was trying to get him to go (have a bowel movement), so I gave him prune juice and MOM (milk of magnesia laxative) and he was straining so hard his face was red. Yes, I gave him prune juice 60 cc and 15 cc of MOM mixed together. Later, I tried 60 cc prune juice. I did not call the doctor; I just used my nursing judgement. I pulled up the aides' tasks and he was 4 days, rolling into 5 days with no bowel movement. If you assume he had a BM on the shift that no one charted, he was on the 9th day on second shift. If he did have a BM on the day it wasn't charted, then it would only have been the 5th shift . (R2) kicked out at me when I gave the first enema. (R2) walked into the general area and screamed, 'I got to[***]' He had 5-6 pea sized pellets in the toilet. I don't know how you count that as a BM. He laid back down, that's when I gave him, about 40 minutes later prune juice and MOM. He came back out yelling that he had to[***] In the bathroom yelling and not cooperative at all, straining and red face, I felt like I needed to check him, first one he didn't cooperate at all, I checked him and there was hard stool and rectal vault was full. I felt we needed to give him an enema. (R2) took of it and squirmed a lot, so I stopped. They walked him in the merry walker . (CNA G) walked him. He was up at 10:00 PM and I gave report to (RN L). (RN L) said nothing about the bowel protocol. At 10:00 PM, I was supervisor and went to the COVID unit and counted off. Around 11:00 PM, (R2) was still walking around with (CNA T). No one said anything about his condition not being okay. I called each unit and spoke with (RN L) and she said (R2) was sleeping and he had no BM. As I was getting ready to leave 6:15 AM (LPN K) called and spoke with (Unit Manager/RN AA) and said there was a lot of bruising and (Unit Manager AA) said she would go look at it and I should go home. Ultrasound showed a cyst at the head of the epididymis. On Tuesday, I went to see what was going on. (RN II) was his nurse Monday night. There was a long bruise. I measured it 13.5 cm long. (Wound Nurse/ RN Q) documented everything before I did. I was just floored as to where this bruise came from. Hospital report - I was shocked - perforation, abscess. I did not speak with (Medical Director R) about it. (Medical Director R) was on vacation for two weeks. I don't know why (Physician Assistant Y) wasn't called in. (Unit Manager/RN EE) is the Unit Manager. Perforation is a potential with enemas or suppositories. I spoke with (Director of Nursing DON B) about that on 7/21/20. If a resident resists an enema . I stopped. (CNA H's) hands, (CNA G) supported his back and held is legs up. (R2's) rectal vault full of stool . didn't come out for us . He was lying on his left side in bed, I checked him with one finger. He yelled. I then attempted another enema. I didn't even think about notifying the doctor. I did not receive discipline and was only educated on enemas . We need to look at the bowel protocol no one mentioned the problem until you brought it to my attention. RN J reported she did not call Son FF or a physician regarding R2 to get an order to administer repeated enemas, give prune juice with unscheduled MOM, to perform digital removal of stool, the inability to instill the first eneam, about the presence of blood, or R2 screaming in pain during the instillation of the enemas. RN J reported she did not check R2's BM record or the MAR indicated [REDACTED]. In an interview, on 8/12/20 at 1:11 PM, RN O reported, I count a hole as no BM. You have nothing else to tell you otherwise. If I know who worked prior, I might message them but if I don't know and it's been days prior, I wouldn't know. That's the way we've always done it, count it as a no BM. I gave (R2) MOM on 7/06/20 at 1333. Our computer generates an alert that tells us how many shifts without a BM. If you don't read the date of the alert, you can make a mistake. I clear out alerts after 24 hours makes it clearer communication. Not everyone clears them out. RN O continued, When I saw (R2) on Wednesday 14th, . I walked into a night mere his testes were huge, he had a big bruise and skin tears. I was off for a couple days and when I came back it was necrotic. I heard from supervisor that he had a rectal perforation and it was really horrible. He was very, very painful, I couldn't get him out of bed he would cry out and cling to you. Even when turned side to side. The ice packs were applied, it was shiny; it was so tight - scrotum. We gave pain meds, but he was thrashing around because of the pain. He wanted up but he couldn't. When he came back from the hospital, he was on [MEDICATION NAME] (liquid narcotic medication). He had declined a lot and I knew I would never be able to heal that. I feel definitely at the end he was very comfortable the [MEDICATION NAME] once it got increased. During care he was in discomfort. In an interview, on 8/13/20 at 9:17 AM, CNA E reported, On Sunday (7/12/20 first shift), my immediate help is what can we do comfort-wise? (R2's) scrotum was engorged. What can we do to help him? It was uncomfortable for him to walk. What could we put on him that wouldn't bind or pinch? You could tell by his face and grimacing he was in pain . We applied cold compresses - that seemed to help some . (R2) was in pain when scooting. (CAN GG) sat with him on her breaks to talk to him and we put country music. He used to sing with music. I don't do a lot of the charting. It is done on the computer. It gives an alert if it's been seven shifts. I'm not tech savvy. I don't know if you can go back to fill it in. It will go in the red if we haven't charted. In an interview, on 8/12/20 at 10:10 AM, LPN K (who worked first shift 7/13/20) reported, In report from (RN L) and she told me about (R2's) rectum and wanted me to look at it with her. After she left, I took measurements. The skin tear was hard to see because it blended in with the bruising. She said he had an enema and she wasn't sure what happened. (R2) had very soft stool so the bleeding wasn't from that. I called (Unit manager AA) supervisor and told her about it. I asked her to come down to see it. I said, This is concerning. I told her about the rectal bleeding, bruising and skin tear. (RN J) was still in the supervisor's office and I heard her saying the bruising was possibly from him plopping down and the bleeding could be from a hard stool and she said nothing about the skin tear. (Unit manager AA) came down and saw it she seemed shocked when she saw it. It wasn't as the notes described it. This did not just appear. His scrotum was not swollen the day before. I've never seen anything like that from an enema. I know him well enough and seen him a few days before. He just appeared painful and not getting up he didn't want to sit up. He laid on his side and seemed different, looked very tired, he looked out of it - there was a look in his eyes. He wasn't himself. He never got better, never walked again, or used a urinal again. His stools were soft almost, liquid and a couple times blood tinged. The blood on the pad, I thought was coming from his rectum. When I was there, the doc or (physician extender) did not visit him. The Bowel protocol says after 7 shifts MOM, after 8 shifts a suppository, after 9 shifts it would be an enema. Does not say give 2 enemas. (RN L) told me that (RN F) gave 2 enemas and that they walked him and that he had prune juice and milk of magnesia on her shift second; she comes in at 6:00 PM - 10:00 PM). I think he was on the Bowel Program and already had an enema. Sometimes it doesn't get cleared on the dashboard (computer). That's why we look at their actual tasks bowel records and what the aides wrote. I didn't look back to see if the shift before her gave MOM. No, she didn't follow the protocol. I did not receive education after this happened. I heard he had 240 or 360 prune juice. That is not part of the bowel protocol. I heard she gave MOM in the prune juice. I feel that he should not have 2 enemas. I asked (RN L) and did (RN J) to come down and see this they said no. Not sure where the bruising came from or how that would have happened. The CNAs said that he was walked laps and given a lot prune juice and MOM and I was told the first one (enema) didn't all go in. I think maybe the enema caused the bruising. Maybe (R2) was poked with the enema roughly. He's had plenty of enemas and we've never held him down. If I knew that they had 2 aides holding him down, I would say he was refusing and that was abuse. Walking him if he was tired? He shouldn't have been walked a lot like they said. He should have been left alone . (RN J) didn't follow protocols. Review of the education RN J received revealed, Education on Policy and Procedure of disposable enemas . 1. Enema procedure - policy provided; 2. Impacted (stool), dis-impaction, scope of practice; 3. Manual removal of fecal impaction; 4. Assessment . Complete an abdominal assessment (bowel sounds, abdominal extension, pain or discomfort with our without touch to abdomen); 4. Options other than digital dis-impaction: Abdominal flat plate (x-ray), Monitor/assess resident; 5. Communication with physician .In the future, I will assess the resident and the need for initiating or continuing the Bowel Program, to prevent the potential of trauma during procedure . The document was signed and dated by DON B and RN J on 7/21/20 (not timed). Review of R2's Medication Administration Record [REDACTED]. Linzess Capsule 72 MCG. Give 1 capsule by mouth in the morning related to constipation (start date 5/08/20 - end date 7/28/20). 2. Polyethylene [MEDICATION NAME] Powder (also known as [MEDICATION NAME]) give 17 gram by mouth in the morning

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235197	A. BUILDING _____ B. WING _____	08/14/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HILLSDALE CO MEDICAL CARE FACI	140 W MECHANIC ST HILLSDALE, MI 49242

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0684 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 5) for constipation (start date 4/30/20 - end date 7/28/20). 3. Senna-[MEDICATION NAME] Sodium Tablet 8/6-50 mg. Give 1 tablet by mouth at bedtime for constipation (start date 4/28/20 - 7/28/20). 4. Bowel Program per facility protocol every 8 hours as needed for Constipation: no bowel movement on the 7th shift Give 30 ml of Milk of Magnesium; no bowel movement on the 8th shift Give [MEDICATION NAME] suppository; no bowel movement on the 9th shift Give [MEDICATION NAME] enema. If no bowel movement on the 10th shift contact physician (start date 4/29/20 - end date 8/02/20). Review of R2's Care Plans revealed he did not have a plan of care for bowel function/dysfunction. Review of R2's Bowel Elimination Record (documented by CNAs) revealed the 2:00 PM - 10:00 PM shift on 7/08/20 was blank, indicating that R2's bowel elimination had not been documented on that shift and therefore, it could not be determined whether he had had a BM during that timeframe. If R2 had a BM on that shift, it would mean, according to the Bowel Protocol, it should not have been initiated/medication should not have been administered on 7/11/12 at all. The Professional Standard of Quality for documentation of the residents health care in a medical record is the information must be true and complete. (Fundamentals of Nursing, Concepts, and Practice. Mosby. Potter, P.A., Perry, A.G., 1985) R2's Medication Administration Record [REDACTED]. There was documentation on the MAR indicated [REDACTED]. Review of Nursing Progress Notes revealed the above nurses did not notify the physician regarding their decisions to administer these medications/procedures. In it's entirety, the facility Bowel Program, dated 2/28/19, read as follows: Policy Statement: Nursing department will pursue and provide such care as will refresh and provide comfort to the resident and assure that elimination is occurring appropriately Purpose: To aid in evaluation of resident's bowel habits, to establish regular routines, and to decrease or prevent the incidence of constipation. Forms used: Bowel program is monitored in PCC (Point Click Care Electronic Medical Record); Procedure: Residents are assessed upon admission by nursing department in regard to the resident's bowel pattern and bowel regularity. All CNA's must address bowel movements in PCC. Alerts will be sent to the nurse in appropriate time frames rt (sic). If no BM (bowel movement) in six shifts, beginning on the seventh shift, the nurse will give 30 cc's of MOM (Mild of Magnesia) p.o. (orally). If no results, at the beginning of the eight shift, a [MEDICATION NAME] suppository is given rectally. If no results, at the beginning of the ninth shift, give [MEDICATION NAME] Enema. If no results are recorded, consult physician. *May given 30cc's MOM with physician's orders [REDACTED]. Review of the facility Disposable Enemas Policy and Procedure, (not dated) revealed, no instruction to administer a second enema if only a partial enema is administered, did not instruct staff to proceed with a rectal exam, or how to proceed if there is resistance when administering the enema or if blood appears. The policy did not instruct staff to assess for bowel sounds or abdominal swelling. According to the Policy, .
F 0757 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake MI 306 and MI 141. Based on interview and record review, the facility failed to ensure two of three residents reviewed for unnecessary drugs, (Resident #2 and #3) did not receive unnecessary drugs, resulting in excessive doses, medications administered without indication for use, without adequate monitoring, and in the presence of adverse consequences (bowel perforation for R2). Findings include: According to the Significant Change Minimum Data Set (MDS), dated [DATE], Resident #2 (R2) was severely, cognitively impaired, needed extensive assistance of two or more staff with bed mobility, was always incontinent of bowel, had one unstageable Stage I pressure ulcer over a bony prominence and one skin tear, and [DIAGNOSES REDACTED]., winces, wrinkled forehead, furrowed brow, clenched teeth or jaw), protective body movements or postures (bracing, guarding, rubbing or massaging a body part/area, clutching or holding a body part during movement). According to R2's previous MDS, dated [DATE], he was occasionally incontinent of bowel, had no indications of pain or [MEDICAL CONDITION]. Review of R2's MDS dated [DATE] revealed no [MEDICAL CONDITION]. R2's MDS, dated [DATE] revealed Death in facility. Review of R2's Certificate of Death revealed the cause of his death was Perianal (in or in the tissues near the anus) abscess (full of puss). According to Resident #3 (R3's) MDS, dated [DATE], she was severely cognitively impaired, was always continent of stool and had [DIAGNOSES REDACTED].) According to a Witness Statement, dated 7/14/20 (not timed), 7/12/20 2010 pm shift: I (CNA G) witnessed an unsettling enema procedure performed by my floor nurse in Snap Dragon Valley (Alley), (RN J). (RN J) asked (CNA H) and myself to assist her in an enema orchestrated on an Alzheimer patient (R2) The nurse instructed me to hold the residents' legs and instructed (CNA H) to hold his arms and torso . the nurse then proceeded to jam the tip into the resident's rectum. The resident instantly started to shout, scream and cry. I felt really upset but continued to do what I was instructed because I trusted my nurse and figured the patient was having a behavior with the discomfort of the enema. We then cleaned up the resident and put a clean brief on him. Moments later I assisted (CNA W) in the bathroom as she helped toilet (R2) and we discovered blood in the brief and blood coming out of (R2's) rectum. I went to (RN J) and instantly reported the blood. She said that's normal and it could be because he's so impacted. Several minutes later we (CNA H and I) were asked to do another enema with the nurse. This time it was very unsettling as I watched the nurse now lubricate her gloves and shove her fingers inside the rectum to help 'break up the compacted stool'. (R2) screamed and cried and shouted, 'please make it stop . oh, fuc* I'm going to die, get out of there' and much more as tears fell from his eyes. Stool and blood was on the glove once the nurse pulled her hand out. The next enema was given, and the resident was washed up and changed into a new brief and pants. (RN J) then instructed to walk (R2) around to move his bowels. I walked him around the rest of the shift and he was so tired he was falling asleep and then told the nurse I felt he was unsafe to continue to walk around and I was told to keep him moving . (R2) showed signs of pain and discomfort and couldn't even sit down. I feel the need to report this . In an interview, on 8/11/20 2:28 PM, CNA G reported, I never helped with an enema before. (CNA H) and myself assisted. I was instructed to hold his lower half and (CNA H) to hold his upper extremities. (RN J) applied her gloves, no lubricant (pre-lubricated) administered enema into him and he clenched his buttocks, started shouting, Get the hell out of me'. (RN J) started laughing and we were giggling because he said a lot of funny things as usual, but it started to hurt him and (RN J) kept pushing the fluid in and it wasn't working. I don't know how much was pushed in. (RN J) disposed of it, exited, we cleaned him up, put a brief on him and I was instructed to walk him around, we were giving him prune juice and [MEDICATION NAME] (laxative). (CNA W) and I took him to the bathroom, sat him down and I noticed a lot of blood in his brief. I told (RN J) and she did not go and look at him. In a half hour we assisted, and it wasn't a joking matter. He was screaming in pain and saying to get it out of him. He was shaking. The enema as painful and he said, 'Please kill me. Get it the hell out of me.' When we moved him, he was painful after it. (RN J) instructed me to walk him but his knees were shaking, and he couldn't sit down on his bottom. I told the (RN J) he looks really tired, and she said keep him moving. (R2) said, 'I said he can't sit down'. (RN J) told me I couldn't lay him down, told to keep administering prune juice and [MEDICATION NAME] mixed together. He only had a sip or two because he kept spitting it out. (CNA T) came on and saw his injuries to his rectum and they called the Administrator (A) around 4:00 AM or 5:00 AM in the morning. I did not report anything. I didn't think there was going to be rectal damage until Tuesday (7/14/20) when I came back to work and (CNA S) told me (R2's) butt looked terrible, bruised, swollen, bleeding, and he had not out of bed. (R2) was usually always on the go. Now bedridden because of an enema. I went home and filled out a statement, messaged (CNA W) and (CNA H) and we all reported it the same day . On the second enema she stuck at least 2 fingers to break up the stool and when she pulled her fingers out there was loose stool, very little, and a small amount blood on her finger. (RN J) had her fingers in there maybe 35 seconds or less. Prior to this, his scrotum was never enlarged. I was unsettling when I saw necrotic tissue - this was after he returned from the hospital. (R2) was placed on comfort care and I don't think he was out of bed from the day the enemas were administered . ignoring the blood in the brief and continually walking him when he was too tired. I don't like how this was handled . I heard rumors that son was not notified this happened to his dad . (Then, after I reported it), (RN J) didn't speak to me for 6 hours while working with her - I was uncomfortable. (RN J) knows I reported her. I talked to (CNA JJ) and told her I was uncomfortable working with (RN J). (RN J) told others I was not fit to work this job. (CNA H) thought it was unsettling . She brought me into the bathroom and said that was f'd up and that she reported it right away when she found the injuries. I witnessed two enemas, prune juice and [MEDICATION NAME] given . I think there was abuse . During it, he was in pain, saying please stop and that wasn't being done and that made me sad for him. After, they didn't contact the family and I didn't like that and then walking the resident when fatigued and in pain. In a telephone interview, on 8/12/20 at 10:00 PM, CNA (Certified Nursing Assistant) T stated, (CNA W) I took (R2) to the restroom around 11:15. (R2) had blood in the toilet, brief and on his legs. It was dripping down his legs and, on the floor, - droplets falling. Told (RN L) as soon as we came out of his room. (RN L) told us she was told there would be blood and not to worry about it. Same amount in the next two briefs. Every couple of hours. Second time around 1:00 AM and (CNA W) left at 2:00 AM and (CNA GG) came in at 2:00 AM. The next brief change was around 5:00 AM; at that time, it was the same as before. Then we washed him, and we made (RN L) go in and look because she wouldn't look before. She was playing Candy Crush on her phone and she usually leave doesn't

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235197	A. BUILDING _____ B. WING _____	08/14/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HILLSDALE CO MEDICAL CARE FACI	140 W MECHANIC ST HILLSDALE, MI 49242

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 0757 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 6) leave the nurses' station. We asked (RN L) to give (R2) pain medication a few different times through the night, then at 5:00 AM we said, 'At least give him Tylenol', and she said he didn't have an order and we needed to wait until the first shift nurse came in. You could tell he was painful when I came in. He wouldn't sit down, and his bottom was painful when he sat down on the bed. He could only lay on his right side. He would holler and push away if we tried to prop him on his left side. It was unusual for him. I was extremely pissed-off that she wouldn't get him some pain medication. At 6:00 AM, in the parking lot we called (DON/Director of Nursing B) about what had happened. We told her what we had walked into at 10:00 PM and that he had been bleeding all night, that he was in pain and wasn't given anything all night. Yes, I felt I was reporting abuse. I believe it was done when (RN F) was with him. (RN L) - I believe she didn't do anything to help him all night; (CNA GG) and I said, 'You need to get up and go look at him.' I have concerns about her. She doesn't give pain meds when they are needed . They think someone didn't chart a BM . they were discussing that at report. If we forget to chart, you can go back in and chart. No one has ever called to ask if I missed charting. (Quality Assurance CC) used to check the books to make sure they were filled in, but I don't know of anyone checking now. In an interview, on 8/12/20 at 10:10 AM, LPN K (who worked first shift 7/13/20) reported, In report from (RN L) and she told me about (R2's) rectum and wanted me to look at it with her. After she left, I took measurements. The skin tear was hard to see because it blended in with the bruising. She said he had an enema and she wasn't sure what happened. (R2) had very soft stool so the bleeding wasn't from that. I called (Unit manager AA) supervisor and told her about it. I asked her to come down to see it. I said, This is concerning. I told her about the rectal bleeding, bruising and skin tear. (RN J) was still in the supervisor's office and I heard her saying the bruising was possibly from him plopping down and the bleeding could be from a hard stool and she said nothing about the skin tear. (Unit manager AA) came down and saw it she seemed shocked when she saw it. It wasn't as the notes described it. This did not just appear. His scrotum was not swollen the day before. I've never seen anything like that from an enema. I know him well enough and seen him a few days before. He just appeared painful and not getting up he didn't want to sit up. He laid on his side and seemed different, looked very tired, he looked out of it - there was a look in his eyes. He wasn't himself. He never got better, never walked again, or used a urinal again. His stools were soft almost, liquid and a couple times blood tinged. The blood on the pad, I thought was coming from his rectum. When I was there, the doc or (physician extender) did not visit him. The Bowel protocol says after 7 shifts MOM, after 8 shifts a suppository, after 9 shifts it would be an enema. Does not say give 2 enemas. (RN L) told me that (RN F) gave 2 enemas and that they walked him and that he had prune juice and milk of magnesia on her shift second; she comes in at 6:00 PM - 10:00 PM). I think he was on the Bowel Program and already had an enema. Sometimes it doesn't get cleared on the dashboard (computer). That's why we look at their actual tasks bowel records and what the aides wrote. I didn't look back to see if the shift before her gave MOM. No, she didn't follow the protocol. I did not receive education after this happened. I heard he had 240 or 360 prune juice. That is not part of the bowel protocol. I heard she gave MOM in the prune juice. I feel that he should not have 2 enemas. I asked (RN L) and did (RN J) to come down and see this they said no. Not sure where the bruising came from or how that would have happened. The CNAs said that he was walked laps and given a lot prune juice and MOM and I was told the first one (enema) didn't all go in. I think maybe the enema caused the bruising. Maybe (R2) was poked with the enema roughly. He's had plenty of enemas and we've never held him down. If I knew that they had 2 aides holding him down, I would say he was refusing and that was abuse. Walking him if he was tired? He shouldn't have been walked a lot like they said. He should have been left alone . (RN J) didn't follow protocols. In an interview, on 8/13/20 at 10:54 AM, third shift House Supervisor/Registered Nurse/RN J reported, It came up on the computer that (R2) was due (for an enema) and it said how many shifts and that is what I went by. No, I was not told he was on bowel protocol by (Licensed Practical Nurse/LPN DD) or that she gave a suppository (earlier that day). (Former Quality Assurance CC) would not have found it because she didn't work weekends. I can't tell what the system does. We learned to use the computer to decide two years ago when we learned how to use the EMR (electronic medical record). (Resident #3) was on bowel program Friday. Regarding R2, RN (Registered Nurse) J said, I was trying to get him to go (have a bowel movement), so I gave him prune juice and MOM (milk of magnesia laxative) and he was straining so hard his face was red. Yes, I gave him prune juice 60 cc and 15 cc of MOM mixed together. Later, I tried 60 cc prune juice. I did not call the doctor; I just used my nursing judgement. I pulled up the aides' tasks and he was 4 days, rolling into 5 days with no bowel movement. If you assume, he had a BM on the shift that no one charted, he was on the 9th day on second shift. If he did have a BM (bowel movement) on the day it wasn't charted, then it would only have been the 5th shift . (R2) kicked out at me when I gave the first enema. (R2) walked into the general area and screamed, 'I got to[***]' He had 5-6 pea sized pellets in the toilet. I don't know how you count that as a BM. He laid back down, that's when I gave him, about 40 minutes later prune juice and MOM. He came back out yelling that he had to[***] In the bathroom yelling and not cooperative at all, straining and red face, I felt like I needed to check him, first one he didn't cooperate at all, I checked him and there was hard stool and rectal vault was full. I felt we needed to give him an enema. (R2) took of it and squirmed a lot, so I stopped. They walked him in the merry walker . (CNA G) walked him. He was up at 10:00 PM and I gave report to (RN L). (RN L) said nothing about the bowel protocol. At 10:00 PM, I was supervisor and went to the COVID unit and counted off. Around 11:00 PM, (R2) was still walking around with (CNA T). No one said anything about his condition not being okay. I called each unit and spoke with (RN L) and she said (R2) was sleeping and he had no BM. As I was getting ready to leave 6:15 AM (LPN K) called and spoke with (Unit Manager/RN AA) and said there was a lot of bruising and (Unit Manager AA) said she would go look at it and I should go home. Ultrasound showed a cyst at the head of the epididymis. On Tuesday, I went to see what was going on. (RN II) was his nurse Monday night. There was a long bruise. I measured it 13.5 cm long. (Wound Nurse/ RN Q) documented everything before I did. I was just floored as to where this bruise came from. Hospital report - I was shocked - perforation, abscess. I did not speak with (Medical Director R) about it. (Medical Director R) was on vacation for two weeks. I don't know why (Physician Assistant Y) wasn't called in. (Unit Manager/RN EE) is the Unit Manager. Perforation is a potential with enemas or suppositories. I spoke with (DON B) about that on 7/21/20. If a resident resists an enema . I stopped. (CNA H's) hands, (CNA G) supported his back and held is legs up. (R2's) rectal vault full of stool . didn't come out for us . he must of had a BM on the next shift. He was lying on his left side in bed, I checked him with one finger. He yelled. I then attempted another enema. I didn't even think about notifying the doctor. I did not receive discipline and was only educated on enemas. No, I was not suspended. We need to look at the bowel protocol no one mentioned the problem until you brought it to my attention. RN J reported she did not call Son FF or a physician regarding R2 to get an order to administer repeated enemas, give prune juice with unscheduled MOM, or perform digital removal of stool. RN J reported she did not check R2's BM record or the MAR to assure that protocol was being followed. R2's Medication Administration Record revealed no documentation of MOM (Milk of Magnesia) given on 7/11/20. There was documentation on the MAR that a suppository was administered on 7/11/20 at 3:32 AM by LPN II, an enema was administered on 7/11/20 at 1:43 PM by RN O; and an enema was administered on 7/12/20 at 7:37 PM by RN J. Review of Nursing Progress Notes revealed the above nurses did not notify the physician regarding their decisions to administer these medications/procedures. Review of R2's Bowel Elimination Record (documented by CNAs) revealed the 2:00 PM - 10:00 PM shift on 7/08/20 was blank, indicating that R2's bowel elimination had not been documented on that shift and therefore, it could not be determined whether he had had a BM during that timeframe. If R2 had a BM on that shift, it would mean, according to the Bowel Protocol, it should not have been initiated/medication should not have been administered on 7/11/12 at all. Review of R3's Bowel Elimination Record also revealed blanks in charting during July 2020. R3's Bowel Elimination Record revealed the Bowel Protocol was initiated when MOM administered on 7/07/20 at 5:50 AM, (no suppository was given on the following shift, and an enema was given on 7/07/20 at 9:28 PM. The Bowel Protocol was initiated again for R3 when MOM was administered on 7/09/20 at 5:44 AM. In an interview, on 8/13/20 at 12:28 PM, DON B reported that on 7/30/20, R3 refused MOM on multiple after attempts, so they went to a suppository on the next shift - no, they did not notify the doctor. The administration of these medications was outside of the facility Bowel Program protocols and the physician was not notified. DON B said, We need to update and clarify procedures on the Bowel Program. In its entirety, the facility Bowel Program, dated 2/28/19, read as follows: Policy Statement: Nursing department will pursue and provide such care as will refresh and provide comfort to the resident and assure that elimination is occurring appropriately Purpose: To aid in evaluation of resident's bowel habits, to establish regular routines, and to decrease or prevent the incidence of constipation. Forms used: Bowel program is monitored in PCC (Point Click Care Electronic Medical Record); Procedure: Residents are assessed upon admission by nursing department in regard to the resident's bowel pattern and bowel regularity. All CAN's must address bowel movements in PCC. Alerts will be sent to the nurse in appropriate time frames rt (sic). If no BM (bowel movement) in six shifts, beginning on the seventh shift, the nurse will give 30 ccs of MOM (Milk of Magnesia) p.o. (orally). If no results, at the beginning of the eight shift, a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235197	A. BUILDING _____ B. WING _____	**08/14/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HILLSDALE CO MEDICAL CARE FACI	**140 W MECHANIC ST HILLSDALE, MI 49242**

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 0757 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 7) [MEDICATION NAME] suppository is given rectally. If no results, at the beginning of the ninth shift, give [MEDICATION NAME] Enema. If no results are recorded, consult physician. *May given 30cc's MOM with physician's orders [REDACTED]. In an interview, on 8/13/20 at 12:29 PM, DON B was queried as to her thoughts on RN J administering prune juice with MOM, B said, I don't think it (Bowel Protocol) says 3 MOMs. It says just MOM prior to the enema. I glanced at the MAR and there was an enema given earlier and then (RN J) gave 2 more. Regarding the blank in R2's Bowel elimination charting, DON B said, No documentation on the 9th - they should have verified it. I would agree (RN J) did not follow bowel protocol. DON B did not investigate to the administration of Bowel Protocol (Milk of Magnesia, suppositories or enemas) on residents when they were not needed. During a telephone interview on 8/13/20 at 1:05 PM, Medical Director (MD) R, . Yes, the perforation explains it all (the scrotal swelling, necrotic tissue, bruising, bleeding, pain). I know he got some enemas .