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	345356	A. BUILDING _____ B. WING _____	C 11/27/2019

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F 000	INITIAL COMMENTS A complaint investigation was conducted from 11/25/2019 through 11/26/2019. Event ID #JLC411. 1 of 6 allegations was substantiated resulting in a deficiency.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, staff and physician interview, the facility failed to identify a change in condition for 1 of 3 sampled residents who had been on antibiotics (Resident #1). The findings included: The Mayo Clinic "C-Diff Infection" says C-Diff is a bacterium that can cause symptoms ranging from diarrhea to life threatening inflammation of the colon and most commonly affects older adults in hospitals or in long term care facilities and typically occurs after the use of antibiotic medications. The most common symptoms of mild to moderate infection are watery diarrhea three or more times a day for 2 or more days and mild abdominal cramping and tenderness. Symptoms of severe infection include watery diarrhea 10-15 times per day with abdominal cramping and pain which may be severe, rapid	F 684	The plan for correcting this specific deficiency. Notification from survey team regarding deficiency was November 26, 2019. Resident was no longer in our center. A procedure of implementation an acceptable plan of correction. An audit was completed on all current resident's bowel movement records for residents with water stools. No residents met the SPICE guidelines. The audit was completed on November 30, 2019. On December 17, 2019 an all staff in-service will be held for staff education of the signs and symptoms of C-Diff per the SPICE guidelines. This will be presented by the Assistant Director of Nursing, the Antimicrobial Stewardship RN.	12/18/19

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

Electronically Signed | 12/16/2019

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.

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F 684	Continued From page 1 heart rate, nausea, loss of appetite and swollen abdomen. Web MD "What is C-Diff" notes the watery diarrhea of a person with C-Diff has a very strong, stinky odor and in more serious infections there may be blood in the stool. Review of the hospital records revealed Resident #1 presented to the Emergency Department (ED) from home on 9/16/19 with nausea, vomiting and diarrhea and was admitted to the hospital with pneumonia and sepsis and treated with antibiotics. The resident was discharged home on 9/19/19 and fell on the same day and returned to the ED where she was admitted back to the hospital with a fracture of her left distal femur. The resident completed her course of antibiotics for pneumonia while in the hospital and was discharged on 9/26/19. Resident #1 was admitted to the facility on 9/26/19 for rehabilitation and had diagnoses that included fracture of the left femur, post hemorrhagic anemia, rheumatoid arthritis and paroxysmal atrial tachycardia. A physician's note dated 9/26/19 revealed the following: Patient is here for rehab. Had a femur fracture, also had pneumonia. Some pain. Otherwise stable. Denies any acute issues. Physical exam revealed vital signs within normal limits. General appearance: No acute distress. Lungs clear to auscultation. Abdomen: soft, non-tender. Assessment/Plan: Monitor progress. There was a physician's order dated 9/27/19 for Lomotil (a medication for diarrhea) 2 milligrams (mg) by mouth as needed after each loose stool	F 684	The monitoring process to ensure that the plan of correction is effective and that specific deficiency remain corrected or in compliance. A daily audit of each current resident's bowel movement documentation in Point Click Care (medical record) will be done by nursing management. Any resident identified with three watery stools will have a stool culture done and follow the SPICE guidelines regarding results. Results will be shared with the charge nurses and aides on that unit. The audit will be done daily for 12 weeks to ensure compliance and will be signed off by the Director of Nursing or the Assistant Director of Nursing. Data results will be monitored and reviewed monthly by the monthly Infection Control committee. The results of the monthly Infection Control meeting will be present for review at the monthly Quality Assurance Process Improvement Committee for 3 months with subsequent plan of correction as needed. The Director of Nursing is responsible for overall compliance.	

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and was given on 9/27/19 at 2:57 PM. Review of the Medication Administration Record revealed the resident received 10 doses of Lomotil for loose stools while in the facility.

Review of the initial Care Plan dated 9/27/19 noted the following: Resident had a decline in activities of daily living (ADLs) due to a fracture with a goal to improve ADL function and physical therapy and occupational therapy was ordered. Provide prompt incontinence care.

The Admission Minimum Data Set (MDS) Assessment dated 9/30/19 revealed the resident was cognitively intact and required extensive assistance with bed mobility, transfers, dressing, toileting and bathing and was independent with eating with set-up help. The MDS noted the resident had no limitation in range of motion of the upper extremities and limited range of motion of the lower extremities on one side. The MDS revealed the resident was occasionally incontinent of urine and frequently incontinent of bowel.

The Care Area Assessment (CAA) for ADLs dated 9/30/19 noted the resident required limited to extensive assistance with most ADLs due to impaired mobility related to a fracture. She was alert and oriented and able to communicate her needs. She had a femur fracture and was non-weight bearing on the left leg.

A progress note by the social worker dated 9/30/19 revealed Resident #1 stated she had slight depression that was mainly due to the diarrhea she was suffering from when admitted to the facility.

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A nurse's note dated 10/3/19 noted the resident requested a medication for a loose stool and stated: "My stomach has been torn up all day."

A progress note by the social worker dated 10/7/19 revealed the resident reported the diarrhea was not a problem.

A physician ' s progress note dated 10/10/19 revealed the following for Resident #1: "She is doing better. She is getting rehab. Denies any acute issue. Pain is stable. No nausea, no vomiting. She did not have any other acute problem. She has occasional diarrhea, but not severe, no smell. No abdominal pain, no fever or chills. Otherwise, she has done good. General Appearance: No acute distress. Lungs: Clear. Abdomen: Non-tender. Alert and pleasant. Assessment/Plan: She appears to be stable. Monitor symptoms. Monitor diarrhea. Continue rehab."

Review of the Daily Skilled Documentation Evaluation Form revealed this assessment was performed daily on each shift by the nurse and revealed no vomiting. Abdomen was documented as soft and non-tender with bowel sounds in all 4 quadrants.
Review of the bowel record for Resident #1 noted the resident had loose stools on most days. It was documented the resident did not have a bowel movement (BM) at all on 10/2/19 or on 10/6/19 through 10/8/19.

On 11/25/19 an interview was conducted with Nursing Assistant (NA) #1. NA #1 stated the resident complained she had explosive diarrhea but when she changed her there would only be a small amount of liquid stool that did not have an

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unusual odor. The NA further stated she did not recall the resident having any complaints of nausea or abdominal pain.

An interview was conducted with NA #2 on 11/25/19 at 2:26 PM. NA #2 stated the resident did not have many bowel movements on her shift but did have a loose BM. The NA stated she had cared for a resident with Clostridium Difficile (C-Diff) and Resident #1 did not have that smell to her stool.

On 11/25/19 at 2:35 PM an interview was conducted with the weekend Nursing Supervisor who stated she also worked some during the week. The Nursing Supervisor stated Resident #1 had runny, frequent BMs and had recently been on antibiotics. The Nursing Supervisor further stated the resident ' s BMs had no foul odor and the resident had no abdominal pain or other symptoms of C-Diff. The Nursing Supervisor continued and stated she called the physician on 9/27/19 to obtain the order for Lomotil for the resident ' s loose stools.

On 11/25/19 at 3:08 PM an interview was conducted with NA #3. The NA stated when she was assigned to Resident #1 she would usually have one mushy BM on her shift but did not have a foul odor.

An interview was conducted with Nurse #1 on 11/25/19 at 3:19 PM. The Nurse stated in report it was passed on to her the resident had requested Lomotil. The Nurse further stated she did not recall the loose stools being an on-going thing and stated she might have mentioned during report if the diarrhea continued they might need to get a stool sample for C-Diff.

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An interview was conducted with Nurse #2 on 11/25/19 at 3:45 PM. The Nurse stated the hospital records noted the resident had diarrhea while in the hospital. The Nurse further stated she assisted the NA to change the resident on one occasion and the stool was not formed but was soft and had no odor.

On 11/25/19 at 3:58 PM an interview was conducted with the physician that cared for the resident while in the facility. The Physician stated he saw the resident on admission and one other time while she was in the facility. The Physician further stated she had occasional diarrhea with no blood, no smell and had no pain. The Physician continued and stated the resident barely complained of diarrhea to him. The Physician stated after the resident was discharged to the hospital, he received a call from the physician at the hospital that the resident tested positive for C-Diff.

An interview was conducted with NA #4 on 11/25/19 at 4:24 PM. The NA stated when she worked with the resident the resident would have one or two liquid, brown stools one of which was slimy with mucous and would sometimes be a small amount and sometimes a large amount. The NA stated she told Nurse #3 about the resident's stools.

An interview was conducted with Nurse #3 on 11/26/19 at 2:35 AM. The Nurse stated Resident #1 had loose stools and was on a medication for the loose stools and was not resolving so she conferred with another nurse and the resident's stools did not have the consistency or odor of C-Diff and the resident had no abdominal pain or

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cramping.

On 11/26/19 at 8:29 AM an interview was conducted with the Social Worker (SW). The SW stated when she interviewed the resident for the Mood section of the MDS during the initial care plan meeting the resident stated she had slight depression because of the diarrhea she had in the hospital and continued to have since admission here. The SW stated she did not recall the date but later asked the resident if she still had diarrhea and the resident and a family member stated the diarrhea was a little better but she still had some diarrhea.

On 11/26/19 at 8:36 AM an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated she never saw the family until 10/14/19, the day the resident was discharged to the hospital. The ADON stated on that day a family member came up to her and stated the resident was not feeling well so she walked down to the resident ' s room with the family member. The ADON continued and stated when they reached the room the family member told her the resident had been having diarrhea since she was admitted here. The ADON stated a NA was in the room at that time and she asked the NA what the resident's stools were like and the NA told her the resident had just had a loose stool but her stools had not been liquid like the one she just had. The ADON continued and stated the NA told her the resident had been having a little blob of stool that looked like pudding. The ADON stated she looked at the stool in the bed pan at that time and was a very small amount of liquid stool that did not have a foul odor and no blood was observed. The ADON stated the resident was alert and oriented to

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person, place, time and situation but was not very conversational and she had to pry information out of the resident. The ADON stated she asked the resident what she wanted to do and the resident stated she wanted to go to the hospital. The NA referred to by the ADON no longer worked at the facility and attempts to contact the NA were unsuccessful.

On 11/26/19 at 8:53 AM an interview was conducted with the Director of Nursing (DON) who stated the resident came to the facility from the hospital where she had loose stools. The DON stated she had no complaints from the family while the resident was in the facility and there was no discussion in their morning meetings regarding the resident ' s loose stools.

On 11/26/19 at 2:15 PM an interview was conducted with the infection control nurse who stated she started working in the facility the middle of September 2019. The Nurse further stated there had not been any residents with C-Diff in the facility except for Resident #1 who was diagnosed after her discharge to the hospital on 10/14/19.

On 11/27/19 at 1:30 PM the Administrator stated in an interview she felt the resident ' s bowel movements had no odor and the staff would not have suspected the resident had C-Diff.