STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165601	A. BUILDING _____ B. WING _____	C 06/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES -WEST DES MOIN	5010 GRAND RIDGE DRIVE WEST DES MOINES, IA 50265

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F 000	INITIAL COMMENTS Correction date: 7/12/19 The following information relates to the investigation of complaints #83158-C, 83292-C, #83538-C, and #83560-C and abuse allegations #83106-A and #83542-A. Complaints #83292-C, #83538-C, and #83560 were substantiated. Complaint #83158-C was not substantiated. See Code of Federal Regulations (42 CFR) Part 483, Subpart B-C.	F 000		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This Requirement is not met as evidenced by: Based on record review and interviews the facility failed to adequately investigate and report allegations of abuse for 1 of 3 sampled (Resident #3). The facility reported a census of 73.	F 610		

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

Admin 7/11/19

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 610	Continued From page 1 Findings include: 1. The Minimum Data Set (MDS) assessment dated 3/18/19 documented Resident #3 had a diagnosis of multiple sclerosis. Resident #1 had no cognitive impairments. The MDS dated 3/18/19 revealed required extensive assistance of two staff for most activities of daily living. The Care Plan revised 3/5/19 documented Resident #3 had a self-care deficit and directed the staff to provide assistance with hygiene, grooming, dressing and transfer with assistance of 2 staff with a sit to stand lift. During an interview on 6/4/19 at 11:08 a.m., Resident #3 alleged Staff P abused her the last week of April. Resident #3 said she reported the allegation to Staff V (Registered Nurse) and the Administrator. Resident #3 reported her lower extremities are paralyzed. Resident #3 reported the incident occurred at 1:30 a.m. Resident #3 requested the bedpan. Staff P placed the bedpan under her. Resident #3 asked Staff P to reposition her. Staff P repositioned her. Resident #3 told Staff P the other aides put a brief or towel over the bedpan to prevent spillage. Staff P stated, "I've done this many times, I know what I'm doing." Staff P left Resident #3 did not cover her up, stood right by her for a minute, and asked, "Are you done?" The Resident #3 stated, "I can't go with you standing here." Staff P asked Resident #3 if she was done several times. Resident #3 finally said, "Why don't you just come and take me off of it then." Resident #3 reported Staff P removed the bedpan. Staff P then floated her heels with pillows and just let her legs drop	F 610		

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F 610	Continued From page 2 onto the pillows. Resident #3 asked Staff P to get the nurse. Staff P told Resident #3 she would let the nurse know. Resident #3 reported Staff P left her exposed. Resident #3 waited 30 minutes and then called the facility on her cell phone. Staff Q (Licensed Practical Nurse) answered the phone and then went directly to Resident #3's room. Staff Q walked the room and observed Resident #3 exposed and stated, "Oh my, what do we have here". Resident #3 reported Staff P had always been rough around the edges. Resident #3 has not seen Staff P again. Resident #3 reported the incident to the Administrator. During an interview on 6/4/19 at 1:20 p.m., Staff Q (Licensed Practical Nurse) reported she received the call from Resident #3 and went directly to her room. Staff Q reported Resident #3 was completely exposed and tearful. Resident #3 reported Staff P would not reposition her legs. Resident #3 had a bedpan in place and looked uncomfortable. The head and foot of Resident #3's bed was in the raised position. Resident #3 told Staff Q that she told Staff P she was hurting her and the Resident #3 tried to explain the angrier and more defiant Staff P became. Resident #3 reported Staff P just stood there and she asked her to leave, as she could not go to the bathroom with Staff P standing there. Staff Q had another aide assist Resident #3. Staff Q saw Staff P in the hall. Staff P asked, "What's Resident #3's problem?" Staff Q directed Staff P to stay out of Resident #3's room. Staff Q questioned Staff P because obviously something happened between them. Staff P stated, "That's the way Resident #3 is, she's the queen bee." Staff Q did not tell Staff P what Resident #3 alleged because Staff P had aggressive and defensive tendencies. Staff Q did not report the allegation.	F 610		

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F 610	Continued From page 3 During an interview on 6/4/19 at 12:35 p.m., the Administrator reported Resident #3 did not report mistreatment by Staff P at the end of April. The Administrator reported she checked in with Resident #3 frequently due to prior allegations. During an observation and interview on 6/4/19 at 2:55 p.m., the Administrator stated to Resident #3, "I understand you reported abuse". Resident #3 stated, "I told you and Staff V about it right after it happened; on Staff V's last day here." Resident #3 told the Administrator what happened, consistent with what she told this surveyor. The Administrator reported she remembered Resident #3 told her. The Administrator did not recall Resident #3 using the word abuse and did not considered what happened to be abuse. Resident #3 stated, "I've never been treated so badly, wouldn't you consider what I told you to be some kind of abuse?" During an interview on 6/6/19 at 3:45 p.m., Staff V did not recall being present when Resident #3 reported an allegation of abuse in April 2019. Staff V remembered providing education to the staff on how to transfer Resident #3. Staff V reported Resident #3 had a history of making allegations. Staff V reported the allegations are real to Resident #3. Staff V reported Resident #3 can be very particular and thinks she is being mistreated; even during routine/normal cares. During an interview on 6/12/19 at 7:42 a.m., Staff P reported she was in Resident #3's room shortly after 10:00 p.m. Resident #3 was upset and crying and reported she had been waiting for her medications for 2 hours. Staff P informed Staff Q. Staff P returned to Resident #3's room to let	F 610		

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F 610	Continued From page 4 her know she spoke to the Nurse. Resident #3 was still upset. Resident #3 requested the bedpan. Resident #3 was upset and stated, "This does not feel right". Staff P asked what she meant. Resident #3 stated, "Everything is wrong; nothing is right." Staff P directed Resident #3 to use the bedpan. Staff P reported she covered Resident #3 up. Staff P reported she stayed in the room for a good 15 minutes and asked the Resident #3 if she was done. Resident #3 stated, "This is not right; I pay $6000 to be here. This place sucks, needs more help and I'm important too, I can't go because you're in here". Staff P reported she waited in the room before and Resident #3 never complained about it. Staff P offered to leave the room but Resident #3 told her to take her off the bedpan. Staff P said Resident #3 liked things done right away and gets upset easily. Resident #3 yelled, "leave me and go get the nurse" when she started to take her off the bedpan. Staff P told Resident #3 she could not leave her on the bedpan because she did not know how long it would take the nurse. Staff P rolled Resident #3 and removed the bedpan. This upset Resident #1 even more. Staff P reported she covered Resident #1back up. This caused her to become even more upset. Resident #3 just wanted Staff P to stop everything at that given point and leave her alone. Staff P said she had to take the bedpan out from under her and had to cover her; just leaving her in that situation would have been a worse decision. Resident #3 stated, "Get the nurse so she could put me on the bedpan." Staff P left the room and directly to Staff Q. Staff P told Staff Q that Resident #3 was upset and wanted her assistance with the bedpan. Staff Q reported she did not have time at that minute. Staff Q reported 15 or 20 minutes later Resident #3 called the nurse's station and Staff Q went to her room.	F 610		

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F 610	Continued From page 5 Staff Q then told Staff P not to return to Resident #According to Staff P, the Administrator called her about a week ago and asked when she last went into Resident #3's room. Staff P told her she last went in to Resident #3's room about a month before. Staff P said the Administrator informed her of the allegation of abuse at that time. Staff P reported Resident #3 had the ability to uncover herself. Staff P denied leaving Resident #3 uncovered. The Patient Protection Abuse, Neglect, Exploitation, Mistreatment& Misappropriation Prevention policy dated 11/8/16 directed the facility to adopt and operationalize an abuse prevention system that included screening, protection of patients, identification and investigation of all allegations of abuse and reporting and responding to the appropriate individuals or agencies. The policy revealed the facility must develop and implement written policies and procedures that prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property and establish policies and procedures to investigate any such allegations.	F 610		
F 684 SS=G	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 clinical record review and interviews the	F 684		

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F 684	Continued From page 6 facility failed to provide treatment and care to each resident based on the comprehensive assessment in accordance with professional standards of practice and the comprehensive person centered care plan for 2 of 2 sampled (Resident #1 and #2) with Clostridium difficile (C. diff). Resident #1 had loose stools for two weeks. The facility failed to communicate with the Nurse Practitioner that Resident #1 had loose odorous stools. The facility failed to submit a stool specimen until 10 days after the staff initially reported Resident #1's symptoms. The facility obtained three stool specimens on three different dates for evaluation. The lab rejected the samples due to inadequate prep and communicated this to the facility on the lab report with instructions to call the lab. The facility failed to properly assess, provide meaningful interventions, and failed to return a call to the lab. On 5/28/19, Resident #1 presented with an elevated temperature and confusion above baseline and transferred to the hospital where the resident passed away due to septic shock. The facility reported a census of 73 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 5/8/19 documented Resident #1 had diagnoses of stroke, seizure disorder and depression. Resident #1 had no cognitive impairments. The MDS dated 5/8/19 documented Resident #1 required extensive assistance of two staff all activities of daily living. Resident #1 had bowel and bladder incontinence. The Care Plan initiated on 6/15/19 revealed Resident #1 dependent on staff for toilet use,	F 684		

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F 684	Continued From page 7 dressing, bathing and transfers. The Care Plan directed the staff to report gastrointestinal distress such as nausea, constipation and diarrhea. The Progress Note dated 5/18/19 at 5:13 p.m. documented a Nurse Aide informed the nurse Resident #1 had a bowel movement that smelled of C. diff. The Nurse received an order to obtain a stool specimen to check for C. diff. The 5/1/19 to 5/31/19 Electronic Treatment Administration Record (TAR) revealed the staff obtained stool specimens on 5/19/19 at 5:54 a.m. and 5/25/19 at 3:10 p.m. The Progress Note dated 5/20/19 at 9:52 a.m. revealed the Nurse Practitioner assessed the redness in Resident #1's abdominal folds and groin area. The Nurse Practitioner documented Resident #1 had no other concerns. The Bacteriology Routine Testing collected 5/20/19 at 7:00 a.m. revealed "test canceled" reason not available and please call lab. The Details for Order #59910010725 revealed the test cancelled on 5/20/19 at 2:56 p.m. due to "Prep Inadequate". An untitled document submitted by the facility dated 5/20/19 at 2:56 p.m. revealed the lab cancelled the test for "Prep Inadequate" (59910010725). The document revealed no documentation from facility or lab communicated the lab cancelled. The Progress Note dated 5/22/19 at 3:38 p.m. revealed the Unit Manager assessed Resident #1	F 684		

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F 684	Continued From page 8 for pain. Resident #1 reported constant pain at a level "8" and declined pain medications. Lab Order #59910010744RG noted that the facility collected the ordered stool specimen on 5/23/19 at 10:10 a.m. Details for Order #59910010744 noted that the lab cancelled the test on 5/23/19 at 8:18 p.m. due to "Prep Inadequate". The Progress Note dated 5/23/19 at 8:16 p.m. revealed the lab called the Unit Manager and reported a new stool specimen needed as the lab unable to run the collected specimen. The lab directed to place the new specimen in an orange top stool with orange/red liquid. The Orders between 5/5/19 and 6/4/19 revealed an order dated 5/23/19 to cancel test due to specimen not in proper preservative. The Lab Order #59910010753RG revealed Resident #1 had a stool specimen collected on 5/24/19 at 8:25 a.m. The Details for Order #59910010753 noted that the lab cancelled the test on 5/28/19 at 7:28 a.m. due to "No Specimen Received". The Orders between 5/5/19 and 6/4/19 revealed no specimen received and called facility on 5/28/19 at 7:19 a.m. to notify of cancel.	F 684		

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F 684	Continued From page 9 The Progress Notes dated 5/24/19 at 9:39 a.m. revealed the Nurse Practitioner assessment for Resident #1's acute visit for evaluation of diarrhea. Resident #1 reported going up to 5 times a day and occurred with almost every meal. The Nursing staff attempted a stool sampled yesterday, but unsuccessful and a repeat needed today. The Progress Note dated 5/24/19 at 1:26 p.m. revealed the staff awaiting the proper cup for the stool sample. The Progress Note dated 5/25/19 at 3:49 a.m. revealed the staff obtained the stool specimen as ordered. The Progress Notes dated 5/26/19 at 10:54 a.m. revealed Resident #1 received Loperamide (anti-diarrheal medication) 2 milligrams by mouth and medication effective. The Progress Notes dated 5/27/19 at 8:37 a.m. revealed Resident #1 received Loperamide 2 milligrams by mouth for diarrhea. The Progress Notes dated 5/28/19 at 3:57 a.m. revealed Resident #1 presented with diarrhea and generalized pain. Resident #1 had a blood pressure of 99/76, temperature of 100.8 degrees Fahrenheit, a pulse of 173 beats per minute and respirations of 24 per minute. Resident #1 less alert compared to baseline. The staff called the physician who ordered to send Resident #1 to the emergency department for evaluation. The Internal Medicine Discharge Summary dated 5/28/19 at 8:29 a.m. documented Resident #1 had diarrhea for more than 10 days and stool specimen sent to the lab by nursing home but no	F 684		

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F 684	Continued From page 10	F 684		

results. Resident #1 received a couple doses of Imodium without improvement. This morning Resident #1 had a temperature of 100.8 degrees Fahrenheit, a blood pressure of 99/76, and respirations of 24 per minute, heart rate of 73 beats per minute and oxygen saturation of 94% on room air. Resident #1 had confusion and transported to the hospital for evaluation. Resident #1 admitted to the Intensive Care Unit for septic shock, C. diff result positive and nasal swab positive for rhino/enterovirus. Resident #1 received oral vancomycin and flagyl with intravenous fluids. Resident #1 had multiple comorbidities and the power of attorney made a decision for comfort cares. Resident #1 passed away on 5/28/19 at 4:39 p.m.

During an interview on 6/5/19 at 9:05 a.m., Staff D (Nurse Aide) recalled on Resident #1 had loose stools on 5/12/19. Resident #1 told Staff D she had loose stools for a while. Staff D reported the odor went all the way down the hall. Staff D reported the concern to Staff C (Registered Nurse) on 5/12/19 at 10:00 a.m. or 11:00 a.m. Staff C commented it smelled like C. diff and she would call the doctor for an order for a stool sample. Staff D also told Staff L (Licensed Practical Nurse). Staff L reported he planned to call the doctor when he had time.

During an interview on 6/5/19 at 1:05 p.m., Staff B (Nurse Aide) recalled Resident #1 had foul smelling loose stools on 5/12/19. Staff B reported the nurse told him on 5/15/19 they were trying to obtain an order to collect a stool sample. Staff B described the smell as horrible and anyone that walked by the room could smell it.

During an interview on 6/5/19 at 10:40 a.m., with Staff K (Nurse Aide) revealed that she and other

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F 684	Continued From page 11 Aids told Staff L (Licensed Practical Nurse) on 5/15/19 about Resident #1 having loose stools. On 5/18/19, she asked Staff H to call the Dr. about Resident #1 having C. diff smelling diarrhea. As she stood at the Nurse's station, Staff K overheard Staff H inform the physician that Resident #1 had diarrhea for close to a week. The Aid said she obtained the sample Staff H asked her to get. During an interview on 6/5/19 at 12:35 p.m., Staff O (Nurse Aide) reported Resident #1 had foul smelling loose stools for 3 weeks before she went to ER. Staff O reported the smell was hard not to notice. Staff O reported Resident #1 had watery and dark green stools. Staff O reported she could tell Resident #1 had C. diff. Staff O and Staff N reported this to the nurses. Staff O reported a week later the nurses asked her to obtain a stool specimen. The nurses kept saying they did not have the right cup. During an interview on 6/5/19 at 3:40 p.m., Staff M (Nurse Aide) reported Resident #1 had foul smelling loose stools for 3 times a day for 2 or 3 weeks before she went to the hospital. The smell lingered in the halls and at the nurse's station. Staff M reported Resident #1 had a roommate and never placed on precautions. During an interview on 6/5/19 at 1:20 p.m., Staff I (Licensed Practical Nurse) reported someone had obtained an order by the time she heard about Resident #1 having foul smelling loose stools. During an interview on 6/3/19 at 1:48 p.m., Staff C (Registered Nurse) reported the facility obtained stool specimens for Resident #1 twice and sent them to the lab However, the lab	F 684		

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rejected the samples as they received then in the wrong cups. Staff C reported the day shift nurses obtain the lab specimens and pass it on to the next shift if they cannot obtain them. Staff C reported the staff should notify the physician if they cannot obtain a specimen.

During an interview on 6/3/19 at 2:00 p.m., Staff A (Licensed Practical Nurse) reported the lab rejected two stool specimens and she wondered why the staff didn't clarify which cup to use before sending the second specimen. Staff A had communication with the lab on 5/24/19. Staff A inquired about the results. The lab informed Staff A the facility sent the sample in the wrong cup. Staff A spent a significant amount of time on the phone with the lab inquiring about the required cups. The lab requested the facility pick the proper cup up from the lab. Staff A passed this on in report to Staff C. Staff A returned to work the following Monday and understood another sample had been collected. On 5/28/19, Staff A realized the facility did not obtain the proper cups. Staff A reported she had to write an order to obtain the correct cups.

During an interview on 6/3/19 at 3:00 p.m., Staff C (Registered Nurse) reported she did not know who ordered lab supplies for the facility. Staff C recalled a series of unsuccessful attempts to obtain the correct cups. Staff C informed the Unit Manager who said she would take care of it.

During an interview on 6/6/19 at 6:25 p.m., Staff J (Licensed Practical Nurse) reported the Nurse Aids called her at home on 5/18/19 and reported Resident #1 had frequent episodes of foul smelling loose stools. Staff J told the Nurse Aides to report it to the nurse. The Nurse Aides told Staff J, they were not doing anything about it.

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F 684	Continued From page 13 During an interview on 6/3/19 at 3:54 p.m., the Unit Manager reported she assessed Resident #1 on 5/22/19 for chronic pain. The Unit Manager could not recall if Resident #1 had bowel symptoms and an order for a stool specimen. The Manager had communication with the lab on 5/23/19. The lab reported they received the stool specimen in the wrong cup and they would need to submit another sample. The Unit Manager passed the information along to the charge nurse. The Unit Manager did not check to see if the cups were available. The Unit Manager reported the lab later told them they could send the specimen in the same cups that they rejected. During an interview on 6/4/19 at 8:00 a.m. and 6/5/19 at 7:30 a.m., the Director of Nurses (DON) reported she started working at the facility on 5/15/19 and implemented 24 hour book to enhance communication. The DON reported the facility also used "alert charting" for Residents with acute issues. The DON reported Resident #1 had not been included on the alert charting. The DON reported she was informed Resident #1 had loose stools on 5/18/19 in morning meeting. The DON reported the sampled had been collected, but then heard the next day the lab refused it because of the wrong cup. The DON reported she assessed Resident #1 but did not document her assessments. The DON did not talk to the lab about cancelling the lab tests. During an interview on 6/4/19 at 9:30 a.m. and 10:28 a.m., the Administrator reported she found out about the lab declining the samples provided on 5/28/19 or 5/29/19. The Administrator reported the staff sent the sampled in a sterile specimen and the lab never informed the facility of a change in their protocol. The Administrator	F 684		

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did not know why all of a sudden the lab refused to process things in the same cups they previously used. The Administrator reported she called the lab last week and they said the containers were enroute. Knowing that, the Administrator left the building; but called back and confirmed that they arrived with the Unit Manager. The Surveyor informed the Administrator the appropriate cups never arrived. The Administrator said, "They should have notified me if they never got them, they knew to do that." The Administrator reported an expectation of staff to notify management if they run into an issue with the lab tests, so they can intervene. The Administrator reported she would have personally gone to the lab and picked them up in order to avoid the delays. The Administrator reported the lab told them yesterday they could send the samples in anything sterile.

During an interview on 6/11/19 at 11:15 a.m., the Nurse Practitioner reported she assessed Resident #1 on 5/20/19. The Nurse Practitioner did not note any odor. The Nurse Practitioner had no knowledge Resident #1 had odorous loose stools on 5/18/19. The Nurse Practitioner learned of an issue on 5/24/19 when the lab rejected the stool specimen. This prompted the Nurse Practitioner to assess Resident #1. The Nurse Practitioner reported an expectation of the staff to notify her of their assessment findings and their difficulty with processing lab specimens. The Nurse Practitioner reported untreated C. diff could be fatal. The Nurse Practitioner reported she learned Resident #2 also had diarrhea when she assessed Resident #1. Resident #1 and Resident #2 informed her they had diarrhea for a week.

During an interview on 6/6/19 at 12:05 p.m., the

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F 684	Continued From page 15 Medical Director recalled the staff calling after hours to report a resident had loose stools. The Medical Director did not recall the staff mentioning foul smelling loose stools or suspicions of C. diff. The Medical Director reported he always orders a stool specimen to rule out C. diff with loose stools. The Medical Director had no knowledge the lab refused to process the stool samples. The Medical Director indicated it would have been helpful to be notified of the lab refusing to process the sample; someone could have intervened sooner. The Medical Director reported she could have wen to the emergency department to get lab results promptly. When asked, the Medical Director reported each person's immune response is different; so he supposed C. diff could be fatal sometimes. The One-On-One In-service Record dated 6/4/19 noted that the Unit Manager provided education on processing lab orders. The education documented if the staff cannot obtain a lab, they need to notify the physician and document in Nurse's Notes and a place a new order for the lab if applicable. The facility failed to assess Resident #1 from onset of symptoms on 5/18/19 to 5/24/19 when the Nurse Practitioner assessed Resident #1. 2. The MDS assessment dated 3/8/19 documented Resident #2 had diagnoses of anxiety, depression and schizophrenia. Resident #2 had no cognitive impairments. The MDS dated 3/8/19 revealed Resident #2 required extensive assistance of two staff for most ADLs and had frequent bowel incontinence.	F 684		

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F 684	Continued From page 16 The Care Plan revised 6/5/19 revised revealed Resident #2 had C. diff and required contact isolation. The Care Plan directed the staff to use gowns and masks when changing contaminated linens, instruct family and staff on preventive measures to contain the infection, administer medication and intravenous therapy as ordered and monitor for symptoms of weakness, dehydration, fever, nausea, vomiting and blood in her stools. The Care Plan focused on gastrointestinal distress related to diarrhea; with pending lab results and directed the staff to report and record episodes of loose stools and increase in abdominal pain. The Progress Notes dated 5/24/19 at 9:51 a.m. revealed the nursing department requested the Nurse Practitioner to assess Resident #2 for diarrhea that started a week ago. The Nurse Practitioner documented Resident #2 reported episodes of loose stools 2 to 3 times a day. The Nurse Practitioner ordered a stool sample for culture and C. diff, encourage fluids, hold laxatives/stool softeners until diarrhea resolves, Loperamide 2 mg every 6 hours for diarrhea and monitor and notify if the Nurse Practitioner if symptoms do not improve or worsen. The Progress Notes dated 5/24/19 at 1:35 p.m. revealed Nurse Practitioner informed awaiting for a proper sample cup. The Progress Notes dated 5/25/19 at 4:22 a.m., revealed Resident #2 had no bowel movement during the shift. The Progress Notes dated 5/29/19 at 6:17 p.m. revealed Resident #2 had no reports of bowel movement today.	F 684		

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F 684	Continued From page 17 The Progress Notes dated 5/30/19 at 12:42 p.m. revealed the Nurse Practitioner visited Resident #2. Resident #2 reported she felt okay and she did not have diarrhea over the last 2 days. Resident #2 reported intermittent nausea, but ate her full breakfast. The Nurse Practitioner referred Resident #2 to a nephrologist for further evaluation. The Progress Notes dated 5/30/19 at 2:21 p.m. revealed Resident #2 had had one loose stool during the shift. The Progress Notes dated 6/4/19 at 7:37 a.m. revealed Resident #2 reported she had loose stools. The nurse asked the nurse aide to report any bowel movements. The Progress Notes dated 6/4/19 at 3:14 p.m., revealed Resident #2 had a loose stool today and the Nurse Practitioner reported Resident #2 had an order for C. diff sample. The Progress Notes dated 6/5/19 at 8:00 a.m., revealed the staff collected the stool specimen. The Bacteriology Routine Testing dated 6/5/19 at 7:30 a.m., revealed Resident #2 tested positive for C. diff and directed to maintain contact precautions. During an interview on 6/11/19 at 11:15 a.m., the Nurse Practitioner reported she assessed Resident #1 on 5/20/19. The Nurse Practitioner did not note any odor. The Nurse Practitioner had no knowledge Resident #1 had odorous loose stools on 5/18/19. The Nurse Practitioner learned of an issue on 5/24/19 when the lab rejected the stool specimen. This prompted the Nurse Practitioner to assess Resident #1. The	F 684		

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F 684	Continued From page 18 Nurse Practitioner reported an expectation of the staff to notify her of their assessment findings and their difficulty with processing lab specimens. The Nurse Practitioner reported untreated C. diff could be fatal. The Nurse Practitioner reported she learned Resident #2 also had diarrhea when she assessed Resident #1. Resident #1 and Resident #2 informed her they had diarrhea for a week. The Progress Notes dated 6/5/19 at 11:06 a.m. revealed the Nurse Practitioner visited Resident #2 and completed a note. Resident #2 had intermittent episodes of loose stools over the last 2 weeks. Resident #2 had two watery stools this morning. A stool sample for C. diff in process. Resident #2 reported some mild abdominal discomfort and nausea. During an interview on 6/3/19 at 12:35 p.m., Resident #2 reported she stayed in her room most of the time. The Resident #1 reported her roommate (Resident #1) had foul smelling stools since she moved in with her 6 months ago. Resident #2 reported her roommate passed away in May reportedly from C. diff. During a subsequent interview on 6/11/19 at 8:08 a.m., Resident #2 reported the staff placed her on isolation for C. diff about 6 days ago. Resident #2 reported C. diff is contagious and she told the facility she got it from her roommate, Resident #1. During an interview on 6/11/19 at 7:57 a.m., Staff N (Nurse Aide) reported Resident #2 had loose stools for as long as Resident #1 had them. Staff N reported Resident #2 placed on isolation last week. Staff N said they asked a Nurse to obtain an order for a stool sample for Resident #2 at the	F 684		

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F 684	Continued From page 19 same time they asked about Resident #1. Staff N reported the nurse informed stated the Resident needed to have 3 loose stools in a row in order to request an order for a specimen. Staff N reported Resident #2 had loose stools every day that she worked.	F 684		
F 770 SS=D	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This Requirement is not met as evidenced by: Based on record review and interviews the facility failed to provide laboratory services to meet the needs of the residents for 1 of 2 sampled (Resident #2). The facility reported a census of 73 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 5/8/19 documented Resident #1 had diagnoses of stroke, seizure disorder and depression. Resident #1 had no cognitive impairments. The MDS dated 5/8/19 documented Resident #1 required extensive assistance of two staff all activities of daily living. Resident #1 had bowel and bladder incontinence. The Care Plan initiated on 6/15/19 revealed Resident #1 dependent on staff for toilet use,	F 770		

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F 770	Continued From page 20 dressing, bathing and transfers. The Care Plan directed the staff to report gastrointestinal distress such as nausea, constipation and diarrhea. The Progress Note dated 5/18/19 at 5:13 p.m. documented a Nurse Aide informed the nurse Resident #1 had a bowel movement that smelled of C. diff. The Nurse received an order to obtain a stool specimen to check for C. diff. The 5/1/19 to 5/31/19 Electronic Treatment Administration Record (TAR) revealed the staff obtained stool specimens on 5/19/19 at 5:54 a.m. and 5/25/19 at 3:10 p.m. The Bacteriology Routine Testing collected 5/20/19 at 7:00 a.m. revealed "test canceled" reason not available and please call lab. The Details for Order #59910010725 revealed the test cancelled on 5/20/19 at 2:56 p.m. due to "Prep Inadequate". An untitled document submitted by the facility dated 5/20/19 at 2:56 p.m. revealed the lab cancelled the test for "Prep Inadequate" (59910010725). The document revealed no documentation from facility or lab communicated the lab cancelled. Lab Order #599100 :0744RG noted that the facility collected the ordered stool specimen on 5/23/19 at 10:10 a.m. Details for Order #59910010744 noted that the lab cancelled the test on 5/23/19 at 8:18 p.m. due	F 770		

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F 770	Continued From page 21 to "Prep Inadequate". The Progress Note dated 5/23/19 at 8:16 p.m. revealed the lab called the Unit Manager and reported a new stool specimen needed as the lab unable to run the collected specimen. The lab directed to place the new specimen in an orange top stool with orange/red liquid. The Orders between 5/5/19 and 6/4/19 revealed an order dated 5/23/19 to cancel test due to specimen not in proper preservative. The Lab Order #59910010753RG revealed Resident #1 had a stool specimen collected on 5/24/19 at 8:25 a.m. The Details for Order #59910010753 noted that the lab cancelled the test on 5/28/19 at 7:28 a.m. due to "No Specimen Received". The Orders between 5/5/19 and 6/4/19 revealed no specimen received and called facility on 5/28/19 at 7:19 a.m. to notify of cancel. During an interview on 6/4/19 at 8:00 a.m. and 6/5/19 at 7:30 a.m., the Director of Nurses (DON) reported she started working at the facility on 5/15/19 and implemented 24 hour book to enhance communication. The DON reported the facility also used "alert charting" for Residents with acute issues. The DON reported Resident #1 had not been included on the alert charting. The DON reported she was informed Resident #1 had loose stools on 5/18/19 in morning meeting. The DON reported the sampled had been collected, but then heard the next day the lab refused it because of the wrong cup. The DON	F 770		

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F 770	Continued From page 22 did not talk to the lab about cancelling the lab tests. During an interview on 6/4/19 at 9:30 a.m. and 10:28 a.m., the Administrator reported she found out about the lab declining the samples provided on 5/28/19 or 5/29/19. The Administrator reported the staff sent the samples in a sterile specimen cup and the lab never informed the facility of a change in their protocol. The Administrator did not know why all of a sudden the lab refused to process things in the same cups they previously used. The Administrator reported she called the lab last week and they said the containers were enroute. Knowing that, the Administrator left the building; but called back and confirmed that they arrived with the Unit Manager. The Surveyor informed the Administrator the appropriate cups never arrived. The Administrator said, "They should have notified me if they never got them, they knew to do that." The Administrator reported an expectation of staff to notify management if they run into an issue with the lab tests, so they can intervene. The Administrator reported she would have personally gone to the lab and picked them up in order to avoid the delays. The Administrator reported the lab told them yesterday they could send the samples in anything sterile. The facility failed to communicate with the lab to complete the labs in a timely manner.	F 770		

ManorCare Health Services –West Des Moines
5010 Grand Ridge Drive
West Des Moines, IA 50265

The plan of correction represents the center's compliance. The following combined plan of correction and allegation of compliance is not an admission to any of the alleged deficiencies and is submitted at the request of Iowa Department of Health and Human Services. Preparations and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of facts alleged or conclusions set forth the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.

F610

§483.12 Investigate/Prevent/Correct Alleged Violation

-Based on record review and interviews the facility must ensure an adequate investigation and report allegations of abuse.

Corrective action taken for residents found to have been affected by deficient practice

-Resident #3 currently resides in the facility and denies any further allegation of abuse.

How the center will identify other residents having the potential to be affected by the same deficient practice

-Residents residing in the facility have the potential to be affected.

-House audit conducted to validate no further allegations of abuse.

What changes will be put into place to ensure that the problem will be corrected and will not recur

-Staff re-educated on abuse policy and reporting abuse.

-Staff Q no longer employed with HCR ManorCare

-Staff P one to one educated provided.

-Abuse coordinator educated on conducting thorough investigations.

Quality Assurance Plan to monitor performance to make sure corrections are achieved and are permanent

-Administrator/designee will complete random weekly audits x4 weeks to ensure ~~patients and~~ staff know how to report abuse.

- Audit findings to be taken through Center's QAA.

Completion Date: 7/12/19

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F684

§483.25 Quality of Care

Based on 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.

Corrective action taken for residents found to have been affected by deficient practice

-Resident #1 no longer resides at the facility.

-Resident #2 currently resides in the facility and has been treated and cleared for C-diff infection.

How the center will identify other residents having the potential to be affected by the same deficient practice

-Residents residing in the facility with loose stools have the potential to be affected.

-Like residents audited to ensure assessments are completed when new onset of loose stools occur.

What changes will be put into place to ensure that the problem will be corrected and will not recur

-Staff educated on assessing a resident when resident has new onset of loose stools.–

-Staff educated on obtaining lab specimens timely and to notify MD of labs unable to be obtained

Quality Assurance Plan to monitor performance to make sure corrections are achieved and are permanent

-DON/designee will complete random weekly audits x4 weeks to ensure assessments are completed on patients with a new onset of loose stools.

-Audit findings to be taken through Center's QAA.

Completion Date: 7/2/19

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F 770

§483.50 Laboratory Services

-The facility must provide or obtain laboratory services to meet the needs of its residents.

Corrective action taken for residents found to have been affected by deficient practice

-Resident #1 no longer resides at facility.

How the center will identify other residents having the potential to be affected by the same deficient practice

-Residents residing in the facility that require laboratory services have the potential to be affected.

-Like residents audited to ensure laboratory services meet the needs of the resident.

What changes will be put into place to ensure that the problem will be corrected and will not recur

-Staff re-educated on laboratory services and process for completing lab orders.

- Laboratory service vendor changed on 6/17/19

Quality Assurance Plan to monitor performance to make sure corrections are achieved and are permanent

-DON/designee will complete random weekly audits x4 weeks to ensure laboratory services and tracking are in place.

-Audit findings to be taken through Center's QAA.

Completion Date: 7/12/19

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F770

§483.50 Laboratory Services

-The facility must provide or obtain laboratory services to meet the needs of its residents.

Corrective action taken for residents found to have been affected by deficient practice

-Resident 2 no longer resides at facility.

How the center will identify other residents having the potential to be affected by the same deficient practice

-Residents residing in the facility that require laboratory services have the potential to be affected.

-The residents audited to ensure laboratory services meet the needs of the resident.

What changes will be put into place to ensure that the problem will be corrected and will not recur:

-Staff re-educated on laboratory services and process for completing lab orders.

- Laboratory service vendor changed on 6/1/19

Quality Assurance Plan to monitor performance to make sure corrections are achieved and are permanent

-DON/designee will complete random weekly audits of orders to ensure laboratory services and tracking are in place.

-Audit findings to be taken through Center's QAA.

Completion date: 7/12/19