STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035279	A. BUILDING _____ B. WING _____	**02/27/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ACACIA HEALTH CENTER	**4555 EAST MAYO BLVD PHOENIX, AZ 85050**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0583 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Keep residents' personal and medical records private and confidential.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policies, the facility failed to ensure one resident's (#205) medical record confidentiality was maintained by failing to ensure parts of resident #205's medical record was not included in resident #200's medical records. Findings include: -Resident #205 was admitted (MONTH) 25, (YEAR) with [DIAGNOSES REDACTED]. -Resident #200 was admitted to the facility on (MONTH) 6, (YEAR) with [DIAGNOSES REDACTED]. Review of the clinical record revealed resident #200 left the faciity on (MONTH) 20, (YEAR) for an appointment around 4:10 p.m. However, when the resident arrived at the physician's office, included in the resident's paperwork were the face sheet and the medication profile for resident #205. An interview was conducted on (MONTH) 26, 2019 at 1:46 p.m. with the medical records coordinator (staff #33). She stated that when a resident goes out to an appointment, the medical records department uses a check sheet to gather the needed documentation which would include the face sheet, progress notes, medication records, and any other documentation that the appointment would require. Staff #33 stated that the documentation is placed in an envelope and the check list is attached to the envelope. She stated that each resident's record is assembled individually and should not contain any other resident's paperwork in the packet. The coordinator stated that the envelope is given to the nurse who will give it to the resident, the resident's family member, or the driver to ensure the physician's office receives it. She further one of the staffing coordinators (staff #124) had prepared resident #200's packet. She also stated that had the physician's office notified them of the problem, she would have directed them to destroy the documents as it would be a HIPAA (Health Insurance Portability and Accountability Act) violation. During an interview conducted on (MONTH) 26, 2019 at 2:38 p.m. with the Director of Nursing (DON/staff #12), she stated that up until recently the staffing coordinator had been assembling the information packet for the residents to take with them to the physician's office. She stated that once the packet was completed, the staffing coordinator would give the envelope to the nurses who would give it to the resident, the resident's family member, or the driver. The DON stated that the envelope should only contain documents related to the resident. She further stated that the physician's office should have contacted them for clarification regarding resident #200 and that they would have requested that they destroy the second resident's documents. An interview was conducted on (MONTH) 26, 2019 at 2:50 p.m. with the staffing coordinator (staff #124). She stated that she had been responsible for assembling the paperwork for each resident's office visits. Staff #124 stated that she would include a copy of the face sheet, current medication list, progress notes, lab results, and other documents needed by the physician's office and place them in an envelope. She stated the envelope is then given to the nurse who will give it to the transportation driver, resident, or the resident's family member. Staff #124 also stated that she generally assembled one resident's record at a time but that occasionally she had assembled two or three resident's records at the same time. The facility's policy regarding Confidentiality of Information and Personal Privacy revealed the facility will safeguard the personal privacy and confidentiality of all resident personal and medical records. The policy included access to resident personal and medical records will be limited to authorize staff and business associates. Review of the facility's policy titled Privacy Notice revealed the facility is required by law to maintain the privacy of Protected Health Information (PHI).

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