STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555093	A. BUILDING _____ B. WING _____	07/15/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ST EDNA SUBACUTE AND REHABILITATION CENTER	1929 N. FAIRVIEW STREET SANTA ANA, CA 92706

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

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F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, facility document review, facility P&P review, the facility failed to notify the physician when a resident had persistent diarrhea over the course of three months and weight loss. Resident 1 was found to have a foreign object (bottle) inside of his colon which required a surgical removal. * Resident 1 had a change in his baseline bowel habits; 73 episodes of loose stool or diarrhea between 3/15/20 through 5/5/20. Resident 1's physician was only notified twice (4/6/20 and 4/14/20) of Resident 1's episodes of loose stool/diarrhea. * Resident 1's CNAs documented Resident 1 had multiple episodes of diarrhea; however, for the same timeframe, Resident 1's LVN documented Resident 1 did not have diarrhea/loose stools. * Resident 1 had a physician's orders [REDACTED]. After the [MEDICATION NAME] was ordered, Resident 1 had 10 episodes of diarrhea; however, the medication was not administered. These failures had the potential for Resident 1 to have a significant delay in identifying the foreign object in the resident's colon, which might have prevented Resident 1 from requiring the surgery. Findings: Review of Resident 1's operation procedure note from Hospital 1 dated 5/7/20, showed Resident 1 had a sigmoid colon resection with a [MEDICAL CONDITION] and removal of a foreign body from his colon. Resident 1 had a bottle measuring approximately 20 cm in length removed from his colon. Review of the Police Department 1 report dated 5/8/20, showed Resident 1 had a bottle surgically removed from his colon at Hospital 1. Resident 1's surgeon believed the bottle had been inside Resident 1's colon for a long period of time due to the bottle being located far inside the resident's colon. Resident 1 was admitted to Hospital 1 in March 2020 for abdominal pain and rectal bleeding. The Nursing Director of Hospital 1 was able to review a CT scan image from March 2020 admission and identified the bottle was present in Resident 1's colon at that time. The Nursing Director stated the hospital staff had not identified the bottle at that time. On 5/20/20 at 0824 hours, an interview was conducted with Resident 1. Resident 1 was alert, oriented, and capable of making his needs known. Resident 1 was asked if anyone had abused him, to which he replied, no. Resident 1 stated several months ago he inserted the bottle himself, however, he forgot about it. Resident 1 stated he had engaged in this type of behavior in the past. Review of the facility's P&P titled Change of Condition dated 2016 showed the licensed nurse will appropriately assess, document, and communicate a resident change of condition to the primary care physician. The purpose of the Change of Condition policy is to provide treatment and services to address changes in accordance with resident needs. Medical record review for Resident 1 was initiated on 5/9/2020. Resident 1 was admitted to the facility on [DATE], and readmitted [DATE]. a. On 5/14/20 at 1643 hours, and interview was conducted with CNA 1. CNA 1 stated she was familiar with Resident 1 and frequently took care of him on the day shift. CNA 1 stated Resident 1 had a change in his health starting approximately 2 months ago. CNA 1 stated Resident 1 lost his appetite, was not eating a large percentage of his meals, was nauseous, sustained a fall, and had episodes of diarrhea for several months. CNA 1 stated Resident 1 had multiple episodes of diarrhea almost every day. CNA 1 described Resident 1's diarrhea as black in color with a very strong bad odor. CNA 1 stated she documented episodes of diarrhea in Resident 1's medical record and always informed the charge nurse. CNA 1 stated Resident 1's primary charge nurse was LVN 1. CNA 1 stated she always informed LVN 1 when Resident 1 had diarrhea and described the color, amount, and odor. CNA 1 stated she was not aware if LVN 1 had assessed Resident 1's diarrhea. CNA 1 stated she felt nothing was being done because Resident 1 was not getting better, at which point CNA 1 stated she informed RN 1. CNA 1 stated she informed RN 1 that Resident 1 was having diarrhea for approximately two months. CNA 1 stated she provided RN 1 with a description of the color and odor of Resident 1's diarrhea. On 5/20/20 at 0919 hours, an interview was conducted with CNA 2. CNA 2 stated Resident 1's baseline bowel habits consisted of regular formed stools. However, during the months of March, April, and May 2020, Resident 1 started having frequent episodes of diarrhea. CNA 2 described Resident 1's diarrhea as dark black in color with an extremely bad odor. CNA 2 stated Resident 1's stools in the past were not dark black and did not have a foul odor. CNA 2 stated she documented when Resident 1 had episodes of diarrhea in the resident's medical record and informed her charge nurse (LVN 1). On 5/20/20 at 1000 hours, an interview and concurrent medical record review for Resident 1 was conducted with LVN 1. LVN 1 stated she worked on the day shifts, Monday through Friday at the facility and was assigned to care for Resident 1 during the months of March, April, and May 2020. When asked about the facility's P&P on a change in a resident's bowel habits as to how to determine a resident had a change in bowel habits, such as loose stool or diarrhea, LVN 1 stated three episodes of loose stool/diarrhea or persistent loose stool/diarrhea was considered a resident change in condition. LVN 1 stated in addition to CNA's reporting a change in a resident's bowel habits, the LVN would also review the CNA's documentation for resident bowel habits in the medical record. LVN 1 stated for a resident change of condition, she would assess the resident and document her assessment in the medical record. LVN 1 stated she would then notify the resident's physician and monitor the resident for 72 hours. LVN 1 stated Resident 1's baseline bowel habits were regular and formed bowel movements. Review of Resident 1's Bowel and Bladder (B&B) Function dated 3/2020 and 4/2020, showed between 3/15 and 4/6/20, Resident 1's CNA documented Resident 1 had 20 episodes of loose stool/diarrhea. LVN 1 stated 20 episodes of loose/stool diarrhea was a change from Resident 1's baseline condition and should have been reported to Resident 1's physician. LVN 1 was asked if the CNAs reported Resident 1 episodes of loose/stool diarrhea to her. LVN stated she was not sure. LVN 1 reviewed Resident 1's medical record and verified she had not reported Resident 1's change of condition to the physician. Further review of Resident 1's medical record failed to show anyone at the facility reported this change of condition to the resident's physician or the facilitiy's Medical Director. Review of the Change in Condition Evaluation form dated 4/6/20 at 1459 hours, showed Resident 1 complained of loose stool and a poor appetite. On 4/6/20 at 1545 hours, Resident 1 was identified to be non-responsive with shallow breathing and was subsequently transferred to the acute care hospital emergency department via 911. Resident 1 was readmitted to the facility on [DATE]. Review of Resident 1's Change of Condition Evaluation dated 4/14/20, showed Resident 1 reported episodes of diarrhea off and on. Resident 1's NP was informed and the NP ordered [MEDICATION NAME] (antidiarrheal medication) 2 mg orally every six hours to be administered as needed for diarrhea. LVN 1 stated starting on 4/14/20, Resident 1 was to be monitored for diarrhea every shift for 72 hours. LVN 1 verified she cared for Resident 1 on 4/15, 4/16, and 4/17/20, and monitored Resident 1 for episodes of diarrhea. Review of LVN 1's progress noted dated 4/15/20 at 1531 hours, showed Resident 1 had no loose bowel movements during her shift. However, review of a B&B Function form dated April 2020 showed Resident 1's CNA documented two episodes of diarrhea on 4/15/20 at 0830 and at 1342 hours. Review of LVN 1's progress notes dated 4/17/20 at 1329 hours, showed Resident 1 had no episodes of loose bowels. However, review of a B&B Function form dated April 2020 showed Resident 1's CNA documented one episode of diarrhea on 4/17/20 at 0800 hours. LVN 1 verified Resident 1's medical record showed he had three episodes of diarrhea during the time in which LVN 1 was responsible for monitoring Resident 1 for diarrhea. LVN 1 verified her documentation was inconsistent with Resident 1's medical record. Review of Resident 1's Medication Administration Record

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) [REDACTED]. Review of Resident 1's Skilled Care assessment dated [DATE] at 1505 hours, showed Resident 1 did not have diarrhea on 3/30/20, during the day shift. However, review of the B&B Function dated March 2020 showed Resident 1's CNA documented two episodes of diarrhea on 3/30/20 at 1000 hours and 1410 hours. Review of Resident 1's Skilled Care assessment dated [DATE] at 1441 hours, showed Resident 1 did not have diarrhea during the 4/10/20 morning shift. However, further review of Resident 1's April 2020 B&B Function showed Resident 1's CNA documented one episode of diarrhea on 4/10/20 at 1351 hours. LVN 1 verified her assessments and documentation were inconsistent with what the CNAs had documented in regards to Resident 1's bowel movements. Review of 25 Skilled Care Assessments between 3/29/20 through 4/14/20, completed by different licensed nurses showed no documentation Resident 1 was experiencing any episodes of diarrhea or change in bowel function. However, Review of Resident 1's B&B Function dated March and April 2020 showed Resident 1 had 31 episodes of loose stool/diarrhea between 3/29 to 4/14/20. LVN 1 verified these findings. Review of Resident 1's B&B Function for April and May 2020 showed between 4/14 and 5/5/20, Resident 1's CNA documented Resident 1 had 25 episodes of loose stool and 12 episodes of diarrhea. However, there was no documentation to show Resident 1's physician was notified. LVN 1 verified the findings and stated Resident 1's physician should have been notified as this was a change of condition. On 7/9/20 at 1400 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 stated she was familiar with Resident 1 and had overseen his care for approximately 2 years. RN 1 stated if the resident had a change in condition, the assessment would be conducted, the vital signs would be obtained, and the residents' physician would be notified in order to provide treatment and services to address the resident change of condition. RN 1 reviewed Resident 1's medical record and stated Resident 1's baseline bowel habits were regular and consistent formed bowel movements. Review of Resident 1's B&B Function dated March and April 2020 showed between 3/15 and 4/6/20, Resident 1's CNA documented Resident 1 had 20 episodes of loose stool/diarrhea. RN 1 verified Resident 1's medical record failed to show documentation the physician was notified. RN 1 stated she was unaware and was not notified of Resident 1's episodes of loose stool/diarrhea. RN 1 stated a change in condition assessment should have been conducted and Resident 1's physician should have been notified in an attempt to determine the cause of Resident 1's loose stool/diarrhea. Review of Resident 1's Change of Condition Evaluation dated 4/14/20, showed Resident 1 reported episodes of diarrhea off and on. Resident 1's NP was informed and on 4/14/20 the NP ordered [MEDICATION NAME] 2 mg orally every 6 hours to be administered as needed for diarrhea. Review of Resident 1's B&B Function dated April and May 2020 showed Resident 1 had 10 episodes of diarrhea between 4/14 and 5/1/20, and Resident 1's physician was not notified. RN 1 stated Resident 1 had an order for [REDACTED]. RN 1 verified the findings and stated the [MEDICATION NAME] should have been administered, the change of condition assessment should have been conducted, and Resident 1's physician should have been notified. Review of Resident 1's B&B Function for April and May 2020 with RN 1 was conducted. RN 1 verifiefd Resident 1 had 25 episodes of loose stool and 12 episodes of diarrhea documented. RN 1 verified there was no documented evidenvce the resident's physician or NP were notified. b. Review of Resident 1's medical record showed Resident 1 weighed 143 pounds on 3/1/20. On 5/1/2020, Resident 1 weighed 119 pounds; a loss of 16.78% loss of body weight. On 6/4/20 at 1000 hours, an interview was conducted with Resident 1's physician (Physician 1). Physician 1 was informed the medical record showed Resident 1 had 73 episodes of loose stool or diarrhea between 3/15 to 5/5/20, and had a bottle surgically removed from his colon on 5/7/20. Physician 1 stated his expectation was the facility should have notified him of Resident 1's persistent loose stools and diarrhea.