STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345258	A. BUILDING _____ B. WING _____	C 04/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSITIONAL HEALTH SERVICES OF KANNAPOLIS	1810 CONCORD LAKE ROAD KANNAPOLIS, NC 28083

(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) COMPLETION DATE
F 000	INITIAL COMMENTS The survey team entered the facility on 04/03/2017 to conduct a revisit and complaint survey and exited on 04/04/2017. Additional information was obtained on 04/06/2017 and 04/07/2017. Therefore, the exit date was changed to 04/07/2017.	F 000		
F 157 SS=G	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that	F 157		5/2/17

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

Electronically Signed | 04/27/2017

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F 157	Continued From page 1 all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and physician interviews, the facility failed to notify the physician of the resident ' s change in condition when a resident experienced daily diarrhea, resulting in a delay of treatment of a bacterial infection, acute on chronic renal failure and a hospitalization for 1 of 3 residents (Resident #1.) Findings included: Resident #1 was admitted on 1/25/17 for rehabilitation after a hip fracture surgery. The resident had the diagnoses of femur fracture and chronic kidney disease stage III. The admission minimum data set dated 1/30/17 revealed the resident was cognitively intact and required extensive assistance of one staff member with activities of daily living.	F 157	F 157 SS=G Notify of Changes 1. Resident #1 was transferred to the hospital and discharged from the facility on 3/10/17. 2. On 4/28/17, the Director of Clinical Services (DCS) and or registered nurse designee completed a quality improvement monitoring of 93 current residents to identify residents with a change in condition including any episodes of diarrhea/loose stools, vomiting, decreased urinary output or decreased fluid intake to validate that the residents' physician and/or nurse practitioner (NP) and responsible party (RP) were notified of these changes. The physician and/or NP and RP received notification of any residents identified. 3. By 5/2/17, the DCS and/or registered	

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A review of the bowel movement log revealed Resident #1 started having diarrhea on 2/24/17 and had one or more loose bowel movements per day until 3/9/17, with the exception of 3/3/17 she received Imodium and there was a formed stool. The bowel movements were loose and no other description was provided.

02/24/2017	8:28 PM	BM large	Loose
02/25/2017	11:22 AM	BM medium	Formed
02/25/2017	9:24 PM	BM small	Loose
02/25/2017	11:37 PM	BM large	Loose
02/26/2017	1:27 PM	BM extra large	Loose
02/27/2017	1:25 PM	BM large	Loose
02/27/2017	6:32 PM	BM small	Loose
02/28/2017	8:45 AM	BM large	Loose
02/28/2017	11:43 AM	BM extra large	Loose
03/01/2017	12:52 PM	BM large	Loose
03/01/2017	8:41 PM	BM small	Loose
03/02/2017	12:04 AM	BM small	Loose
03/02/2017	9:07 AM	BM extra large	Loose
03/02/2017	8:17 PM	BM small	Loose
03/02/2017	11:41 PM	BM large	Loose
03/03/2017	1:14 PM	BM medium	Formed
03/03/2017	9:36 PM	BM small	Loose
03/03/2017	11:23 PM	BM large	Loose
03/04/2017	9:01 PM	BM small	Loose
03/05/2017	9:35 PM	BM large	Loose
03/06/2017	12:39 PM	BM extra large	Loose
03/06/2017	6:03 PM	BM large	Loose
03/07/2017	11:16 AM	BM medium	Loose
03/07/2017	4:46 PM	BM small	Loose
03/08/2017	1:46 PM	BM extra large	Loose
03/08/2017	6:24 PM	BM small	Loose
03/08/2017	11:42 PM	BM large	Loose
03/09/2017	11:58 PM	BM extra large	Loose

A progress note dated 2/27/17 revealed the Nurse Practitioner (NP) saw the resident for loose

nurse designee completed reeducation to licensed nurses and nursing assistants on regulation 483.10(g)(14) regarding timely notification of changes in residents' condition to prevent a delay of a new diagnosis and treatment and Consulate policy N-105 "Change in Resident Condition". Education included the expectation of the licensed nurse to notify the residents' physician and/or NP and RP when a resident exhibits a change in condition including any episodes of diarrhea/loose stool, vomiting, decreased urinary output or fluid intake and to document this notification on an SBAR (Situation Back ground Assessment and Review and notification) tool in the residents' medical record. Newly hired licensed nurses and nursing assistants to be educated upon hire.

The licensed nurse to notify the residents' physician and/or NP and RP when a resident exhibits a change in condition including any episodes of diarrhea/loose stool, vomiting, decreased urinary output or fluid intake and to document this notification on an SBAR (Situation Back ground Assessment and Review and notification) tool in the residents' medical record. The licensed nurse supervisor to review SBARs, Stop and Watch Tools, 24 hour reports, Bowel and Bladder Care Tracker reports and nursing shift reports daily and the DCS and IDT (Interdisciplinary Team) to monitor for compliance during the morning clinical meeting Mondays-Fridays to ensure compliance with physician and/or NP and RP notification of residents

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F 157	Continued From page 3 stools that had progressively become more frequent. The note indicated the staff was concerned for C-Difficile infection. The NP noted Resident #1 was on Citrucel and Metamucil for constipation and ordered C-Difficile stool culture and Imodium 4 milligrams (mg) every 6 hours as needed for loose stools. A review of the nurse practitioner ' s order dated 2/27/17 revealed a stool culture for C-Difficile and Imodium 4 mg every 6 hours as needed for diarrhea. A review of the nurses ' notes from 2/27/17 to 3/10/17 revealed the resident had no changes in condition documented, and there was no notation of increase in bowel movements or diarrhea. Nurses ' notes indicated the blood pressure and pulse were stable and within normal limits. A review of the medication administration record (MAR) for 2/27/17 to 3/10/17 revealed the 2/27/17 order for C-Difficile stool sample was added to the MAR, but had no initials for being completed. A progress note dated 3/8/17 revealed the NP saw the resident for diarrhea. The NP re-ordered C-Difficile stool culture and the resident was treated with Imodium 4 mg every 6 hours as needed for loose stools. The resident had a blood pressure of 122/80, a pulse of 86, temperature of 98 F and was in no distress. The labs were reviewed and the creatinine was at baseline. The resident complained of dizziness and the NP planned orthostatic blood pressures. A review of the nurse practitioner ' s order dated 3/8/17 revealed a stool culture for C-Difficile, to assess orthostatic blood pressure for three days,	F 157	who exhibit changes in condition to maintain hydration and health. 4. The DCS/registered nurse designee to conduct quality improvement monitoring of 5 residents' medical record to ensure that the residents' physician and/or NP and RP was promptly notified of changes in condition including any episodes of diarrhea/loose stool, vomiting, decreased urinary output or decreased fluid intake at a frequency of daily for 4 weeks, then 3 times a week for 8 weeks, then 1 time a month . Frequency of monitoring to be modified based on findings. The results of quality improvement monitoring to be reported to the Quality Assurance Performance Improvement Committee monthly by the Administrator and/or DCS. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the monitoring/observation tools for making changes to the corrective action if necessary to maintain substantial compliance and ensure timely physician and/or NP notification of changes in residents' condition to prevent a delay of a new diagnosis and treatment. The Quality Assurance Improvement Committee members consist of, but not limited to, the Administrator, Director of Clinical Services, Medical Director (quarterly at a minimum) and at least three other members to include but not limited to one direct care giver. AOC date: 5/2/17	

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and to discontinue the Citrucel 500 milligrams each day and the Metamucil 6 grams each day.

A review of the physician ' s order dated 3/8/17 revealed normal saline intravenous fluid at 125 cc (cubic centimeters) per hour for one liter.

A progress note dated 3/9/17 indicated the NP saw the resident for an abnormal lab result of creatinine 5.85 (normal range 0.6 - 1.3). The resident ' s blood pressure was 140/70 and pulse 80. The same progress note further revealed the assessment was acute kidney injury on chronic kidney disease from dehydration. The resident was started on intravenous fluids at 125 cubic centimeters (cc) per hour. The nephrologist ordered a stat (urgent) renal ultrasound for today and repeat the basic metabolic panel (BMP) tomorrow.
A review of the physician ' s order dated 3/9/17 revealed an additional order for normal saline intravenous fluid at 125 cc per hour for one liter and to repeat the BMP lab.

A review of Resident #1 ' s laboratory results for a stool culture of C-difficile collected on 3/9/17 revealed the stool was positive for C-difficile on 3/13/17.

A review of the physician ' s order dated 3/10/17 stated to send Resident #1 to the emergency room for an evaluation of the dehydration.

The NP indicated in a progress note dated 3/10/17 she saw the resident for elevated white blood cell count (WBC). The resident ' s blood pressure was 106/60 and pulse 62. The assessment was worsening kidney function and elevated WBC. The resident had acute kidney

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F 157	Continued From page 5	F 157		

injury due to diarrhea. The NP sent the resident to the emergency room for evaluation.

Resident #1 was admitted to the hospital on 3/10/17 and the hospital history and physical was reviewed. The hospital course documented Resident #1 had C-Difficile colitis and acute renal failure in the setting of a generalized debilitated state and moderate malnutrition. The resident was seen by her nephrologist and was treated with Flagyl (antibiotic) and IV fluids. The resident had a two-week history of diarrhea with weakness. The discharge summary revealed diagnoses were nonoliguric (body was unable to stop urinating when dehydrated), acute kidney injury on chronic kidney disease, C-Difficile colitis, leukocytosis (elevated white blood cells), anemia, hypocalcemia (low calcium), and metabolic acidosis (body was too acidic to function, must be treated or can be fatal). The resident received aggressive IV fluid resuscitation for acute dehydration. At the time of the hospital discharge on 3/22/17, the resident ' s creatinine returned to baseline.

On 4/3/17 at 4:50 pm an interview was conducted with the NP. The NP stated that on 2/27/17 she was informed by staff Resident #1 was having loose stools, but not every day. The NP stated that she asked the resident about her diarrhea and was informed the diarrhea was every day. The NP ordered the C-Difficile stool culture on 2/27/17 for the resident ' s diarrhea. When the NP asked the staff for the results of the C-difficile test on 3/6/17, the NP was informed the results were pending. The NP stated she did not write any new orders to complete a stool for C-Difficile, but was waiting for the C-Difficile results from 2/27/17. The NP stated she was not aware until

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3/8/17 that the stool culture had not been done. The NP stated that her expectation was for staff to follow orders as written and to notify her of any changes. The resident was sent to the emergency room on 3/10/17 and was referred to her nephrologist while she was hospitalized.

On 4/4/17 at 8:40 am an interview was conducted with the Director of Nursing (DON). The DON stated that she expected staff to follow physician ' s orders. The DON also stated that the nursing staff was educated regarding the lab process and to contact the physician or NP if the resident had a change in condition.

On 4/4/17 at 9:00 am an interview was conducted with Nursing Assistant (NA) #1. NA #1 stated that the resident had 4 to 6 loose bowel movements on day shift for over a week leading up to the hospitalization. NA #1 stated she reported to the nurse that Resident #1 had multiple bowel movements.

An additional interview was conducted on 4/6/17 at 2:02 pm via telephone with NA #1. NA #1 stated that the diarrhea was more than once a day and frequency was not documented because she did not have time to document and provide resident care. NA #1 stated that the diarrhea was liquid with mucous and foul smelling. She informed the nurse on duty at least once a shift over 10 days the resident had diarrhea. NA #1 stated that the resident was tired and commented that everything she eats goes right through her. The resident also had a decrease in appetite. NA #1 stated that she discussed the resident ' s diarrhea with the NP on 3/8/17.

An interview was conducted on 4/6/17 at 3:40 pm

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F 157	Continued From page 7 via telephone with the resident ' s physician. The physician stated he remembered Resident #1 and had reviewed the records when the stool culture was missed as part of quality review. The physician explained he was informed by the facility that the order for C-Difficile stool sample on 2/27/27 was missed. The physician stated he was informed by his NP that the resident had one loose stool a day. The resident did not present with a C-Difficile infection because the facility staff informed the NP that Resident #1 had one bowel movement a day. On 4/7/17 at 11:40 am an interview was conducted via telephone with Nurse #4. Nurse #4 stated that she remembered Resident #1 and was on duty 3/3/17 for day shift. Resident #1 had two loose stools on day shift and that she administered Imodium once at 10:00 AM per the resident ' s request. Nurse #4 stated she did not have a concern for dehydration because the resident was drinking fluids and there was no further diarrhea after the resident received the Imodium. Nurse #4 stated she would inform the physician if a resident had repeated need for an as needed medication or concerns regarding diarrhea.	F 157		
F 281 SS=G	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced	F 281		4/27/17

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F 281	Continued From page 8	F 281	Past noncompliance: no plan of correction required.	

by:
Based on record review, staff interviews and physician interviews, the facility failed to complete a lab order for a stool culture for a bacterial infection (Clostridium difficile) resulting in a delay of diagnosis and treatment which caused the resident to become dehydrated and to develop acute renal failure for 1 of 3 residents (Resident #1.)

Findings included:
Resident #1 was admitted on 1/25/17 for rehabilitation after a hip fracture surgery. The resident had the diagnoses of femur fracture and chronic kidney disease stage III.

The admission minimum data set for Resident #1 dated 1/30/17 revealed the resident was cognitively intact and required extensive assistance of one staff member with activities of daily living. The resident was continent of bowel and occasionally incontinent of urine.

A review of the bowel movement log revealed Resident #1 started having diarrhea on 2/24/17 and had one or more loose bowel movements per day until 3/9/17, with the exception of 3/3/17 when she received Imodium and there was a formed stool. The bowel movements were loose and no other description was provided.

A progress note dated 2/27/17 revealed the Nurse Practitioner (NP) saw the resident for loose stools that had progressively become more frequent. The note indicated the staff was concerned for C-Difficile infection. The NP noted Resident #1 was on Citrucel and Metamucil for constipation and ordered C-Difficile stool culture and Imodium 4 milligrams (mg) every 6 hours as

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F 281	Continued From page 9	F 281		

needed for loose stools.

A review of the nurse practitioner ' s order dated 2/27/17 revealed a stool culture for C-Difficile and Imodium 4 mg every 6 hours as needed for diarrhea.

A review of the medication administration record (MAR) for 2/27/17 to 3/10/17 revealed the 2/27/17 order for C-Difficile stool sample was added to the MAR, but had no initials for being completed.

A review of Resident #1 ' s laboratory results from 2/27/17 through 3/8/17 revealed there was no laboratory result present for a stool culture for C-Difficile, which was ordered on 2/27/17.

A review of the laboratory results of the resident ' s creatinine dated 3/7/17 revealed the creatinine (kidney function) result was 5.85 (normal range 0.6 - 1.3) and the blood urea nitrogen (BUN) [shows hydration] result was 33 (normal range 3-25). The resident ' s baseline creatinine was 1.6.

A progress note dated 3/8/17 revealed the NP saw the resident for diarrhea. The NP re-ordered C-Difficile stool culture and the resident was treated with Imodium 4 mg every 6 hours as needed for loose stools. The resident had a blood pressure of 122/80, a pulse of 86, temperature of 98 F and was in no distress. The labs were reviewed and the creatinine was at baseline. The resident complained of dizziness and the NP planned orthostatic blood pressures.

A review of the nurse practitioner ' s order dated 3/8/17 revealed a stool culture for C-Difficile, to assess orthostatic blood pressure for three days,

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and to discontinue the Citrucel 500 milligrams each day and the Metamucil 6 grams each day.

A progress note dated 3/9/17 indicated the NP saw the resident for an abnormal lab result of creatinine 5.85 (normal range 0.6 - 1.3). The resident ' s blood pressure was 140/70 and pulse 80. The same progress note further revealed the assessment showed an acute kidney injury on chronic kidney disease from dehydration. The resident was started on intravenous fluids at 125 cubic centimeters (cc) per hour. The nephrologist ordered a stat (urgent) renal ultrasound for today and repeat the basic metabolic panel (BMP) tomorrow.

A review of the physician ' s order dated 3/9/17 revealed an additional order for normal saline intravenous fluid at 125 cc per hour for one liter and to repeat the BMP lab.

A review of Resident #1 ' s laboratory results for a stool culture of C-difficile collected on 3/9/17 revealed the stool was positive for C-difficile on 3/13/17. Laboratory results of the resident ' s creatinine (kidney function) dated 3/10/17 was 9.61 (normal range 0.6 - 1.3). The blood urea nitrogen (BUN) [shows hydration] result was 55 on 3/10/17 (normal range 3-25). The resident ' s baseline creatinine was 1.6.

A review of the physician ' s order dated 3/10/17 stated to send Resident #1 to the emergency room for an evaluation of the elevated creatinine and BUN.

The NP indicated in a progress note dated 3/10/17 she saw the resident for elevated white blood cell count (WBC). The resident ' s blood

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pressure was 106/60 and pulse 62. The assessment was worsening kidney function and elevated WBC. The lab result showed a creatinine of 9.61 and a BUN 55. The resident had acute kidney injury due to diarrhea (kidney became injured due to a lack of blood flow). The NP sent the resident to the emergency room for evaluation.

Resident #1 was admitted to the hospital on 3/10/17 and the hospital history and physical was reviewed. The hospital course documented Resident #1 had C-Difficile colitis and acute renal failure in the setting of a generalized debilitated state and moderate malnutrition. The resident was seen by her nephrologist and was treated with Flagyl (antibiotics) and IV fluids. The resident had a two-week history of diarrhea with weakness. The resident ' s creatinine increased to 9.7. The discharge summary revealed diagnoses were nonoliguric (body was unable to stop urinating when dehydrated), acute kidney injury on chronic kidney disease, C-Difficile colitis, leukocytosis (elevated white blood cells), anemia, hypocalcemia (low calcium), and metabolic acidosis (body was too acidic to function, must be treated or can be fatal). The resident received aggressive IV fluid resuscitation for acute dehydration and sodium bicarbonate for acidosis. At the time of the hospital discharge on 3/22/17, the resident ' s creatinine returned to baseline at 1.6.

Resident #1 was not interviewed because she had been discharged at the time of the site visit.

On 4/3/17 at 4:50 pm an interview was conducted with the NP. The NP stated that on 2/27/17 she was informed by staff Resident #1 was having

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loose stools, but not every day. The NP stated that she asked the resident about her diarrhea and was informed the diarrhea was every day. The NP ordered the C-Difficile stool culture on 2/27/17 for the resident ' s diarrhea. When the NP asked the staff for the results of the ordered C-difficile test on 3/6/17, the NP was informed the results were pending. The NP stated she did not write any new orders to complete a stool for C-Difficile, but was waiting for the C-Difficile results from 2/27/17. The NP stated she was not aware until 3/8/17 that the stool culture had not been done. The NP stated that she contacted the resident ' s nephrologist on 3/9/17 regarding the resident ' s elevated creatinine, and the nephrologist ordered a stat (immediate) ultra sound of the kidneys. The NP stated that the physician ordered on 3/8/17 for the resident to go to the ER. The NP thought that the resident was to go for an evaluation of the elevated creatinine of 5.85, but instead the resident went to the ER to have an IV placed. The NP stated that her expectation was for staff to follow orders as written. The NP stated that the physicians and NPs now have direct access to the lab results on-line to improve follow up.

The NP further stated the increased creatinine lab result was related to acute injury to the kidney from dehydration secondary to diarrhea. The NP stated that another creatinine lab level was completed on 3/10/17 and it had increased to 9.6, and it had not improved after Resident #1 received intravenous fluids. The resident was sent to the emergency room on 3/10/17 and was referred to her nephrologist while she was hospitalized.

On 4/4/17 at 8:40 am an interview was conducted

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with the Director of Nursing (DON). The DON stated that she expected staff to follow physician ' s orders.

On 4/4/17 at 10:30 am an additional interview was conducted with the DON. The DON stated a root cause analysis was conducted for the missed C-difficile lab order dated 2/27/17. The DON stated that the error was investigated, education was provided for all staff that was responsible for lab process, a quality improvement/quality assurance summary was documented, there was a QAPI (quality assurance performance improvement) meeting, which included the medical director, and a prospective review of lab orders and the process was performed. The four-point plan of correction was completed. An audit revealed no other missed labs at the time of the incident and no other missed labs since the incident to date.

The four-point plan of correction was reviewed and all components were present on 3/31/17.

An additional interview was conducted on 4/6/17 at 2:02 pm via telephone with NA #1. NA #1 stated that she discussed the resident ' s diarrhea with the NP and a culture was ordered, and NA #1 collected that specimen.

An interview was conducted on 4/6/17 at 3:40 pm via telephone with the resident ' s physician. The physician stated he had reviewed the records when the stool culture was missed as part of quality review. The physician explained he was informed by the facility that the order for C-Difficile stool sample on 2/27/27 was missed.

The facility provided its plan of action on 4/4/17 at

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11:00 am. A review of the plan of action dated 3/9/17 for the incident revealed Resident #1 had a missed physician order for C-Difficile laboratory dated 2/27/17. On 3/8/17 the management team created an error report and on 3/9/17 a retrospective laboratory process audit going back to 2/27/17 was performed. On 3/10/17 a Quality Assurance/Performance Improvement committee meeting was held and a root cause analysis was performed. The error was determined that the C-Difficile stool culture was not placed into the laboratory vendor ' s electronic system. On 3/8/17 the management team put in place an audit of all laboratory orders and the process for three times a week for 30 days and each week thereafter. The Consultant Nurse reviewed the laboratory error report, plan of action documentation, education in-service attendance record, and prospective/ongoing audits. No other laboratory errors were identified.

Further review of the plan of action showed in-servicing of all nursing staff of the laboratory process and follow up was completed on 3/9/17. The documentation showed audits were performed on 3/9/17, 3/10/17, 3/13/17, 3/15/17, 3/17/17, 3/20/17, 3/22/17, 3/24/17, 3/27/17, 3/29/17, and 3/31/17, and there were no further laboratory processing errors. Sign-in sheets for in-services were reviewed and interviews with the staff revealed they were aware of the process for timely completion of laboratory orders.

An interview was conducted on 4/6/17 at 2:10 pm via telephone with Nurse #2. Nurse #2 stated the expected laboratory process was that the laboratory vendor would draw or retrieve a specimen the day after it was ordered and placed in their system, unless the request was for urgent

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F 281	Continued From page 15 (stat). Nurse #2 stated the process as follows: order received; order placed in E-lab (electronic access to laboratory vendor); lab to be drawn is placed in the nurses ' station lab log book; laboratory staff come to the facility to draw the blood or receive the specimen; the lab result is placed in E-lab; and a reminder to check for lab result is placed in the medication administration record. Nurse #2 stated that all orders have a three piece carbon and the gold piece is reconciled each day to ascertain that the order was followed. Nurse #2 also stated that the vendor provided lab services and results on the weekend, and the staff retrieved the results from the vendor ' s website.	F 281		
F 309 SS=G	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 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, including but not limited to the following:	F 309		5/2/17

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F 309	Continued From page 16 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and physician interviews, the facility failed to recognize and to assess for a change in condition when a resident experienced daily diarrhea, resulting in a delay of a diagnosis and treatment of a bacterial infection (Clostridium difficile), for 1 of 3 residents (Resident #1.) Findings include: Resident #1 was admitted on 1/25/17 for rehabilitation after a hip fracture surgery. The resident had the diagnoses of femur fracture and chronic kidney disease stage III. The resident had a care plan dated 1/25/17 for potential imbalance of nutrition and hydration. The admission minimum data set dated 1/30/17 revealed the resident was cognitively intact and required extensive assistance of one staff member with activities of daily living. A review of the bowel movement log revealed Resident #1 started having diarrhea on 2/24/17	F 309	F309 SS=G QOC r/t recognizing and assessing changes in condition r/t diarrhea 1. Resident #1 was transferred to the hospital and discharged from the facility on 3/10/17. 2. On 4/28/17, the Director of Clinical Services (DCS) and or Registered Nurse designee completed a quality improvement monitoring of 93 current residents to identify residents with a change in condition including any episodes of diarrhea/loose stools, vomiting, decreased urinary output or decreased fluid intake to validate that the licensed nurse recognized and assessed the change in condition and documented finding in the residents' medical record. Any identified residents to be assessed by the licensed nurse until condition resolves to maintain hydration and health. 3. By 5/2/17, the DCS and/or registered	

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and had one or more loose bowel movements per day until 3/9/17, with the exception of 3/3/17 she received Imodium and there was a formed stool. The bowel movements were loose and no other description was provided.

02/24/2017	8:28 PM	BM large	Loose
02/25/2017	11:22 AM	BM medium	Formed
02/25/2017	9:24 PM	BM small	Loose
02/25/2017	11:37 PM	BM large	Loose
02/26/2017	1:27 PM	BM extra large	Loose
02/27/2017	1:25 PM	BM large	Loose
02/27/2017	6:32 PM	BM small	Loose
02/28/2017	8:45 AM	BM large	Loose
02/28/2017	11:43 AM	BM extra large	Loose
03/01/2017	12:52 PM	BM large	Loose
03/01/2017	8:41 PM	BM small	Loose
03/02/2017	12:04 AM	BM small	Loose
03/02/2017	9:07 AM	BM extra large	Loose
03/02/2017	8:17 PM	BM small	Loose
03/02/2017	11:41 PM	BM large	Loose
03/03/2017	1:14 PM	BM medium	Formed
03/03/2017	9:36 PM	BM small	Loose
03/03/2017	11:23 PM	BM large	Loose
03/04/2017	9:01 PM	BM small	Loose
03/05/2017	9:35 PM	BM large	Loose
03/06/2017	12:39 PM	BM extra large	Loose
03/06/2017	6:03 PM	BM large	Loose
03/07/2017	11:16 AM	BM medium	Loose
03/07/2017	4:46 PM	BM small	Loose
03/08/2017	1:46 PM	BM extra large	Loose
03/08/2017	6:24 PM	BM small	Loose
03/08/2017	11:42 PM	BM large	Loose
03/09/2017	11:58 PM	BM extra large	Loose

A progress note dated 2/27/17 revealed the Nurse Practitioner (NP) saw the resident for loose stools that had progressively become more frequent. The note indicated the staff was

nurse designee completed reeducation to licensed nurses and nursing assistants on regulation 483.24, 483.25(k)(l) regarding providing the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, consistent with the residents' comprehensive assessment and plan of care. Education also included Consulate policy N-105 "Change in Condition" and N-107 "Change of Shift Report", Consulate Best Practices "24-Hour Report" and "Daily Clinical Meeting" and Interact tools "Stop and Watch", "SBAR" and "Care Path for Dehydration" regarding the expectation of the licensed nurse to recognize and assess a resident when he/she exhibits a change in condition including any episodes of diarrhea/loose stool, vomiting, decreased urinary output or decreased fluid intake to prevent dehydration. Newly hired licensed nurses and nursing assistants to be educated upon hire.

The licensed nurse and nursing assistant will monitor residents for a change in condition including any episodes of diarrhea/loose stool, vomiting, decreased urinary output or decreased fluid intake. The nursing assistant will document observed changes in resident condition utilizing the "Stop and Watch" tool and will document diarrhea episodes in Care Tracker as indicated and communicate to the licensed nurse for further assessment and intervention. The licensed nurse to assess residents for changes in condition and dehydration risk as appropriate, notify physician and/or NP

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F 309	Continued From page 18 concerned for C-Difficile infection. The NP noted Resident #1 was on Citrucel and Metamucil for constipation and ordered C-Difficile stool culture and Imodium 4 milligrams (mg) every 6 hours as needed for loose stools. A review of the nurse practitioner ' s order dated 2/27/17 revealed a stool culture for C-Difficile and Imodium 4 mg every 6 hours as needed for diarrhea. A review of the nurses ' notes from 2/27/17 to 3/10/17 revealed the resident had no changes in condition documented, and there was no notation of increase in bowel movements or diarrhea. Nurses ' notes indicated the blood pressure and pulse were stable and within normal limits. A review of the medication administration record (MAR) for 2/27/17 to 3/10/17 revealed the 2/27/17 order for C-Difficile stool sample was added to the MAR, but had no initials for being completed. Resident #1 received Imodium on 2/27/17, 2/28/17 at 6:00 am, 3/3/17 at 10:00 am, and 3/5/17. No documentation of the results/response was present on the MAR. A review of the basic metabolic panel (BMP) laboratory result revealed Resident #1 ' s average baseline creatinine (kidney function) dated 3/1/17 was 1.6 (normal range 0.6 - 1.3). The resident had a weekly BMP to evaluate the kidney function, hydration, and electrolyte level. A review of the laboratory results of the resident ' s creatinine dated 3/7/17 revealed the creatinine result was 5.85 and the blood urea nitrogen (BUN) [shows hydration] result was 33 (normal range 3-25).	F 309	and RP, obtain and complete new orders as indicated and continue to monitor residents' response to treatment until resolved. The licensed nurse to document their initial clinical assessment of residents change in condition on the SBAR (Situation Back ground Assessment and Review and notification) tool in the residents' medical record and in nurses notes within the medical record until condition resolved. Communicate to be noted on the 24 hour report and verbalized during change of shift report to ensure continued monitoring and assessment of residents' change in condition. The licensed nurse supervisor to review SBARs, Stop and Watch Tools, 24 hour reports, Bowel and Bladder Care Tracker reports and nursing shift reports daily and the DCS and IDT (Interdisciplinary Team) to monitor for compliance during the morning clinical meeting Mondays-Fridays to ensure residents who exhibit changes in condition are recognized, assessed and treated effectively to prevent dehydration. 4. The DCS/registered nurse designee to conduct quality improvement monitoring of 5 residents' medical record to ensure that residents with a change in condition including episodes of diarrhea/loose stool, vomiting, decreased urinary output or decreased fluid intake are recognized, assessed and treated effectively to prevent dehydration at a frequency of daily for 4 weeks, then 3 times a week for 8 weeks, then 1 time a month.. Frequency of quality monitoring to be modified based on findings.	

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F 309	Continued From page 19 A progress note dated 3/8/17 revealed the NP saw the resident for diarrhea. The NP re-ordered C-Difficile stool culture and the resident was treated with Imodium 4 mg every 6 hours as needed for loose stools. The resident had a blood pressure of 122/80, a pulse of 86, temperature of 98 F and was in no distress. The labs were reviewed and the creatinine was at baseline. The resident complained of dizziness and the NP planned orthostatic blood pressures. A review of the nurse practitioner ' s order dated 3/8/17 revealed a stool culture for C-Difficile, to assess orthostatic blood pressure for three days, and to discontinue the Citrucel 500 milligrams each day and the Metamucil 6 grams each day. A review of the physician ' s order dated 3/8/17 revealed normal saline intravenous fluid at 125 cc (cubic centimeters) per hour for one liter. A review of the physician ' s order dated 3/8/17 stated to send the resident to the emergency room to have an intravenous catheter placed. A progress note dated 3/9/17 indicated the NP saw the resident for an abnormal lab result of creatinine 5.85 (normal range 0.6 - 1.3). The resident ' s blood pressure was 140/70 and pulse 80. The same progress note further revealed the assessment was acute kidney injury on chronic kidney disease from dehydration. The resident was started on intravenous fluids at 125 cubic centimeters (cc) per hour. The nephrologist ordered a stat (urgent) renal ultrasound for today and repeat the basic metabolic panel (BMP) tomorrow. A review of the physician ' s order dated 3/9/17	F 309	The results of quality improvement monitoring to be reported to the Quality Assurance Performance Improvement Committee monthly by the Administrator and/or DCS. The Quality Assurance Performance Improvement Committee to evaluate the effectiveness of the monitoring/observation tools for making changes to the corrective action if necessary to maintain substantial compliance and provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, consistent with the residents' comprehensive assessment and plan of care. The Quality Assurance Improvement Committee members consist of, but not limited to, the Administrator, Director of Clinical Services, Medical Director (quarterly at a minimum) and at least three other members to include but not limited to one direct care giver.. AOC date: 5/2/17	

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revealed an additional order for normal saline intravenous fluid at 125 cc per hour for one liter and to repeat the BMP lab.

A review of Resident #1 ' s laboratory results for a stool culture of C-difficile collected on 3/9/17 revealed the stool was positive for C-difficile on 3/13/17. Laboratory results of the resident ' s creatinine (kidney function) dated 3/10/17 was 9.61 (normal range 0.6 - 1.3). The blood urea nitrogen (BUN) [shows hydration] result was 55 on 3/10/17 (normal range 3-25).

A review of the physician ' s order dated 3/10/17 stated to send Resident #1 to the emergency room for an evaluation of the elevated creatinine and BUN.

The NP indicated in a progress note dated 3/10/17 she saw the resident for elevated white blood cell count (WBC). The resident ' s blood pressure was 106/60 and pulse 62. The assessment was worsening kidney function and elevated WBC. The lab result showed a creatinine of 9.61 and a BUN 55. The resident was had acute kidney injury due to diarrhea. The NP sent the resident to the emergency room for evaluation.

Resident #1 was admitted to the hospital on 3/10/17 and the hospital history and physical was reviewed. The hospital course documented Resident #1 had C-Difficile colitis and acute renal failure in the setting of a generalized debilitated state and moderate malnutrition. The resident was seen by her nephrologist and was treated with Flagyl (antibiotics) and IV fluids. The resident had a two-week history of diarrhea with weakness. The resident ' s creatinine increased

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to 9.7. The discharge summary revealed diagnoses were nonoliguric (non-urine sparing), acute kidney injury on chronic kidney disease, C-Difficile colitis, leukocytosis (elevated white blood cells), anemia, hypocalcemia (low calcium), and metabolic acidosis. The resident received aggressive IV fluid resuscitation for acute dehydration. At the time of the hospital discharge on 3/22/17, the resident ' s creatinine returned to baseline at 1.6.

On 4/3/17 at 4:50 pm an interview was conducted with the NP. The NP stated that on 2/27/17 she was informed by staff Resident #1 was having loose stools, but not every day. The NP stated that she asked the resident about her diarrhea and was informed the diarrhea was every day. The NP ordered the C-Difficile stool culture on 2/27/17 for the resident ' s diarrhea. When the NP asked the staff for the results of the C-difficile test on 3/6/17, the NP was informed the results were pending. The NP stated she did not write any new orders to complete a stool for C-Difficile, but was waiting for the C-Difficile results from 2/27/17. The NP stated she was not aware until 3/8/17 that the stool culture had not been done. The NP stated that she contacted the resident ' s nephrologist on 3/9/17 regarding the resident ' s elevated creatinine, and the nephrologist ordered a stat (immediate) ultra sound of the kidneys. The NP stated that the physician ordered on 3/8/17 for the resident to go to the ER. The NP thought that the resident was to go for an evaluation of the elevated creatinine of 5.85, but instead the resident went to the ER to have an IV placed. The NP stated that her expectation was for staff to follow orders as written.

The NP further stated the increased creatinine lab

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result was related to acute injury to the kidney from dehydration secondary to diarrhea. The NP stated that another creatinine lab level was completed on 3/10/17 and it had increased to 9.6, and it had not improved after Resident #1 received intravenous fluids. The resident was sent to the emergency room on 3/10/17 and was referred to her nephrologist while she was hospitalized.

On 4/4/17 at 8:40 am an interview was conducted with the Director of Nursing (DON). The DON stated that she expected staff to follow physician ' s orders.

On 4/4/17 at 9:00 am an interview was conducted with Nursing Assistant (NA) #1. NA #1 stated that the resident had 4 to 6 loose bowel movements on day shift for over a week leading up to the hospitalization. NA #1 explained she was not aware of a stool culture order for 2/27/17, but obtained the stool sample on 3/8/17 for the nurse. NA #1 stated she reported to the nurse that Resident #1 had multiple bowel movements.

On 4/4/17 at 9:10 am an interview was conducted with Nurse #1. Nurse #1 stated she was out on leave when the first order for stool culture on 2/27/17 was written. Nurse #1 processed the second order for C-difficile stool culture on 3/8/17. Nurse #1 stated she was aware of the diarrhea from the 24-hour nursing shift report, but there was no diarrhea on her shift.

On 4/4/17 at 10:30 am an additional interview was conducted with the DON. The DON stated a root cause analysis was conducted for the missed C-difficile lab order dated 2/27/17. She explained the nurse that missed the C-Difficile lab had

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resigned and 2/27/17 was three days before the nurse ' s last day. The DON felt that the nurse was distracted and the incident was isolated.

An additional interview was conducted on 4/6/17 at 2:02 pm via telephone with NA #1. NA #1 stated that the diarrhea was more than once a day and frequency was not documented because she did not have time to document and provide resident care. NA #1 stated that the diarrhea was liquid with mucous and foul smelling. She informed the nurse on duty at least once a shift over 10 days the resident had diarrhea. NA #1 stated that the resident was tired and commented that everything she eats goes right through her. The resident also had a decrease in appetite. NA #1 stated that she discussed the resident ' s diarrhea with the NP and a culture was ordered, and NA #1 collected that specimen. She cannot remember the date.

An additional interview was conducted on 4/6/17 at 2:10 pm via telephone with Nurse #1. Nurse #1 stated that she only had Resident #1 for one shift and the resident did not have lose stools and she never gave Imodium. She was aware that a stool culture was ordered 2/27/17, but was not aware that it had not been collected.

An interview was conducted on 4/6/17 at 2:10 pm via telephone with Nurse #2. Nurse #2 stated that she had limited contact with Resident #1, but she was aware that the resident had an order to receive intravenous fluids for an elevated creatinine. Nurse #2 stated that the laboratory vendor would draw or retrieve a specimen the day after it was ordered and placed in their system, unless the request was for urgent (stat). Nurse #2 stated that the process for completing lab

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orders was that the vendor provided lab services and results on the weekend, and the staff retrieved the results from the vendor ' s website.

An interview was conducted on 4/6/17 at 3:40 pm via telephone with Nurse #3. Nurse #3 stated that the resident did not have diarrhea on her night shift on 3/8/17, and she did not administer Imodium. Nurse #3 stated she informed the NP by telephone of the resident ' s creatinine increase to 5.85. She explained the NP did not inquire about the results of the C-Difficile. Nurse #3 stated giving Imodium with C-Difficile was contraindicated. She also stated that the nursing staff was moved around the facility, and she could not remember if Resident #1 had a decline because of the diarrhea.

An interview was conducted on 4/6/17 at 3:40 pm via telephone with the resident ' s physician. The physician stated he remembered Resident #1 and had reviewed the records when the stool culture was missed as part of quality review. The physician explained he was informed by the facility that the order for C-Difficile stool sample on 2/27/27 was missed. The physician stated he was informed by his NP that the resident had one loose stool a day. The resident did not present with a C-Difficile infection because the facility staff informed the NP that Resident #1 had one bowel movement a day. The physician stated he will review the record to evaluate when the intravenous fluids (IV) were started in response to the creatinine increase of 5.85 on 3/8/19. The physician stated his understanding was that the resident needed IV access and received IV access on 3/8/17 and the fluids were started on that evening (3/8), not 3/9/17.

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On 4/7/17 at 8:30 am an interview was conducted again with the resident ' s physician. The physician stated that on 3/7/19 the weekly basic metabolic panel lab (BMP) was ordered. The BMP result was reported to him on 3/8/17 at 6:41 pm. The physician stated he asked staff for the resident ' s status: vital signs, mentation, and overall condition. The physician stated the resident remained at baseline according to staff. Intravenous fluids were ordered and the resident ' s nephrologist was notified. The physician stated he was paged at 7:53 pm on 3/8/17 because staff were unable to place an intravenous catheter. At 7:55 pm the physician responded to send the resident to the emergency room. The resident had an intravenous catheter placed at the emergency room at 9:06 pm. The resident returned to the facility and intravenous fluids were started at 10:29 pm at 125 milliliters per hour. The resident received a liter of fluid overnight. The physician stated the NP saw the resident on 3/9/17 in the morning and ordered a second liter of fluid. The physician stated he discussed the delay of C-Difficile results with the facility DON. The physician was informed that the DON called the lab vendor and the C-Difficile could take 3 to 5 days to complete. The physician stated that Imodium could be given by nursing when there was no confirmation of C-Difficile, which was standard practice. The NP was informed that the resident had diarrhea once a day.

On 4/7/17 at 11:40 am an interview was conducted via telephone with Nurse #4. Nurse #4 stated that she remembered Resident #1 and was on duty 3/3/17 for day shift. Resident #1 had two loose stools on day shift. The nursing assistant assisted the resident for one episode and Nurse #4 assisted for the second episode.

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F 309	Continued From page 26 Nurse #4 stated that the stool was brown, of loose consistency, with no odor or mucous, and of moderate amount. Nurse #4 administered Imodium at 10:00 am, which was requested by the resident. The resident had no further stools on her shift. Nurse #4 stated that when she provided an as needed medication, she reviewed how often previous doses were given. Nurse #4 cannot remember the previous doses without reviewing the chart. Nurse #4 remembered the resident was drinking well and requested a snack on her shift. Nurse #4 received a 24-hour nursing report at start of shift and there were no reports of diarrhea. Nurse #4 stated she did not have a concern for dehydration because the resident was drinking fluids and there was no further diarrhea. Nurse #4 stated she would inform the physician if a resident had repeated need for an as needed medication or concerns regarding diarrhea.	F 309		
F 327 SS=G	483.25(g)(2) SUFFICIENT FLUID TO MAINTAIN HYDRATION (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (2) Is offered sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and physician interviews, the facility failed to assess 12 days of loose stool and failed to maintain	F 327	F327 SS=G Sufficient fluid to maintain hydration	5/2/17

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F 327	Continued From page 27 hydration status which resulted in the resident ' s dehydration and acute on chronic renal failure requiring hospitalization for 1 of 3 residents (Resident #1). Findings included: Resident #1 was admitted on 1/25/17 for rehabilitation after a hip fracture surgery. The resident had the diagnoses of femur fracture and chronic kidney disease stage III. The resident had a care plan dated 1/25/17 for potential imbalance of nutrition and hydration. The admission minimum data set dated 1/30/17 revealed Resident #1 was cognitively intact and required extensive assistance of one staff member with activities of daily living. The resident was continent of bowel and occasionally incontinent of urine. A review of the bowel movement log revealed Resident #1 started having diarrhea on 2/24/17 and had one or more loose bowel movements per day until 3/9/17, with the exception of 3/3/17 she received Imodium and there was a formed stool. The bowel movements were loose and no other description was provided. A progress note dated 2/27/17 revealed the Nurse Practitioner (NP) saw Resident #1 for loose stools that had progressively become more frequent. The note indicated the staff was concerned for C-Difficile infection (infection of the gastrointestinal tract). The NP noted the resident was on Citrucel and Metamucil for constipation and ordered C-Difficile stool culture and Imodium 4 milligrams every 6 hours as needed for loose stools.	F 327	1. Resident #1 was transferred to the hospital and discharged from the facility on 3/10/17. 2. On 4/28/17, the Director of Clinical Services (DCS) and or Registered Nurse designee completed a quality improvement monitoring of 93 current residents to identify residents with a change in condition including any episodes of diarrhea/loose stools, vomiting, decreased urinary output or decreased fluid intake to validate that the licensed nurse recognized, assessed and provided treatments as ordered to maintain hydration and health and documented finding in the residents' medical record. Any identified residents were assessed by the licensed nurse and treatments provided per physicians' order with continued nursing assessment until condition resolved to maintain hydration and health. 3. By 5/2/17, the DCS and/or registered nurse designee completed reeducation to licensed nurses and nursing assistants on regulation 483.25(g)(2) related to maintaining hydration and health consistent with the residents' comprehensive assessment and plan of care. Education also included Consulate policy N-105 "Change in Condition" and N-107 "Change of Shift Report", Consulate Best Practices "24-Hour Report" and "Daily Clinical Meeting" and Interact tools "Stop and Watch", "SBAR" and "Care Path for Dehydration" regarding the expectation of the licensed nurse to recognize, assess and provide treatment as ordered by the physician and/or NP	

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F 327	Continued From page 28 A review of the nurse practitioner ' s order dated 2/27/17 revealed a stool culture for C-Difficile and Imodium 4 mg every 6 hours as needed for diarrhea. A review of the medication administration record (MAR) for 2/27/17 to 3/10/17 revealed the 2/27/17 order for C-Difficile stool sample was added to the MAR, but had no initials for being completed. A review of the laboratory results of the resident ' s creatinine dated 3/7/17 revealed the creatinine (kidney function) result was 5.85 (normal range 0.6 - 1.3) and the blood urea nitrogen (BUN) [shows hydration] result was 33 (normal range 3-25). The resident ' s baseline creatinine was 1.6 on March 1, 2017. A progress note dated 3/8/17 revealed the NP saw the resident for diarrhea. The NP re-ordered C-Difficile stool culture and the resident was treated with Imodium 4 mg every 6 hours as needed for loose stools. The resident complained of dizziness and the NP planned orthostatic blood pressures. A review of the nurse practitioner ' s order dated 3/8/17 revealed a stool culture for C-Difficile, to assess orthostatic blood pressure for three days, and to discontinue the Citrucel 500 milligrams each day and the Metamucil 6 grams each day. A progress note dated 3/9/17 indicated the NP saw the resident for an abnormal lab result of creatinine 5.85 (normal range 0.6 - 1.3). The resident ' s blood pressure was 140/70 and pulse 80. The same progress note further revealed the assessment showed an acute kidney injury on chronic kidney disease from dehydration. The	F 327	when a resident exhibits a change in condition including any episodes of diarrhea/loose stool, vomiting, decreased urinary output or decreased fluid intake to maintain hydration and health. Newly hired licensed nurses and nursing assistants will be educated upon hire. The licensed nurse and nursing assistant to monitor residents for a change in condition including any episodes of diarrhea/loose stools, vomiting, decreased urinary output or decreased fluid intake. The nursing assistant to document observed changes in resident condition utilizing the “Stop and Watch” tool and to document diarrhea/loose stool episodes in Care Tracker as indicated and communicate to the licensed nurse for further assessment and intervention. The licensed nurse to assess residents for changes in condition and dehydration risk as appropriate, notify physician and/or NP and RP, obtain and complete new orders as indicated and continue to monitor residents’ response to treatment until resolved. The licensed nurse to document their initial clinical assessment of residents change in condition on the SBAR (Situation Back ground Assessment and Review and notification) tool in the residents’ medical record and in nurses notes within the medical record until condition resolved. Communicate will be noted on the 24 hour report and verbalized during change of shift report to ensure continued monitoring and assessment of residents’ change in condition. The licensed nurse supervisor will review SBARs, Stop and Watch Tools,	

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F 327	Continued From page 29 resident was started on intravenous fluids at 125 cubic centimeters (cc) per hour. The nephrologist ordered a stat (urgent) renal ultrasound for today and repeat the basic metabolic panel (BMP) tomorrow. A review of the physician ' s order dated 3/9/17 revealed an additional order for normal saline intravenous fluid at 125 cc per hour for one liter and to repeat the BMP lab. A review of Resident #1 ' s laboratory results for stool culture of C-difficile dated 3/9/17 revealed the stool was positive for C-difficile on 3/13/17. Laboratory results of the resident ' s creatinine (kidney function) dated 3/10/17 was 9.61 (normal range 0.6 - 1.3). The blood urea nitrogen (BUN) [shows hydration] result was 55 on 3/10/17 (normal range 3-25). The resident ' s baseline creatinine was 1.6. A review of the physician ' s order dated 3/10/17 stated to send Resident #1 to the emergency room for an evaluation of dehydration (as a result of elevated creatinine and blood urea nitrogen lab tests). Resident #1 was admitted to the hospital on 3/10/17 and the hospital history and physical was reviewed. The hospital course documented Resident #1 had C-Difficile colitis and acute renal failure in the setting of a generalized debilitated state and moderate malnutrition. The resident was seen by her nephrologist and was treated with Flagyl (antibiotic) and IV fluids. The resident had a two-week history of diarrhea with weakness. The discharge summary revealed diagnoses were nonoliguric (body was unable to stop urinating when dehydrated), acute kidney	F 327	24 hour reports, Bowel and Bladder Care Tracker reports and nursing shift reports daily and the DCS and IDT (Interdisciplinary Team) to monitor for compliance during the morning clinical meeting Mondays-Fridays to ensure residents who exhibit changes in condition are recognized, assessed and treated effectively to maintain hydration and health. 4. The DCS/registered nurse designee to conduct quality improvement monitoring of 5 residents' medical record to ensure that residents with a change in condition including episodes of diarrhea/loose stool, vomiting, decreased urinary output or decreased fluid intake are recognized, assessed and treated effectively to maintain hydration and health at a frequency of daily for 4 weeks, then 3 times a week for 8 weeks, then 1 time a month. Frequency of quality monitoring to be modified based on findings. The results of quality improvement monitoring to be reported to the Quality Assurance Performance Improvement Committee monthly by the Administrator and/or DCS. The Quality Assurance Performance Improvement Committee to evaluate the effectiveness of the monitoring/observation tools for making changes to the corrective action if necessary to maintain substantial compliance and ensure that residents maintain hydration and health, consistent with the residents' comprehensive assessment and plan of care. The Quality	

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F 327	Continued From page 30 injury on chronic kidney disease, C-Difficile colitis, leukocytosis (elevated white blood cells), anemia, hypocalcemia (low calcium), and metabolic acidosis (body was too acidic to function, must be treated or can be fatal). The resident received aggressive IV fluid resuscitation for acute dehydration. At the time of the hospital discharge on 3/22/17, the resident ' s creatinine returned to baseline. Resident #1 was not interviewed because she had been discharged at the time of the site visit. On 4/3/17 at 4:50 pm an interview was conducted with the NP. The NP stated that on 2/27/17 she was informed by staff Resident #1 was having loose stools, but not every day. The NP stated that she asked the resident about her diarrhea and was informed the diarrhea was every day. The NP ordered the C-Difficile stool culture on 2/27/17 for the resident ' s diarrhea. When the NP asked the staff for the results of the C-difficile test on 3/6/17, the NP was informed the results were pending. The NP stated she did not write any orders, but was waiting for the C-Difficile results from 2/27/17. The NP stated she was not aware until 3/8/17 that the stool culture had not been done. The NP stated that her expectation was for staff to follow orders as written. The NP further stated the increased creatinine lab result was related to acute injury to the kidney from dehydration secondary to diarrhea. NP stated the delay in treatment of C-Difficile caused the continuing diarrhea and resulting dehydration. The NP stated that another creatinine lab level was completed on 3/10/17 and it had increased to 9.6, and it had not improved after Resident #1 received intravenous fluids. The resident was	F 327	Assurance Improvement Committee members consist of, but not limited to, the Administrator, Director of Clinical Services, Medical Director (quarterly at a minimum) and at least three other members to include but not limited one direct care giver. AOC date: 5/2/17	

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sent to the emergency room on 3/10/17 and was referred to her nephrologist while she was hospitalized.

On 4/4/17 at 9:00 am an interview was conducted with Nursing Assistant (NA) #1. NA #1 stated that the resident had 4 to 6 loose bowel movements on day shift for over a week leading up to the hospitalization. NA #1 stated she reported to the nurse that Resident #1 had multiple bowel movements. The resident was assisted to the bathroom to urinate. NA #1 stated she could not remember if the amount of urine had decreased. NA #1 stated that all residents have fluids of their choice at the bedside.

On 4/4/17 at 9:10 am an interview was conducted with Nurse #1. Nurse #1 stated she was out on leave when the first order for stool culture on 2/27/17 was written. Nurse #1 stated she was aware of the diarrhea from the 24-hour nursing shift report. Resident #1 had fluids at the bedside.

An additional interview was conducted on 4/6/17 at 2:02 pm via telephone with NA #1. NA #1 stated that the diarrhea was more than once a day and frequency was not documented because she did not have time to document and provide resident care. NA #1 stated that the diarrhea was liquid with mucous and foul smelling. She informed the nurse on duty at least once a shift over 10 days the resident had diarrhea. NA #1 stated that the resident was tired and commented that everything she eats goes right through her. The resident also had a decrease in appetite. NA #1 stated that she discussed the resident ' s diarrhea with the NP and a culture was ordered, and NA #1 collected that specimen. She could

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not remember the date.

An additional interview was conducted on 4/6/17 at 2:10 pm via telephone with Nurse #1. Nurse #1 stated that she only had Resident #1 for one shift and never gave Imodium for diarrhea on her shift. She was aware that a stool culture was ordered 2/27/17, but was not aware that it had not been collected.

An interview was conducted on 4/6/17 at 3:40 pm via telephone with the resident ' s physician. The physician stated he remembered Resident #1 and had reviewed the records when the stool culture was missed as part of quality review. The physician explained he was informed by the facility that the order for C-Difficile stool sample on 2/27/27 was missed. The physician stated he was informed by his NP that the resident had one loose stool a day. The physician stated he would review the record to evaluate when the intravenous fluids (IV) were started in response to diarrhea caused dehydration creatinine increase of 5.85 on 3/8/19. The physician stated his understanding was that the resident needed IV access and received IV access on 3/8/17 and the fluids were started on that evening (3/8), not 3/9/17.

On 4/7/17 at 8:30 am an interview was conducted again with the resident ' s physician. The physician stated that on 3/7/19 the weekly basic metabolic panel lab (BMP) was ordered. The BMP result was reported to him on 3/8/17 at 6:41 pm. The physician stated he asked staff for the resident ' s status: vital signs, mentation, and overall condition. The physician stated the resident remained at baseline according to staff. Intravenous fluids were ordered and the resident '

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s nephrologist was notified. The physician stated he was paged at 7:53 pm on 3/8/17 because staff were unable to place an intravenous catheter. At 7:55 pm the physician responded to send the resident to the emergency room. The resident had an intravenous catheter placed at the emergency room at 9:06 pm. The resident returned to the facility and intravenous fluids were started at 10:29 pm at 125 milliliters per hour. The resident received a liter of fluid overnight. The physician stated the NP saw the resident on 3/9/17 in the morning and ordered a second liter of fluid. The physician stated he discussed the delay of C-Difficile results with the facility DON and the cause of dehydration was from the diarrhea.

On 4/7/17 at 11:40 am an interview was conducted via telephone with Nurse #4. Nurse #4 stated that she remembered Resident #1 and was on duty 3/3/17 for day shift. Resident #1 had two loose stools on day shift. The nursing assistant assisted the resident for one episode and Nurse #4 assisted for the second episode. Nurse #4 stated that the stool was brown, of loose consistency, with no odor or mucous, and of moderate amount. Nurse #4 administered Imodium at 10:00 am, which was requested by the resident. The resident had no further stools on her shift. Nurse #4 stated that when she provided an as needed medication, she reviewed how often previous doses were given. Nurse #4 cannot remember the previous doses without reviewing the chart. Nurse #4 stated she would inform the physician if a resident had repeated need for an as needed medication or concerns regarding diarrhea.