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TOUCHSTONE OF MAYVILLE	1071 HORICON ST MAYVILLE, WI 53050

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments On 07/22/2026, with information obtained through 07/31/2026, the Bureau of Assisted Living, Southern Regional Office, conducted 4 complaint investigations and a verification visit at Touchstone of Mayville, a community-based residential facility (CBRF), located in Mayville, WI. As a result of the survey, 5 deficiencies were identified. Four deficiencies are repeat deficiencies. See Statement of Deficiencies (SOD) 3M3K12, dated 11/11/2025, SOD 3M3K11, dated 07/14/2025, SOD I87Y16, dated 07/02/2024, SOD I87Y15, dated 01/10/2024, and SOD I87Y14, dated 08/03/2023, SOD I87Y13, dated 03/29/2023, and SOD I87Y11, dated 05/24/2022. One of 4 complaints was substantiated. Under statutory provisions of Wis. Stat. Chapter 50, a $200 revisit fee is being assessed. Census: 10	N 000		
N 161	83.12(3)(a) Investigate injuries of unknown source. Investigating injuries of unknown source. A CBRF shall investigate any of the following: 1. An injury that was not observed by any person. 2. The source of an injury to a resident that cannot be adequately explained by the resident. 3. An injury to a resident that appears suspicious because of the extent of the injury or the location of the injury on the resident. This Rule is not met as evidenced by: Based on record review and interview, the	N 161		

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

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provider did not ensure that an injury sustained by Resident 6, a lumbar spine compression fracture, which was not observed by a person nor could adequately be explained by him/her, was investigated.

This is a repeat deficiency. See Statement of Deficiencies (SOD) I87Y14, dated 08/03/2023.

Findings include:

On 07/24/2026, at approximately 11:15 a.m., Surveyor interviewed Family Member H. Family Member H reported that Assistant Administrator D reached out to him/her to report that Resident 6 had experienced a change at some point after his/her admission as demonstrated by increased agitation and only wanting to sleep. Family Member H reported that Resident 6 was then hospitalized for discovery of a lumbar spine compression fracture. Family Member H reported that the provider's staff reported not being sure if Resident 6 had fallen but that they had been concerned about a fall Resident 6 experienced at some point when his/her spouse was helping him/her take a shower at the facility.

On 07/30/2026, Surveyor reviewed Resident 6's record. Resident 6's diagnoses included complete loss of vision, complete loss of bilateral ear hearing, lumbar back pain, frequent falls, and antineutrophilic cytoplasmic antibody vasculitis. An inpatient hospital discharge summary, dated 04/27/2026, identified that Resident 6 had been hospitalized from 04/17/2026 - 04/27/2026. Admission diagnoses included intractable low back pain, right hip contusion, and a closed compression fracture of his/her L2 lumbar vertebra. The summary narrative detailed that Resident 6 had been admitted for "acute

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worsening back pain" and also documented, "[His/her] admission was prompted by severe back pain with associated right hip and leg pain, limited mobility, and inability to ambulate, with imaging revealing an acute nondisplaced L2 vertebral body compression fracture...further evaluation with nuclear medicine bone scan confirmed an acute/subacute L2 compression deformity..." The History and Physical (H&P) section of the record from his/her admission on 04/17/2026 documented, "...[S/he] has been experiencing significant pain in [his/her] back, right shoulder, right leg, and hip, which worsens with movement and has caused [him/her] to cry out in pain. The pain began yesterday and has become more intense today..." The "Assessment" section of the H&P documented that Resident 6's chronic prednisone use "may contribute for osteoporosis."

Resident 6's record contained no entries or information about this injury or related hospitalization.

At approximately 2:07 p.m., Surveyor interviewed Caregiver G about the L2 fracture incident. Caregiver G reported that s/he was aware of the incident. Caregiver G reported that Resident 6 had been complaining of back pain, which wasn't helped by acetaminophen, and then later s/he refused to stand. Caregiver G reported that because of the onset of the debilitating pain the decision was made to send him/her out to the emergency department. Caregiver G denied that Resident 6 experienced a fall or any other event that caused the fracture. Caregiver G reported that a doctor from the hospital had reported that the fracture was due to Resident 6's prolonged prednisone use. Caregiver G reported that this was in the medical record. (Of note, Surveyor

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N 161	Continued From page 3 was unable to find a medical assessment in Resident 6's medical records suggesting the L2 fracture itself was caused solely by chronic prednisone use.) At approximately 3:44 p.m., Surveyor interviewed Assistant Administrator D regarding the L2 fracture incident. Assistant Administrator D reported that s/he was told by Family Member H that Resident 6's long-term prednisone use was likely the source of Resident 6's L2 fracture. On 07/31/2026, at approximately 2:00 p.m., Surveyor interviewed Administrator C. Administrator C acknowledged Surveyor's concern that there had been no investigation into the L2 compression fracture experienced by Resident 6.	N 161		
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that Resident 6 received all prescribed medications in the dosages and at intervals prescribed by his/her practitioner. Resident 6 was prescribed a glutose gel that was to be administered when his/her blood sugar levels were <70. On 2 of 3 occasions that this	N 352		

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occurred during his/her admission, staff did not administer the gel.

Resident 6 did not receive approximately 54 doses of his/her polyethylene glycol.

This is a repeat deficiency. See Statement of Deficiencies (SOD) 3M3K11, dated 07/14/2025, SOD I87Y16, dated 07/02/2024, and SOD I87Y15, dated 01/10/2024.

Findings include:

On 07/23/2026, Surveyor reviewed Resident 6's record. Resident 6 was admitted to the provider on 03/23/2026 with diagnoses including type II diabetes mellitus and constipation. Resident 6's individual service plans - one from 03/23/2026 and one from 07/20/2026 - identified that Resident 6 required staff to administer his/her medications. Surveyor Resident 6's prescriptions and medication administration records (MARs) throughout his/her admission. An order directed for staff to check his/her blood sugar 4 times daily, and s/he was prescribed a NovoLog FlexPen for insulin administration before each meal. His/her prescriptions included glutose 15 gel tubes, active as of 04/07/2026, with instructions to, "Squeeze contents of 1 tube into mouth and swallow as needed for [blood sugar] less than 70."

Resident 6's MARs, which is where his/her blood sugar readings were documented by staff, identified 3 times his/her blood sugar was <70. Of these occasions, there were 2 occasions in which staff did not document having administered Resident 6's glutose gel. This included on 05/10/2026, when his/her recorded blood sugar was 63 at 8:34 a.m., and on 05/26/2026, when

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his/her blood sugar was 65 at 9:08 a.m. On both occasions there were no annotations or notes about the low blood sugars and no evidence of any other follow up checks outside of his/her next routine blood sugar check and insulin administration time. In reviewing the remainder of Resident 6's record, there were no notes about the low blood sugar occasions.

On 07/30/2026, Surveyor reviewed medical records that were part of Resident 6's record which included the following:

- An after visit summary from Resident 6's admission to the emergency department on 04/14/2026 detailed that s/he had been seen in part due to constipation. The summary highlighted changes made to his/her already prescribed polyethylene glycol, and included an as needed (PRN) order for him/her to, "Take 17 g[rams] by mouth as needed. Stir and dissolve powder in any 4 to 8 ounces of beverage, then drink," as well as a scheduled dose order, which read, "Take 17 g[rams] by mouth daily for 14 days..."

- Records detailing Resident 6's hospitalization from 04/17/2026 - 04/27/2026. The discharge summary, dated 04/27/2026, identified that Resident 6 had been admitted in part due to constipation, and in the "Hospital Course" section of the summary, that, "...Additional findings included a moderate to large colorectal stool burden..." The summary identified that, "Initial management included...and bowel regimen for constipation."

Surveyor then reviewed Resident 6's MARs for April 2026, which showed an order for PRN polyethylene glycol active since 04/03/2026 (prior

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to his/her first emergency department admission) with the same dosing instructions (17 grams) as what was later ordered. The scheduled 14-day-daily polyethylene glycol order showed a start date of 04/28/2026 (after his/her hospitalization). Once started, staff initialed off on 41 administrations of his/her polyethylene glycol between 04/29/2026 through 06/08/2026. The only PRN polyethylene glycol administration entries were on 04/15/2026 and 04/17/2026.

In continuing to review Resident 6's medical records, Surveyor also reviewed the following:

- An after visit summary from Resident 6's admission to the emergency department on 05/09/2026 detailed that s/he had been seen in part due to constipation and rectal fecal impaction, which was treated with magnesium citrate and an enema. The summary's "Instructions" section documented that, "Miralax should be given daily to avoid significant constipation." (Of note, MiraLAX is the brand name for polyethylene glycol.)

- Records detailing Resident 6's hospitalization from 06/12/2026 - 06/15/2026. The "Hospital Course" section of the discharge summary noted his/her chronic constipation and documented, "At discharge will schedule miralax but change to 8.5 gram pack qday..." In bold text the note then documented, "[Assisted living facility (ALF)] staff needs to continue to monitor and keep record of [bowel movements] given [his/her] tendency for constipation/impaction."

Surveyor then reviewed Resident 6's MARs for May, June, and July 2026. The May MAR showed the same PRN and scheduled polyethylene glycol orders as his/her April MAR. Staff documented in

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the April MAR having administered polyethylene glycol (under his/her scheduled dose order) daily throughout the month. The June MAR showed the last administration of his/her scheduled polyethylene glycol on 06/08/2026 (from the 14-day scheduled order that began on 04/29/2026). A new entry on that MAR showed the daily scheduled 8.5-gram polyethylene glycol dose with an order start date of 06/15/2026 and instructions to, "Take 8.5 g[rams] by mouth daily. Stir and dissolve powder in any 4 to 8 ounces of beverage, then drink." Even though the instructions were for scheduled daily dosing, the medication was entered in the "PRN" section of the MAR. After 06/08/2026, when staff stopped administering from Resident 16's 14-day daily order, there were no administrations documented of Resident 6's polyethylene glycol.

At approximately 8:18 a.m., Surveyor interviewed Pharmacist I from the pharmacy that dispensed Resident 6's medications. Pharmacist I reported that the pharmacy first received an order for PRN polyethylene glycol on 04/02/2026 and one 510-gram container, which contained 30 once-daily doses, was sent out that day. (Of note, this was consistent with the PRN order in Resident 6's record). Pharmacist I reported that shortly after this, an order was received for polyethylene glycol with instructions to administer once daily for 14 days. Pharmacist I reported that since a bottle had just been recently dispensed from the pharmacy that a new bottle was not sent out. Pharmacist I reported that the only other time polyethylene glycol was dispensed for Resident 6 was on 06/09/2026, when another 510-gram container was sent out. Pharmacist I reported that 06/15/2026 is when the pharmacy received the most current order for polyethylene glycol, this time with instructions to administer a half scoop

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(8.5 grams) daily. When asked how medication orders were managed in the provider's electronic record system, Pharmacist I reported that the pharmacy staff typically put in the order which then gets sent to the record system, but the facility staff has the power to edit the orders and is responsible for verifying the information from the orders.

From the above information, Surveyor noted that 1 bottle of polyethylene glycol had been on hand for Resident 6 since approximately 04/02/2026 and would have been available for staff to administer from when it was ordered for daily administration across 14 days by the medical provider who treated him/her in the emergency department on 04/14/2026. While staff administered polyethylene glycol on 04/15/2026 and 04/17/2026, they did not administer any on 04/16/2026. Resident 6 was then hospitalized from 04/17/2026 through 04/27/2026. Staff then began administering his/her daily polyethylene glycol on 04/29/2026, but did not administer any on 04/28/2026 even though they still would have had the same previous polyethylene glycol container on hand. Staff then initialed that they administered 41 daily administrations of Resident 6's polyethylene glycol from 04/29/2026 through 06/08/2026. Combined with the 2 times staff had documented administering it in April, 04/15/2026 and 04/17/2026, Surveyor noted that there were 43 total documented administrations. Surveyor noted that this all would have come from 1 container, since the only other container of polyethylene glycol from the pharmacy wasn't dispensed until 06/09/2026. Surveyor noted that 43 doses coming from 1 container was inconsistent with the container size, which contained only 30 once-daily doses. From 06/09/2026 through 06/11/2026 (3 potential days

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N 352	Continued From page 9 of administration), staff did not document administering any polyethylene glycol to Resident 6, despite the instructions from the emergency room medical provider on 05/09/2026 for Resident 6 to take MiraLAX daily. On 06/15/2026, the new order was received for Resident 6 to take 8.5 grams of polyethylene glycol daily, however, this seemed to inadvertently get input into Resident 6's MAR as a PRN medication. From 06/16/2026 through 07/22/2026, when Surveyors were onsite, there were no administrations of Resident 6's polyethylene glycol. In total, Resident 6 did not receive approximately 54 doses of his/her polyethylene glycol. On 07/31/2026, at approximately 2:00 p.m., Surveyor interviewed Administrator C regarding the above medication administration concerns. Administrator C reported s/he would look further into the issue and conduct staff training into the concerns. Cross Reference: N0431 83.38(1)(g) Health Monitoring	N 352		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their	N 389		

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N 389	Continued From page 10 involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that there was a change in Resident 6's individual service plan (ISP) when there were changes in his/her needs as related to use of a bed alarm for fall prevention and pressure offloading boots for the prevention of pressure wound injuries on his/her heels. This is a repeat deficiency. See Statement of Deficiencies (SOD) 3M3K12, dated 11/11/2025, SOD I87Y14, dated 08/03/2023, SOD I87Y13, dated 03/29/2023, and SOD I87Y11, dated 05/24/2022. Findings include: On 07/22/2026, Surveyors conducted an investigation which included allegations that resident care plans were not updated in accordance with their needs. On 07/22/2026, at approximately 9:43 a.m., Surveyor interviewed Caregiver G regarding Resident 6's needs. Caregiver G identified that Resident 6 recently had a wound on/near the heel of his/her foot that warranted home health wound care. Caregiver G reported that shortly after the wound developed, the use of pressure offloading boots were implemented for Resident 1 - on his/her right foot to help heal the pressure wound and on his/her left foot to help prevent any pressure wound onset. Caregiver G reported the boots were worn whenever Resident 6 was in bed, and the boots were still a current intervention	N 389		

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even though the right heel wound had since healed.

On 07/22/2026, Surveyor reviewed Resident 6's record. Resident 6 was admitted to the provider on 03/23/2026 with diagnoses including complete loss of vision, complete loss of bilateral ear hearing, lumbar back pain, and frequent falls. Resident 6 also had a diagnosis of a non-pressure chronic ulcer of his/her right heel and midfoot. An inpatient hospital discharge summary, dated 04/27/2026, documented that from 04/17/2026 - 04/27/2026 Resident 6 was hospitalized. The summary noted that during this hospitalization, Resident 6 experienced a witnessed fall that resulted in a scalp laceration, which was repaired with staples, and a hematoma. An incident report for Resident 6, dated 05/16/2026, identified an unwitnessed fall Resident 6 had out of bed. Staff documented they were alerted to the fall upon hearing Resident 6's bed alarm going off. Surveyor reviewed the most recent available ISP for Resident 6, dated 07/20/2026, which did not identify any bed alarm use information but identified that Resident 6 was a fall risk.

On 07/30/2026, Surveyor continued reviewing Resident 6's record. An inpatient hospital discharge summary, dated 06/15/2026, identified that s/he had been hospitalized from 06/12/2026 - 06/15/2026. The note also identified that one of the concerns being addressed during his/her hospitalization was his/her right heel pressure wound. The recommendation made by the authoring medical provider was for "off-loading boots when [s/he] is not walking or when in bed." A home health care medical provider order, dated 07/06/2026, then directed for Resident 6's boots to be used while s/he was in bed. A home health

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progress note, dated 07/30/2026, identified that Resident 6's right heel wound had been healed for the past 2 weeks and directed for Resident 6 to continue to use his/her protective boots when in bed. Surveyor again reviewed the same most recent ISP described above, which did not identify any information regarding Resident 6's pressure offloading boots.

On 07/30/2026, at approximately 10:58 a.m., Surveyor received a reply from Administrator C regarding an earlier inquiry into Resident 6's bed alarm use. Administrator C reported that Resident 6 had a bed alarm implemented due to his/her fall history prior to moving into the facility. That same day, Surveyor reviewed records provided by Administrator C, which included a durable medical equipment requisition order dated 04/03/2026 for a bed alarm.

At approximately 2:07 p.m., Surveyor interviewed Caregiver G regarding use of Resident 6's bed alarm. Caregiver G reported that staff used a bed alarm for Resident 6 whenever s/he was in bed.

At approximately 3:44 p.m., Surveyor interviewed Assistant Administrator D, who also confirmed that staff used a bed alarm for Resident 6 when s/he was in bed.

On 07/31/2026, at approximately 2:00 p.m., Surveyor interviewed Administrator C. Administrator C acknowledged Surveyor's concern that Resident 6's use of pressure offloading boots and a bed alarm were not documented in his/her ISP. Administrator C reported that since Surveyors had been on site, s/he updated the ISP to have this information included. On 07/31/2026, Surveyor reviewed the most current ISP provided by Administrator C,

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N 389	Continued From page 13 dated 07/31/2026, which included information regarding his/her bed alarm and pressure-offloading boot use.	N 389		
N 409	83.37(1)(j) Proof-of-use record. Proof-of-use record. The CBRF shall maintain a proof-of-use record for schedule II drugs, subject to 21 USC 812 (c), and Wisconsin ' s uniform controlled substances act, ch. 961, Stats, that contains the date and time administered, the resident ' s name, the practitioner ' s name, dose, signature of the person administering the dose, and the remaining balance of the drug. The administrator or designee shall audit, sign and date the proof-of-use records on a daily basis. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that a proof-of-use record was maintained for Resident 6's as needed (PRN) oxycodone tablets. Findings include: On 07/22/2026, Surveyor reviewed Resident 6's record. Resident 6 was admitted to the provider on 03/23/2026. Resident 6's medications included oxycodone HCl 5 mg tablets with instructions to, "Take 1 tablet by mouth every 8 hours as needed." The order was originally active as of 04/02/2026. On 07/23/2026, at approximately 10:51 a.m., Surveyor e-mailed Administrator C and requested the proof-of-use record for Resident 6's oxycodone from his/her admission up to the	N 409		

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current day. Surveyor then reviewed the record provided, which was titled "Medication Count Log..." The record showed issuances of Resident 6's oxycodone by staff, with a remaining count done, and showed counts when new tablets were added to the count. The record showed a total of 13 days' worth of entries, but did not show any other daily audits completed, signed, and dated by the administrator or his/her designee.

At approximately 11:55 a.m., Surveyor e-mailed Administrator C and asked if there were any documents showing staff doing routine counts of Resident 6's oxycodone. Surveyor confirmed that the record previously provided tracked only the addition and administration of oxycodone tablets. Surveyor requested any other count records be provided.

At approximately 12:20 p.m., Administrator C e-mailed Surveyor and reported, "In order to provide the specific oxycodone counts requested, I would need to generate individual reports for all three shifts for every day since the date of admission, which could honestly take days. Please note that narcotics are counted during each hand-off of the medication keys. The system is designed to alert us immediately if a count is not completed."

At approximately 12:58 p.m., Surveyor replied to Administrator C's e-mail and asked if there was a way to more easily produce the record and encouraged Administrator C to reach out to the provider's electronic record system company to see if there was a way to generate the record.

At approximately 1:14 p.m., Administrator C replied to Surveyor's e-mail and reported s/he e-mailed his/her contact from the provider's

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N 409	Continued From page 15 electronic record system company and was awaiting a response. On 07/30/2026, at approximately 2:03 p.m., Surveyor e-mailed Administrator C and asked if s/he was able to find a way to produce the daily narcotic medication auditing documentation. At approximately 2:24 p.m., Administrator C replied to Surveyor's e-mail and reported s/he had not received a response on how to run the report other than daily and that s/he sent a follow up e-mail to his/her contact. On 07/31/2026, at approximately 2:00 p.m., Surveyor interviewed Administrator C. Administrator C reported during the interview that s/he had just received a response from the provider's electronic record system company. Surveyor gave a deadline by the end of the day to receive additional records. At approximately 5:02 p.m., Administrator C e-mailed Surveyor and reported s/he was still having difficulties attempting to generate the report. Administrator C reported s/he was still in communication with the provider's electronic record system company to resolve the issues and would continue to troubleshoot the matter.	N 409		
N 431	83.38(1)(g) Health monitoring. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Health	N 431		

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monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure Resident 6's health was monitored in accordance with his/her needs related to constipation and a bowel regimen.

There was no established bowel regimen for Resident 6 despite him/her having been treated in the emergency department or hospital 3 times for constipation and 1 time in the emergency department for fecal impaction during his/her approximate 4-month admission with the provider. Staff interview indicated that follow-up action was to be taken after Resident 6 had 3 days without a bowel movement, although the specific follow-up action was inconsistent between the staff interviewed. Despite that, there were 5 periods that Resident 6 went more than 3

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days without a bowel movement, 4 of which included no evidence of any sort of follow-up actions taken by staff. For the remaining period, staff documented having administered 1 of his/her 2 as needed (PRN) medications directed for constipation, but documented that s/he continued to experience no bowel movement. There was no evidence for this period that staff attempted anything further to help address the issue.

This is a repeat deficiency. See Statement of Deficiencies (SOD) 3M3K12, dated 11/11/2025, SOD 3M3K11, dated 07/14/2025, SOD I87Y16, dated 07/02/2024, and SOD I87Y15, dated 01/10/2024.

Findings include:

On 07/30/2026, Surveyor reviewed Resident 6's record. Resident 6 was admitted to the provider on 03/23/2026 with diagnoses including constipation. Resident 6's medical records included:

- An after visit summary from Resident 6's admission to the emergency department on 04/14/2026 detailed that s/he had been seen in part due to constipation. The summary highlighted changes made to his/her already prescribed polyethylene glycol.

- Records detailing Resident 6's hospitalization from 04/17/2026 - 04/27/2026. The discharge summary, dated 04/27/2026, identified that Resident 6 had been admitted in part due to constipation, and in the "Hospital Course" section of the summary, that, "...Additional findings included a moderate to large colorectal stool burden..." The summary identified that, "Initial

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management included...and bowel regimen for constipation."

- An after visit summary from Resident 6's admission to the emergency department on 05/09/2026 detailed that s/he had been seen in part due to constipation and rectal fecal impaction, which was treated with magnesium citrate and an enema. The summary's "Instructions" section documented that, "Miralax should be given daily to avoid significant constipation." (Of note, MiraLAX is the brand name for polyethylene glycol.)

- Records detailing Resident 6's hospitalization from 06/12/2026 - 06/15/2026. The "Hospital Course" section of the discharge summary noted his/her chronic constipation and documented, "At discharge will schedule miralax but change to 8.5 gram pack qday..." In bold text the note then documented, "[Assisted living facility (ALF)] staff needs to continue to monitor and keep record of [bowel movements] given [his/her] tendency for constipation/impaction."

Surveyor reviewed 2 of 2 ISPs created for Resident 2 during his/her admission, including one dated 03/23/2026 and the most recent one completed 07/20/2026. Neither documented any information about his/her constipation/bowel movement management or bowel regimen needs. Resident 6's prescriptions included PRN polyethylene glycol, active from 04/17/2026 - 06/09/2026 with instructions to, "Dissolve 1 capful...and drink daily as needed for constipation." However, from 04/29/2026 through 06/08/2026, staff documented administering daily polyethylene glycol from a concurrent scheduled dose order. As of 06/09/2026, Resident's prescription changed such that s/he was directed

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to take polyethylene glycol on a scheduled daily basis. Resident 6 had another PRN medication for constipation - docusate sodium 100 mg tablets, active as of 04/03/2026, with instructions to, "Take 1 tablet by mouth daily as needed for constipation."

At approximately 2:07 p.m., Surveyor interviewed Caregiver G. When asked if there was a specific bowel movement protocol that staff followed if Resident 6 did not have regular bowel movements, Caregiver G replied that Resident 6 was to be administered a PRN bowel movement medication after 3 days of him/her having no bowel movement.

At approximately 3:44 p.m., Surveyor interviewed Assistant Administrator D. When asked if there was a specific bowel movement protocol that staff followed if Resident 6 did not have regular bowel movements, Assistant Administrator D replied that staff were to contact Resident 6's medical provider if Resident 6 did not have a bowel movement in 3 days. Assistant Administrator D reported that staff monitored and documented Resident 6's bowel movements in the task administration record (TAR).

Surveyor noted that the responses from Caregiver G and Assistant Administrator D were inconsistent with each other in terms of the follow-up actions staff were to take, and that neither of these courses of action were reflected in PRN medication prescription instructions or Resident 6's ISP.

Surveyor reviewed Resident 6's TARs throughout his/her admission, and identified the following 5 periods in which s/he was documented to have more than 3 days without a bowel movement:

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N 431	Continued From page 20 - 04/11/2026 through 04/17/2026 (7 days) (Of note, although staff documented having administered his/her PRN polyethylene glycol both on 04/15/2026 and 04/17/2026 with "some relief" documented as a result, staff continued to document s/he did not have a bowel movement on these days. There were no administrations of his/her PRN docusate sodium. On 04/14/2026, Resident 6 had been seen in the emergency department in part due to constipation, as described above. Resident 6 was treated in part for constipation during his/her hospitalization which began on 04/17/2026. It was during this hospitalization that documented findings included "moderate to large colorectal stool burden" as described above.) - 04/28/2026 through 05/04/2026 (7 days) (Of note, there were no administrations of his/her PRN docusate sodium. The TAR showed overall that in the 12-day period from 04/28/2026 through 05/09/2026, when Resident 6 went to the emergency department and was diagnosed with fecal impaction as described above, s/he only had 2 bowel movements - one on 05/05/2026 and one on 05/07/2026.) - 05/18/2026 through 05/21/2026 (4 days) (Of note, on 05/21/2026 at 9:17 p.m., staff documented it was "unknown" if Resident 6 had a bowel movement during that shift, but there was no evidence that staff took additional efforts to find out if Resident 6 had a bowel movement, i.e. asking him/her. Both Resident 6's previous and current ISP noted that s/he received "full assistance from staff" for toileting. There were no administrations of his/her PRN docusate sodium.) - 05/30/2026 through 06/02/2026 (4 days) (Of	N 431		

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note, on 06/01/2026 at 9:26 p.m., staff documented it was "unknown" if Resident 6 had a bowel movement during that shift, but there was no evidence that staff took additional efforts to find out if Resident 6 had a bowel movement, i.e. asking him/her. Both Resident 6's previous and current ISP noted that s/he received "full assistance from staff" for toileting. There were no administrations of his/her PRN docusate sodium.)

- 06/07/2026 through 06/10/2026 (4 days) (Of note, there were no administrations of his/her PRN docusate sodium.)

There was no evidence in Resident 6's record that his/her medical provider was notified of the above periods as per the reported protocol from Assistant Administrator D.

On 07/31/2026, at approximately 2:00 p.m., Surveyor interviewed Administrator C regarding the concern about the lack of established bowel movement protocol for Resident 6 in the context of his/her ongoing constipation and recent historical episode of fecal impaction. Administrator C reported that s/he would look further into the issue and conduct follow up staff training regarding the concern.

Cross Reference:
N0352 83.32(3)(h) Rights of Residents: Receive Medication