STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035193	A. BUILDING _____ B. WING _____	08/23/2019

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ALLEGIANT HEALTHCARE OF MESA	3130 EAST BROADWAY ROAD MESA, AZ 85204

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 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, clinical record reviews, and policy review, the facility failed to ensure the administration of medications met professional standards of quality for three residents (#30, #50, and #130). The deficient practice could result in residents not receiving physician ordered medications and pain not being relieved. Findings include: Resident #30 was admitted on (MONTH) 3, (YEAR), with [DIAGNOSES REDACTED]. The care plan regarding hypertension initiated on (MONTH) 12, (YEAR) revealed the goal was that the resident's blood pressure will remain within normal limits. Interventions included administering prescribed medications per the physician orders [REDACTED]. Review of the current physician Order Summary Report revealed an order for [REDACTED]. Review of the Medication Administration Record (MAR) for (MONTH) 2019 revealed [MEDICATION NAME] and [MEDICATION NAME] were held on (MONTH) 16 and (MONTH) 25 due to vital signs being outside of the administration parameters. The MAR for (MONTH) 2019 revealed [MEDICATION NAME] and [MEDICATION NAME] were held due to vital signs being outside of the administration parameters on (MONTH) 3, 12, 18 and 24. Review of the MAR for (MONTH) 2019 revealed [MEDICATION NAME] and [MEDICATION NAME] were held on (MONTH) 1, 3, 9, 15, and 21 due to vital signs being outside of the administration parameters. However, further review of the MAR for June, July, and (MONTH) 2019 and nursing documentation revealed no evidence what the blood pressure was or why [MEDICATION NAME] was held when there were no vital signs parameters ordered for [MEDICATION NAME]. An interview was conducted with a Licensed Practical Nurse (LPN/staff #98) on (MONTH) 22, 2019 at 12:57 PM. The LPN stated that if a resident's blood pressure was outside of the parameters ordered for a medication, he would hold the medication and document the blood pressure in the Vital Summary and in the progress notes. After reviewing the documentation for (MONTH) 1, 2019, the LPN was unable to explain the absence of blood pressure documentation or withholding a medication without parameters. During an interview conducted on (MONTH) 23, 2019 at 1:30 PM with the Director of Nursing (DON/staff #125), the DON stated that she expects the nurses to follow the physician's orders [REDACTED]. The DON stated that she expects the nurse to document the blood pressure when a blood pressure medication is held due to the blood pressure being outside of the ordered parameters. She also stated that she would expect the nurse to notify the physician and document the notification. The DON stated that it is permissible for the nurse to hold a medication based on the nurse's clinical judgement but the nurse must document their actions and the rationale for those actions and notify the physician the medication was held. The DON stated the facility has no policy regarding administering medications with parameters, but it is the policy of the facility to follow physician orders. -Resident #50 was readmitted to the facility on (MONTH) 16, (YEAR), with [DIAGNOSES REDACTED]. Review of the current physician Orders Summary Report revealed no evidence of an order for [REDACTED]. Review of the care plan updated (MONTH) 31, 2019, revealed no care areas regarding self-administration of medication. During an interview conducted with the resident on (MONTH) 19, 2019 at 8:21 a.m., a small cup containing one capsule and one tablet split in half was observed on the resident's bedside table. The resident stated the nurse had left the pills with her earlier that morning. She stated the nurse leaves her medications regularly at the bedside and that she likes to take her pills with food later in the morning. An interview was conducted with a LPN (staff #28) on (MONTH) 23, 2019 at 9:02 a.m. The LPN stated that in order for a resident to self-administer medication, the resident would be assessed for safety, a physician's orders [REDACTED]. An interview was conducted with a LPN (staff #138) on (MONTH) 23, 2019 at 9:24 a.m. She stated the physician would have to write an order for [REDACTED]. The LPN stated the nurse would verify the resident was capable and safe to self-administer medication by having the resident demonstrate taking medications. She also stated that the nurse would document the administration on the MAR. An interview was conducted with the DON (staff #125) on (MONTH) 23, 2019 at 9:32 a.m. The DON stated that if a resident wanted to take their own medications, the nurse would conduct a self-administration assessment. She stated the physician would write an order to self-administer medications, and it would be added to the care plan. The DON said medications could be left with the resident in a locked drawer, and that the medication self-administrations would still be documented on the MAR. The facility's policy for Self-administration of Medications stated the decision for self-administration is done by the interdisciplinary team based on resident preference and/or ability to self-administer. Self-administration is determined by an order after determining that the resident can self-administer. All medications that are self-administered are signed out in the MAR with the nurse's initials. The policy included the nurse will educated the resident as needed. -Resident #130 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the clinical record revealed physician orders [REDACTED]. The admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident scored a 14 on the Brief Interview for Mental Status (BIMS) which indicated the resident had intact cognition. The assessment included the resident received opioids (pain medication) daily during the 7-day look-back period. Review of the (MONTH) 2019 Medication Administration Record (MAR) revealed [MEDICATION NAME] was administered twice for pain levels of 4. The (MONTH) 2019 nursing notes did not indicate why the pain medication was given outside of the physician ordered parameters. The MAR for (MONTH) 2019 revealed [MEDICATION NAME] was administered once for a pain level of 4 Review of the nursing notes for (MONTH) 1 through 21, 2019 revealed no indication as to why the medication was given outside of the physician ordered parameters. An interview was conducted with a Licensed Practical Nurse (LPN/staff#139) at 10:15 a.m. on 8/23/19. She said that when giving an as needed pain medication, she would ask the resident what their current pain level is and then she would review the physician's orders [REDACTED]. She said she remembered this resident and that the resident had various orders for as needed pain medications during her stay in the facility. She said that the physician had changed the orders a time or two and also ordered a scheduled medication to help control the resident's pain. After reviewing the resident's clinical record, she said she did not know why the resident was receiving pain medications outside of the ordered parameters. She stated that she would not administer medications outside of the ordered parameters. In an interview with the Director of Nursing (DON/staff #125) at 1:30 p.m. on 8/23/19, she said that her expectation

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 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) regarding administering as needed pain medications is that the nurses would obtain the resident's pain level and then would administer the pain medication as per the physician's orders [REDACTED]. The DON stated that the facility does not have a specific policy addressing this issue, but said it is the expectation that the physician order [REDACTED].
F 0686 **Level of harm -** Actual harm **Residents Affected -** Some	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record reviews, resident and staff interviews and policies and procedures, the facility failed to ensure that four sampled residents (#'s 73, 131, 113 and 18) received the necessary care and services to promote healing and/or prevent new pressure ulcers from developing. As a result, the condition of Substandard Quality of Care was identified. The deficient practice resulted in preventive measures not consistently being implemented, a lack of thorough and/or accurate pressure ulcer assessments and delays in obtaining and/or providing wound treatments. The number of residents in the facility with pressure ulcers which were greater than stage 1 was 23 residents. Findings include: -Resident #73 was admitted to the facilty on (MONTH) 28, (YEAR), with [DIAGNOSES REDACTED]. A physician's order dated (MONTH) 4, 2019 included for weekly skin checks every Tuesday on the day shift. A skin assessment dated (MONTH) 18, 2019 revealed the resident's skin was intact. Review of the clinical record revealed there was no documentation that the resident had a pressure ulcer to the neck area from (MONTH) through (MONTH) 22, 2019. A skin event assessment dated (MONTH) 23, 2019 revealed a skin issue was identified on the back of the resident's neck, near the right side. Per the assessment, the wound nurse assessed the neck area and implemented a treatment. The assessment did not include a thorough description of the skin issue to the resident's neck. A physician's order dated (MONTH) 23, 2019 was entered into the resident's electronic medical record at 8:37 a.m. by a Licensed Practical Nurse (LPN/wound nurse/staff#18), which included to wipe the left neck with normal saline, apply [MEDICATION NAME] to wound base every other day for skin alteration. However, the documentation in the electronic medical record further showed that the order was immediately discontinued at 8:40 a.m. Continued review of the physician orders revealed that another order for wound treatment to the neck wound was not obtained on (MONTH) 23, 2019. A quarterly Minimum Data Set (MDS) assessment dated (MONTH) 26, 2019 included the resident had long and short term memory problems and was severely impaired with cognitive skills for daily decision making. The MDS assessed the resident to be totally dependent for all activities of daily living (ADLs) and had limited range of motion bilaterally to upper and lower extremities. Per the MDS, the resident was at risk for pressure ulcers, but did not have any pressure ulcers. A care plan for skin integrity updated on (MONTH) 27, 2019 revealed the resident was at risk for breakdown related to [MEDICAL CONDITION], impaired mobility, decreased sensation and muscle contraction. Interventions included for body and skin audits weekly and report any red or open areas of concern to the wound nurse to evaluate. However, the care plan did not reflect the resident had a neck wound. Further review of the clinical record revealed there was no additional documentation regarding the neck wound from (MONTH) 24-30. There were also no physician orders for any wound treatment to the neck from (MONTH) 24-30, nor any documentation that treatments were provided. A skin event record dated (MONTH) 3, 2019 included no skin issues and [MEDICAL CONDITION] care was provided. However, a Wound Assessment Detail Report dated (MONTH) 9, 2019 now included documentation the resident had a facility acquired stage 3 pressure ulcer to the right lateral neck. The neck wound measured 1.5 x 8.0 x 0.1 cm (centimeters) in depth, the wound bed was described as 100% bright beefy red, exudate was light and bloody and wound edge was distinct and attached, with [DIAGNOSES REDACTED] and maceration to periwound. A physician's order was obtained on (MONTH) 10, 2019 and included to cleanse with normal saline and apply silver foam every 2 days, [MEDICAL CONDITION]. A physician's note dated (MONTH) 17, 2019 included the presence of a stage 3 pressure injury to the right posterior neck, due [MEDICAL CONDITION] pressure. The note did not include a description of the pressure ulcer to the neck. The Wound Assessment Detail Report dated (MONTH) 18, 2019 included the neck wound measured 1.1 x 6.2 x 0.1 cm. The wound bed was described as 100% bright beefy red, exudate was light and bloody and wound edge was distinct and attached, with [DIAGNOSES REDACTED] and maceration to periwound. The Wound Assessment Detail Report dated (MONTH) 26, 2019 revealed the neck wound measured 1.1 x 5.0 x 0.1 cm. The wound bed was described as 100% bright beefy red, exudate was light and bloody and wound edge was distinct and attached, with [DIAGNOSES REDACTED] and maceration to periwound. Per the (MONTH) 2019 TAR, wound treatments were provided from (MONTH) 10-31. Review of the Wound Assessment Details Report for (MONTH) 2 and 12, 2019 revealed the neck wound measured 1.5 x 8.0 x 0.1 cm in depth, the wound bed was described as 100% bright beefy red, exudate was scant and bloody and wound edge was distinct and attached, with [DIAGNOSES REDACTED] and maceration to periwound. A wound assessment dated (MONTH) 20, 2019 included the pressure ulcer to the neck measured .5 x 1.8 x .1 cm, had 100% bright beefy red tissue with a scant amount of bloody exudate and the wound edge was distinct and attached with periwound [DIAGNOSES REDACTED] and maceration. A wound care observation was conducted on (MONTH) 22, 2019 at 9:10 a.m., with a wound nurse (LPN/staff #68) and the Director of Respiratory Therapy (staff #77). The respiratory therapist removed [MEDICAL CONDITION] and positioned the resident for wound care. The LPN removed the prior dressing and serosanguineous drainage was noted on the pillow. With some difficulty, due to the resident contracting, the LPN changed the wound dressing according to the physician orders. Staff #68 described the wound as red, with pink/red serosanguineous drainage and the wound measured .4. x 2.0 cm. A telephone interview was conducted on (MONTH) 22, 2019 at 11:36 a.m., with the wound nurse (staff #18-the LPN who initially put in the wound care orders for the neck on (MONTH) 23, and then immediately discontinued the order). She stated that if a new wound is brought to her attention she will assess the situation, contact the provider, chart in the notes, start care and notify the rest of the wound team. Staff #18 stated that if she wrote an order and then discontinued it, it was because she made an error. Staff #18 stated she was unable to recall the situation with resident #73. An interview was conducted with staff #68 on (MONTH) 22, 2019 at 12:14 p.m. He stated that resident #73's wound was identified on (MONTH) 9, 2019. He said he was not aware of any skin concerns prior to this date. He stated that respiratory notified him of blood on [MEDICAL CONDITION] and he immediately went to assess the resident. He stated it was a stage 3, due to the fact that subcutaneous tissue was showing. Staff #68 said that he contacted the provider and put a treatment in place. He said the physician came in later and confirmed it was a stage 3 pressure ulcer. An interview was conducted with the Director of Nursing (DON/staff #125) on (MONTH) 22, 2019 at 1:17 p.m. She stated her expectation is that residents are assessed on admission and weekly for skin issues. She said any identified wounds should be forwarded to the wound team, and the wound team would conduct a follow up assessment of the wound the next day. She stated once a wound is identified, the team should initiate treatments, measurements and staging, in conjunction with the wound doctor. An interview was conducted with staff #77 on (MONTH) 23, 2019 at 8:47 a.m. She stated [MEDICAL CONDITION] for resident #73 are changed 3 times per week. She stated it is the responsibility of both respiratory therapy and nursing to check the skin integrity beneath [MEDICAL CONDITION]. Another interview was conducted with the DON on (MONTH) 23, 2019 at 10:55 a.m. The DON stated she did not know what happened in this case. She stated she could not explain why there were no orders put into place when redness was noted to resident #73's neck (back on (MONTH) 23) to prevent it from progressing to a pressure ulcer. -Resident #131 was admitted to the facility on (MONTH) 26, 2019, with [DIAGNOSES REDACTED]. Review of the admission Braden Scale for Predicting Pressure Ulcer Risk dated (MONTH) 26, 2019, revealed a score of 15, which indicated the resident was at mild risk for developing a pressure ulcer. Review of a skin assessment dated (MONTH) 27, 2019, revealed the resident had a surgical incision to the midline abdomen which was present on admission. The assessment did not list any other skin issues. A care plan dated (MONTH) 27, 2019 included the resident was at risk for impaired skin integrity with a goal that the resident would not have skin breakdown. Interventions were to keep the bed linens dry and wrinkle free, and to keep the

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F 0686 **Level of harm -** Actual harm **Residents Affected -** Some	(continued... from page 2) resident clean and dry. The care plan did not include an intervention to turn and reposition the resident. Review of the admission MDS assessment dated (MONTH) 2, 2019, revealed a BIMS score of 11, which indicated the resident had moderate cognitive impairment. The MDS included the resident required extensive assistance of two or more staff members for bed mobility and transfers. The MDS also included the resident did not have any unhealed pressure ulcers. Regarding the sacrum/coccyx wound: A skin assessment dated (MONTH) 5, 2019 revealed no documentation of any pressure ulcers. Review of the nurse aide documentation from (MONTH) 5-8, 2019 revealed the resident was to be turned and repositioned every 2 hours and as needed. The documentation on (MONTH) 6 and 7 regarding turning and repositioning of the resident every 2 hours and as needed on the second shift was marked as not applicable. A progress note dated (MONTH) 8, 2019 included the resident had a coccyx injury. Per the note, the resident had poor mobility and required one to two person assistance with turning and repositioning. The note included that the wound assessment would be documented during wound rounds. The note did not include a description of the coccyx wound. A care plan for skin breakdown dated (MONTH) 8, 2019 identified the resident had a sacrum pressure ulcer. The goal included the resident would not have further skin breakdown. Interventions included routine measurements of the wounds, treatments as ordered, a pressure reducing mattress and to turn and reposition the resident. The care plan did not include an intervention for any type of cushion for the resident's chair. An initial wound assessment for the coccyx was completed on (MONTH) 9, 2019. The documentation included the resident had an unstageable pressure ulcer which was facility acquired. The wound measurements were 1.5 centimeters (cm) by 1.5 cm, with an unknown depth. The tissue type was described as 100% deep maroon, and the wound edges were distinct and intact, with [DIAGNOSES REDACTED] noted in the periwound. Review of the clinical record revealed a wound photograph from (MONTH) 9, which showed that the wound was not opened. Despite documentation of an unstageable pressure ulcer, there were no physician orders that addressed the sacrum/coccyx pressure ulcer from (MONTH) 9-11, 2019 and there was no documentation of any wound treatments that were provided. A physician's order dated (MONTH) 12, 2019 now included to cleanse the sacrum with normal saline, apply [MEDICATION NAME] and cover with a foam dressing daily. Review of the coccyx wound assessment dated (MONTH) 16, 2019, revealed an unstageable pressure ulcer which measured 1.5 cm by 1.5 cm and 0.1 cm depth. The tissue type was described as 100% deep maroon and the wound edges were distinct and intact, with [DIAGNOSES REDACTED] noted in the periwound. Review of the wound photograph from (MONTH) 16, 2019 in the clinical record revealed the wound was now opened. Review of the TAR for (MONTH) 2019 revealed the treatments were administered as ordered from (MONTH) 12 through 20. The coccyx wound assessment dated (MONTH) 21, 2019 revealed the resident had an unstageable pressure ulcer which measured 1.7 cm by 1.2 cm, with an unknown depth. The wound bed was described as having 100% slough, and the wound edges were distinct and intact, with [DIAGNOSES REDACTED] in the periwound. Regarding the left buttock wound: Review of the shower sheet dated (MONTH) 5, 2019 revealed the resident had redness to the left buttock. A physician's order dated (MONTH) 5, 2019 included for a low air loss mattress. A care plan for the potential for skin integrity due to decreased bed mobility, pain and weakness was revised on (MONTH) 5, 2019. The goal included the resident would not have further skin breakdown. Interventions included a pressure reducing mattress, weekly skin checks and to assist and/or teach the resident to reposition every 2 hours and to report any red, open or areas of concern to the wound nurse to evaluate. The care plan was not updated to reflect the redness on the resident's left buttock. According to the CNA documentation, barrier cream was applied with incontinent episodes and as needed on 3 shifts on (MONTH) 5, on 1 out of 3 shifts on [DATE] and 2 out of 3 shifts on (MONTH) 7. Regarding turning and repositioning the resident every 2 hours and as needed, the documentation showed that on the second shift on (MONTH) 6 and 7 not applicable was marked.Review of the clinical record revealed no further documentation regarding the redness to the left buttocks on (MONTH) 6 or 7, 2019. A progress note dated (MONTH) 8, 2019 now included the resident had a left buttock pressure injury. Per the note, the resident had poor mobility and required one to two person assistance with turning and repositioning. The note further included that the wound assessment would be documented during wound rounds. Review of the initial wound assessment for the left buttocks dated (MONTH) 8, 2019 revealed the resident now had an unstageable pressure ulcer, which was facility acquired. The wound measurements were 8 cm by 4.1 cm with an unknown depth, the wound bed had 60% bright pink or red tissue and 40% slough and wound edges were distinct and intact, with [DIAGNOSES REDACTED] in the periwound. A care plan dated (MONTH) 8, 2019 identified the resident had a left buttock pressure ulcer. Interventions included routine measurements of the wounds, treatments as ordered, a pressure reducing mattress and to turn and reposition the resident. The care plan did not include an intervention for any type of cushion for the resident's chair. A wound assessment dated (MONTH) 9, 2019, revealed the resident had a stage 3 facility acquired pressure ulcer to the left buttocks. The wound measurements were 8 cm by 4 cm by unknown depth. The wound bed was described as having 60% bright pink or red tissue and 40% slough and wound edges were distinct and intact, with [DIAGNOSES REDACTED] to the periwound. Despite documentation of an unstageable pressure ulcer/stage 3 pressure ulcer to the left buttocks, there were no physician's orders for wound treatment which were obtained from (MONTH) 9-11, 2019. The TAR for (MONTH) 2019 also contained no documentation of wound treatments being done from (MONTH) 9-11. A physician's order dated (MONTH) 12, 2019 now included to cleanse the left buttock with normal saline, apply [MEDICATION NAME] and cover with a foam dressing daily. A wound assessment dated (MONTH) 16, 2019 included the resident had a stage 3 pressure ulcer to the left buttocks, which measured 3 by 4 cm, with a depth of 0.1 cm. The wound bed was described as having 60% bright pink or red tissue and 40% slough, and the wound edges were distinct and intact, with [DIAGNOSES REDACTED] in the periwound. Review of the nurse aide documentation from (MONTH) 9-19, 2019, revealed that turning and repositioning the resident every 2 hours and as needed was documented as not applicable at least one shift each day on (MONTH) 9, 10, 11, 13, 14, 15, 16 and 19. Review of the wound assessment dated (MONTH) 20, 2019, revealed a stage 3 pressure ulcer to the left buttocks which measured 1 cm by 1 cm, with an unknown depth. The wound bed was described as having 60% bright pink or red tissue and 40% slough, and the wound edges were distinct and intact, with [DIAGNOSES REDACTED] in the periwound. Review of the (MONTH) 2019 TAR revealed the treatments were administered as ordered from (MONTH) 12 through 20. An observation of wound care for resident #131 was conducted on (MONTH) 21, 2019 at 1:03 p.m., with two wound nurses (LPN/staff #68 and Registered Nurse/staff #94). At this time, there was one wound observed on the resident's left buttock and there was one wound on the lower left buttock. Staff #94 labeled the left buttock wound as the coccyx wound, and the lower left buttock wound was labeled as the left buttock wound. The left buttock wound (which staff #94 labeled the coccyx wound) measured 3 cm by 2.5 cm and contained approximately 75% bright pink tissue and approximately 25% slough. Staff #94 did not measure the lower left buttock wound. Following the cleansing of the two wounds, the resident was repositioned in order to visualize the coccyx area. Observed on the coccyx was a third wound which contained 100% yellowish slough like tissue. At this time, staff #94 did not cleanse the coccyx wound. Staff #94 measured this wound as 1.8 cm by 1.5 cm. Staff #94 then labeled this wound as the coccyx wound. Staff #94 stated that the left buttock wound and the lower left buttock wound were both part of the same wound and relabeled them as the left buttock wound. However, the wounds were observed to be separated by approximately 4 cm of intact tissue. Staff #94 then measured the entire area covering both the left buttock wound and the lower left buttock wound and stated the wound measured 7.9 cm by 3 cm. The lower left buttock wound was not measured separately during this observation. During this same observation, wound treatments were observed. Staff #94 was observed using an applicator to apply [MEDICATION NAME] to the coccyx wound, then used the same applicator and applied the rest of the [MEDICATION NAME] that was left on the applicator to the left buttock wound. She then used a new applicator and applied more [MEDICATION NAME] to the left buttock wound, and then used the same applicator and applied the remainder of the [MEDICATION NAME] to the lower left buttock wound. A wound assessment dated (MONTH) 21, 2019, revealed a stage 3 pressure ulcer to the left buttocks which measured 8 cm by 2.5

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F 0686 **Level of harm -** Actual harm **Residents Affected -** Some	(continued... from page 3) cm, with an unknown depth. (Although, these measurements were different than the measurements during the wound observation). The tissue type was described as having 60% bright pink or red tissue and 40% slough, and the wound edges were distinct and intact, with [DIAGNOSES REDACTED] in the periwound. Review of the clinical record revealed no evidence that the wound on the lower left buttock had been identified as a new wound and thoroughly assessed. An interview was conducted on (MONTH) 22, 2019 at 12:00 p.m., with staff #94. She stated that wounds are assessed, measured and photographed weekly. She said the wound team was responsible for assessing and measuring wounds and performing treatments. She said the wound doctor is responsible for staging the wounds and reviewing and/or changing treatment orders. She stated that common interventions for pressure ulcers would include a low air loss mattress, a wheelchair cushion, heel boots and positioning devices. She said that a regular wheelchair cushion would be a common intervention for a stage 2 pressure ulcer, and a Roho cushion would be a common intervention for a stage 3 or 4 pressure ulcer, however, each resident's needs would be considered on a case by case basis. She stated the wound team would notify therapy to evaluate the resident if a cushion or positioning device was indicated. Staff #94 did not know if the resident currently had a cushion. She stated she had not treated the resident's wounds prior to the wound observation, so she had reviewed the previous wound photos and documentation before administering the wound treatments. She said the description of the location of the coccyx wound was confusing. She said she would have called it the inner left buttock wound. She said the reason she called the two wounds on the left buttock the same wound is because she thought they had originally been part of one large open area that had partially healed in the middle. She said if a new wound was identified, the doctor should be notified and treatments should be initiated. She said the wound team would not wait for the doctor to assess a wound before beginning treatment. She said treatments should be initiated and then modified by the doctor when onsite or the team could send the doctor a photo of the wound for clarification. An observation of the resident was conducted on (MONTH) 22, 2019 at 12:54 p.m., with a LPN (staff #44) present. The resident was observed sitting in a geri-chair. Staff #44 stated the resident was not seated on any type of cushion, just the geri-chair. An interview was conducted with a Certified Nursing Assistant (CNA/staff #162) on (MONTH) 22, 2019 at 12:59 p.m. She stated that she helped transfer the resident out of bed and into his chair that morning. She said the resident did not have a cushion, but was sitting on a pillow. An interview was conducted with the DON (staff #125) on (MONTH) 22, 2019 at 1:17 p.m. She stated her expectation is that residents are assessed on admission and weekly for skin issues. She said any identified wounds would be forwarded to the wound team, and the wound team would conduct a follow up assessment the next day. She stated once a wound was identified, the team should initiate treatments, measurements and staging, in conjunction with the wound doctor. She said if there was intact skin between two wounds, they should be considered as two separate wounds, and if there were multiple wounds in an area, then each wound would be measured, treated and documented separately. She said if a new wound was identified, an assessment and measurements should be conducted right away, and treatments should be initiated. She said common preventative measures for wounds would include a low air loss mattress, skin checks and turning and repositioning. She said turning and repositioning is documented by the CNA's. She said a response of not applicable under turning and repositioning was not acceptable. An interview was conducted with the Director of Rehabilitation (staff #221) on (MONTH) 22, 2019 at 1:41 p.m. He stated the wound team and the therapy department coordinate together to provide preventative treatments for residents. He said common evaluations for residents at risk for pressure ulcers include mobility and positioning evaluations, and evaluations for pressure relieving equipment. He said this resident had received regular treatment and instruction from therapy regarding repositioning in his chair to relieve pressure. Staff #221 said the resident also received verbal instruction on transfers. He said for pressure relieving cushions, a Roho cushion would be good for pressure relief, but not a pillow. He said a pillow was not a pressure relieving device. -Resident #113 was admitted on (MONTH) 31, 2019 with [DIAGNOSES REDACTED]. An admission clinical evaluation dated (MONTH) 31, 2019 included the resident had pressure ulcers. The assessment did not include any additional information regarding the pressure ulcers. Review of a pressure ulcer unavoidable assessment dated (MONTH) 31, 2019 revealed the resident had a history of [REDACTED]. The assessment included the resident had a Braden score of 12, which indicates high risk for developing pressure ulcers. The assessment further included the resident had only one wound to the sacrum which was open, and that the wound team was caring for the wound. The assessment did not include any descriptors of the sacrum wound such as; measurements, a description of the wound bed and surrounding skin, the stage of the wound or if any drainage or odor was present. A wound care note dated (MONTH) 1, 2019 included the resident has pressure ulcers to the coccyx. The note included that co-morbidities placed the resident at risk for skin breakdown and delayed healing. The note did not include any description of the pressure ulcers to the coccyx. A care plan initiated on (MONTH) 1, 2019 included the resident has skin breakdown related to decreases in sensation due to [MEDICAL CONDITION], diabetes, impaired mobility and incontinence. The care plan included the resident had a sacrum pressure ulcer. A goal included that the resident will not have further skin breakdown. Interventions included to discuss compliance with the resident, pressure relieving mattress, routine measurement of wounds and treatment as ordered. Review of the physician orders revealed there were no wound treatment orders obtained for (MONTH) 31 and (MONTH) 1, 2019. Review of a physician wound round note dated (MONTH) 2, 2019 revealed no documentation regarding any pressure ulcers on the coccyx. A wound assessment report dated (MONTH) 2, 2019 included the first thorough assessment of the pressure ulcer since admission (on (MONTH) 31). Per the assessment, the resident had an unstageable pressure ulcer on the sacrum, which was present on admission and measured 6 cm x 6 cm, with unknown depth, wound bed had 60% bright pink or red tissue and had 40% slough, with serosanguineous exudate. The wound assessment report dated (MONTH) 2, 2019 also included a photograph of the sacrum/coccyx. Review of this photograph revealed the edge of a measuring tape which was marked in centimeters. Closer inspection of the photograph revealed a second wound was clearly visible. This wound was separated from the sacrum wound by a region of pink and healthy appearing skin. As seen in the photograph, the second wound measured more than one cm in circumference and appeared to have a dark reddened wound bed with depth. The wound bed also contained two smaller round regions of dark or blackened tissue. The second wound was not identified in this wound assessment report. A wound care note dated (MONTH) 2, 2019 included the resident had been seen by the wound physician for a wound care consultation and there were no new physician's orders, and that [MEDICATION NAME] was being applied to the sacral pressure ulcer. Despite documentation that the resident had an unstageable pressure ulcer to the sacrum/coccyx, there were no physician orders for any wound treatment or for medi-honey to be applied from (MONTH) 2-5, 2019. According to the (MONTH) 2019 TAR, there was no documentation of any treatments that were done to the sacrum/coccyx from (MONTH) 1, through 5. An admission MDS assessment dated (MONTH) 6, 2019 included a BIMS score of 14, which indicated the resident was cognitively intact. The MDS included the resident required extensive physical assistance from two or more staff for bed mobility and personal hygiene, and did not transfer from the bed. Per the MDS, the resident was always incontinent of urine, frequently incontinent of stool and was at risk for developing pressure ulcers. The MDS included the resident had one unstageable pressure ulcer upon admission, had a pressure relieving device on the mattress and received pressure ulcer care. A physician's order dated (MONTH) 6, 2019 now included to cleanse the sacrum/buttock with normal saline, apply medi-honey, silver alginate and cover with a dry dressing one time a day for wound care. The (MONTH) 2019 TAR included the above wound treatment orders. The documentation showed that the wound treatment was initiated on (MONTH) 6. A care plan initiated on (MONTH) 7, 2019 included a potential for skin integrity due to decreased bed mobility, incontinence, pain and weakness. A goal was the resident would have minimized risk of pressure ulcer related breakdown and have good skin integrity. Interventions were to assist the resident to reposition himself every 2 hours, complete body/skin audits at least weekly, pressure reducing mattress to the bed, report any red or open areas of concern to the wound nurse to evaluate and treatments as ordered. The care plan did not reflect any pressure ulcers to the sacrum/coccyx area.

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F 0686 **Level of harm** - Actual harm **Residents Affected** - Some	(continued... from page 4) A wound assessment report dated (MONTH) 9, 2019 included the resident had an unstageable pressure ulcer on the sacrum which measured 6 cm x 6 cm with unknown depth, the wound bed had 60% bright pink or red tissue and 40% slough, with serosanguineous exudate. The assessment also included a photograph of the wound. Closer inspection of the photograph revealed the undocumented second wound (identified by a wound photograph on (MONTH) 2) was now separated from the sacral wound by a slightly larger region of healthy appearing skin. The second wound in the photograph had approximately a one or more centimeter circumference, with a dark, reddened wound bed with depth, and there were no smaller round regions of dark or blackened tissue located within this wound. Further review of the (MONTH) 2019 TAR revealed that wound care was not provided on the following days: (MONTH) 7, 8, 10, 11 and 17. The spaces for staff to initial that the treatments were performed had a 9, indicating other/see nurse notes. Review of the corresponding nurses notes revealed only one nurses note dated (MONTH) 7, 2019, which included the resident had refused wound care. There was no additional documentation regarding why the wound treatments were not provided on the above dates. Review of a wound care note by the wound nurse dated (MONTH) 16, 2019 revealed the resident was seen by the wound physician and there were no new orders at this time. The note included [MEDICATION NAME] to sacral pressure ulcer and to see wound round note for further description of the wound. A physician's wound rounds note dated (MONTH) 16, 2019 included the resident had a stage 3 pressure injury to the right buttock and was receiving medi-honey and foam every 3 days. However, the note did not include any description of the right buttock pressure ulcer, nor any measurements. A wound note dated (MONTH) 19, 2019 included Wound is stable and the resident was followed by the physician frequently for wound care follow up, had a low air loss mattress in place and that an assessment had been documented. A wound assessment report dated (MONTH) 19, 2019 now included a thorough assessment of the sacrum pressure ulcer. The assessment included the resident had an unstageable pressure ulcer on the sacrum which measured 5.3 cm. x 5.3 cm. with unknown depth, with 20% bright pink or red tissue and 80% slough, and had serosanguineous exudate. The wound assessment included a photograph of the wound. Closer inspection of the photograph revealed a deterioration of the sacral wound, with more depth in one region of the wound, and wound margins appeared to have eroded with black tissue along the edges in some areas. The photograph also showed the second undocumented wound was separated from the sacral wound by a region of healthy appearing skin. The undocumented second wound as seen in the photograph had blackened and/or dark tissue in the wound bed. A wound care observation was conducted with a certified wound nurse/LPN (Licensed Practical Nurse/staff #68) on (MONTH) 21, 2019 at 9:40 p.m. Staff #68 measured the proximal right sacral wound which was 2.3 cm. x 3.0 cm. Approximately 2/3 of the wound was covered with yellowish slough like tissue and approximately 1/3 of the wound had dark grey slough like tissue. The margins were macerated and redden, and had two areas that had dark, blackish tissue. During this same observation, an additional wound was identified by the surveyor, which was approximately 1.5 cm below the right sacral wound. The wound nurse
F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and resident and staff interviews, the facility failed to ensure that one of two sampled residents (#108) had clinical indications for the use of an indwelling catheter. The deficient practice could result in residents having indwelling catheters unnecessarily. Findings include: Resident #108 was readmitted to the facility on (MONTH) 10, 2019, with a [DIAGNOSES REDACTED]. Review of a nursing progress note dated (MONTH) 15, 2019, revealed a Foley urinary catheter was inserted and the resident tolerated the procedure well. Review of the current physician Orders Summary Report revealed an order dated (MONTH) 16, 2019 for a Foley urinary catheter. The order did not include a related diagnosis. Review of the physician's progress notes from (MONTH) 10-19, 2019 revealed no evidence of a clinical indication for an indwelling urinary catheter. The care plan dated (MONTH) 21, 2019, revealed the resident was using a Foley urinary catheter. Interventions included emptying the drainage bag each shift and as needed, and maintaining a closed drainage system. An interview was conducted with the resident on (MONTH) 19, 2019 at 11:09 a.m. She stated that she had requested a urinary catheter because she did not want to have to wait to be changed when she soiled her brief. She also said it was difficult for her to get to the bathroom. An interview was conducted with a Licensed Practical Nurse (LPN/staff #28) on (MONTH) 23, 2019 at 9:02 a.m. She stated that clinical indications for an indwelling urinary catheter included [MEDICAL CONDITION] bladder, [MEDICAL CONDITION], or the protection of a wound. She said if a resident requested a catheter, she would discuss it with the physician. The LPN stated that she would not insert a urinary catheter for a resident without a medical reason. During an interview conducted with a LPN (staff #138) on (MONTH) 23, 2019 at 9:24 a.m., the LPN stated that if a resident requested a urinary catheter, she would notify the provider of the resident's request and would not insert a urinary catheter without an order. She said appropriate [DIAGNOSES REDACTED]. The LPN stated that this was the first time she had worked with resident #108 since her surgery and that she did not know why the urinary catheter had been inserted. An interview was conducted with the Director of Nursing (DON/staff #125) on (MONTH) 23, 2019 at 9:32 a.m. She said clinical indications for an indwelling urinary catheter included [MEDICAL CONDITION] bladder or protection of a wound. She stated that limited mobility, difficulty getting to the bathroom, repeated falls, or resident requests would not be appropriate indications for use of a catheter. The DON stated that she was not familiar with the reason for resident #108's indwelling urinary catheter.
F 0691 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, interviews and policy and procedure, the facility failed to ensure one sampled resident (#131) received ostomy care in accordance with professional standards of practice. The deficient practice could result in untimely waste removal, unpleasant odor and skin breakdown. There were twelve residents in the facility receiving ostomy care. Findings include: Resident #131 was admitted to the facility on (MONTH) 26, 2019, with [DIAGNOSES REDACTED]. Review of the admission physician's orders [REDACTED]. Review of the Treatment Administration Record (TAR) for (MONTH) 2019, revealed no evidence that the resident's ostomy appliance had been changed. Review of the CNA documentation for (MONTH) 2019 revealed no evidence that the ostomy appliance had been changed. Review of the admission Minimum Data Set (MDS) assessment dated (MONTH) 2, 2019, revealed a Brief Interview for Mental Status (BIMS) score of 11, which indicated the resident had moderate impaired cognition. The assessment also revealed the resident required extensive assistance for toileting and personal hygiene, and had an ostomy. Review of the care plan dated (MONTH) 5, 2019, revealed the resident had altered elimination related to an [MEDICAL CONDITION]. Interventions included emptying the ostomy bag as needed and ensuring proper ostomy supplies were available. Review of the TAR for (MONTH) 1-19, 2019 revealed no evidence that the resident's ostomy appliance had been changed. Review of the CNA documentation for (MONTH) 1-19, 2019 revealed no evidence that the appliance had been changed. During an interview conducted with the resident's representative on (MONTH) 19, 2019 at 11:41 a.m., the representative stated the resident's ostomy bag was not emptied regularly by staff and that there had been multiple times that the resident's ostomy bag had leaked or burst.

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F 0691 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 5) An interview was conducted with a Certified Nursing Assistant (CNA/staff #36) on (MONTH) 21, 2019 at 8:20 a.m. She said the CNA was responsible for changing the ostomy bag because it could snap off the wafer and a new one could be snapped on. She stated that a resident could alert staff when an ostomy bag was full, or staff would check the ostomy bag every 2 hours for residents who were unable to alert staff. She said changing of ostomy bags was documented under bowel care. The CNA stated that the nurse was responsible for changing the ostomy wafer and that the CNA would alert the nurse or the wound nurse if the wafer was leaking and needed to be changed. An interview was conducted with a Licensed Practical Nurse (LPN/staff #59) on (MONTH) 21, 2019 at 9:35 a.m. The LPN stated the CNA was responsible for changing the ostomy bag and wafer. The LPN also stated that some CNAs might be uncomfortable changing the wafer because they think it is outside of their scope of practice. He said he would provide education to the CNA that it is within their scope of practice to change the entire appliance, and he would provide training as needed. The LPN stated he would change the wafer if the CNA asked him to, or if the CNA was busy. He said most of the time he was not involved in ostomy care. The LPN said the order to change the ostomy appliance weekly did not have a schedule created and because the order did not have a schedule, it most likely would not come up on the TAR for the nurse to review and document. He said the CNA might be changing the bag and wafer, but he did not know where it would be documented. An observation of ostomy care was conducted on (MONTH) 21, 2019 at 1:33 p.m. with a CNA (staff #20 and a Registered Nurse (RN/staff #87). The CNA removed the clip-on ostomy bag, cleansed the stoma, and placed a new bag on the wafer. The wafer was not changed. The surrounding skin appeared clean and dry with no redness observed. The entire appliance appeared clean and dry. The appliance did not have a date written on it. An interview was conducted during the ostomy care observation with staff #20 and #87. Staff #20 said the resident's wafer had been changed earlier that day. She said the CNA would document changing the ostomy bag under bowel care. The CNA stated changing the appliance or wafer was not documented by the CNA and was not included under bowel care. Staff #87 said the appliance would be changed and documented by the nurse. The RN stated that if there was no documentation on the TAR, it would either be in a nursing note or the date would be written on the appliance. An interview was conducted with the Director of Nursing (DON/staff #125) on (MONTH) 23, 2019 at 9:32 a.m. The DON stated that either the CNA or the nurse was responsible for changing the appliance. The DON also said the CNA could change the bag and wafer if trained, or the nurse could change the entire appliance. She said the order to change the ostomy appliance included both the bag and the wafer and that the order would most likely be documented on the TAR. Review of the facility's policy and procedure for Ostomy Care revealed instructions on how to change an ostomy appliance. Instructions included removing the bag, washing around the site, evaluating the resident's skin for breakdown, applying barrier cream or adhesive paste as indicated, replacing a clean or new drainage bag, and documenting the changing of the ostomy bag on the TAR based on the physician's orders [REDACTED].>
F 0757 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interviews, the facility failed to ensure that pain medication parameters were followed for one of five sampled residents (#130). The deficient practice could result in the administration of unnecessary pain medication. Findings include: Resident #130 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the clinical record revealed physician orders [REDACTED]. The admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident scored a 14 on the Brief Interview for Mental Status (BIMS) which indicated the resident had intact cognition. The assessment included the resident received opioids (pain medication) daily during the 7-day look-back period. Review of the pain care plan, initiated 7/31/19, revealed that the resident was on opioids related to her chronic pai[DIAGNOSES REDACTED]. Intervention included administering the medication as ordered. Review of the (MONTH) 2019 Medication Administration Record [REDACTED] The nursing notes for (MONTH) 2019 did not indicate why the pain medication was given outside of the physician ordered parameters. Continued review of the physician orders [REDACTED]. The MAR for (MONTH) 2019 revealed [MEDICATION NAME] was given once for a pain level of 4, four times for a pain level of 5, and four times for a pain level of 6. Review of the nursing notes for (MONTH) 1 through 21, 2019 revealed no indication as to why the medication was given outside of the physician ordered parameters. An interview was conducted with a Licensed Practical Nurse (LPN/staff#139) at 10:15 a.m. on 8/23/19. She said that when giving an as needed pain medication, she would ask the resident what their current pain level is and then she would review the physician's orders [REDACTED]. She said she remembered this resident and that the resident had various orders for as needed pain medications during her stay in the facility. She said that the physician had changed the orders a time or two and also ordered a scheduled medication to help control the resident's pain. After reviewing the resident's clinical record, she said she did not know why the resident was receiving pain medications outside of the ordered parameters. She stated that she would not administer medications outside of the ordered parameters. The LPN stated that when the pain level parameters changed for [MEDICATION NAME], it is possible that some of the staff did not realize the order had changed. She also said that when the order for [MEDICATION NAME] changed, it created a gap in pain coverage for pain levels of 4 and 5. The LPN stated the physician should have been notified for clarification. In an interview with the Director of Nursing (DON/staff #125) at 1:30 p.m. on 8/23/19, she said that her expectation regarding administering as needed pain medications is that the nurses would obtain the resident's pain level and then would administer the pain medication as per the physician's orders [REDACTED]. The DON reviewed the resident's clinical record and said that the resident should have had coverage for pain levels of 4 and 5 and that the nurse on the floor should have clarified this order. The DON also stated the resident should not have received the pain medications outside of the ordered parameters. The DON stated that the facility does not have a specific policy addressing this issue, but said it is the expectation that the physician order [REDACTED].
F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews and policy review, the facility failed to ensure an order for [REDACTED]. Findings include: Resident #81 was readmitted on (MONTH) 18, 2019, with [DIAGNOSES REDACTED]. Review of the clinical record revealed a physician's orders [REDACTED]. Further review of the order did not reveal the duration for the prn [MEDICATION NAME] order. Review of the Medication Administration Record [REDACTED]. Review of the Consultant Pharmacist's note to the attending physician/provider from the Medication Regimen Review record dated (MONTH) 1, 2019 revealed a recommendation for [MEDICATION NAME] 0.5 milligrams by mouth every 24 hours prn for 90 days for continued behaviors related to anxiety. The note did not include any documented response from the physician/provider. Review of the MAR for (MONTH) 2019 revealed the resident was administered [MEDICATION NAME] 7 times, the last time being (MONTH) 17. During an interview conducted with a Licensed Practical Nurse (LPN/staff #47) on (MONTH) 21, 2019 at 3:06 p.m., the LPN stated that the physician orders [REDACTED]. After reviewing the prn [MEDICATION NAME] order for [REDACTED].

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F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 6) An interview was conducted with the Director of Nursing (DON/staff #125) on (MONTH) 21, 2019 at 3:13 p.m. The DON stated that prn [MEDICAL CONDITION] medications are limited to 14 days and reordered after the 14 days if the resident continues to require the [MEDICAL CONDITION] medication. The DON stated that the provider put the prn [MEDICATION NAME] order for [REDACTED]. The facility's policy titled [MEDICAL CONDITION] Medication dated (MONTH) (YEAR), included the facility will make every effort to comply with state and federal regulations related to the use of psychopharmacological medications in the long term care facility to include regular review for continued need, appropriate dosage, side effects, and risks and/or benefits. The policy also included orders for prn [MEDICAL CONDITION] medications will be time limited (i.e., times 2 weeks) and only for specific clearly documented circumstances.
F 0867 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.** Based on concerns identified during the survey, review of the facility assessment, staff interviews and policy and procedures, the Quality Assessment and Assurance (QA) committee failed to identify quality deficiencies regarding pressure ulcers. As a result, substandard quality of care was identified. The deficient practice resulted in delayed identification of new and existing pressure ulcers, a lack of thorough and accurate pressure ulcer assessments, preventive measures not consistently being implemented and delays in obtaining and/or providing wound treatments. Findings include: During the survey, concerns were identified regarding a lack of care and services related to pressure ulcers for four residents. Concerns included that preventive measures were not consistently being implemented, there was a lack of thorough and/or accurate pressure ulcer assessments and delays in obtaining and/or providing wound treatments. Review of the facility's assessment dated (MONTH) 27, 2019, revealed the purpose was to determine what resources were necessary to care for residents competently during day to day operations. The assessment is used to make decisions about direct care staff needs, as well as facility capabilities to provide services to the residents. The assessment stated that types of care provided by the facility included pressure injury prevention and care, skin care, and wound care for surgical and other skin wounds. The assessment described the process for evaluating what policies and procedures might be required in the provision of care, and how it would ensure those met current professional standards of practice by stating that the need to revise, update or create a new policy and procedure could be uncovered through a variety of ways, which included but were not limited to Resident Council, morning/clinical meetings and Quality Assurance and Performance Improvement (QAPI) meetings. Items that potentially needed to be revised, updated or created would be brought to the Governing Body's attention and discussed and dealt with accordingly. The assessment stated that policies and procedures were reviewed and discussed generally continuously. In addition, the facility utilized consultants to ensure the best and appropriate care for all residents. An interview was conducted with the Administrator (staff #88) on (MONTH) 23, 2019 at 2:00 p.m. He stated the QA committee regularly monitored wound care in the facility. He said the monitoring had consisted of a brief overview, including the number of wounds and if there was an increase and/or decrease of wounds. He said the wound director had not been reporting any details of wounds, nor had the QA committee monitored reports such as how wound treatments were documented in the Treatment Administration Record/Medication Administration Record. He said the QA committee had discovered concerns regarding wound care during the survey process, but not prior to the survey. Review of the facility's QAPI policy revealed that quality deficiencies related to facility operations and practices causing negative outcomes are monitored through the QAPI process. Actions taken were directed toward enhancing quality of care for residents. The QAPI Committee also serves a preventative function by reviewing and improving systems. The committee meets at least monthly to develop and implement appropriate plans of action to correct identified quality deficiencies. The facility collects and analyzes data about performance from a variety of sources including but not limited to open and closed record audits, center logs, tracking forms, events reports, and consultant reports. The QAPI committee identifies root causes and develops appropriate corrective plans of action.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, staff interviews, review of facility policy and procedures, and the Guidelines for Preventing Health-Care--Associated Pneumonia, the facility failed to ensure infection control was maintained for one resident (#28) observed for [MEDICAL CONDITION] care and suctioning. The deficient practice could result in increased risk of respiratory infections in residents with tracheostomies. Findings include: Resident #28 was readmitted on (MONTH) 11, 2019, with [DIAGNOSES REDACTED]. Review of the physician Order Summary Report for (MONTH) 2019 revealed orders for [MEDICAL CONDITION] care twice a day and as needed and to change the inner cannula every day and as needed dated (MONTH) 12, 2019. Review of the care plan regarding an altered airway status included a goal that the resident would have a clean and healthy [MEDICAL CONDITION] and stoma site. Interventions included observing for signs and symptoms of respiratory distress, suctioning as needed, and [MEDICAL CONDITION] care every shift and as needed. An observation of [MEDICAL CONDITION] care and suctioning was conducted on (MONTH) 23, 2019 at 8:20 AM with a Respiratory Therapist (RT/staff #123). The RT was observed to wash her hands and donned clean gloves. She then opened the packages of supplies, and replaced the oxygen mask and [MEDICATION NAME] suction tip. She removed the drainage sponge from under the [MEDICAL CONDITION]. The RT then cleaned around the [MEDICAL CONDITION] site with sterile saline soaked gauze and dried the site with gauze. The RT removed and discarded the inner cannula of the [MEDICAL CONDITION]. Without changing her unclean gloves, the RT placed the clean inner cannula in the [MEDICAL CONDITION] and placed a clean drainage sponge under the [MEDICAL CONDITION]. The RT then donned a sterile glove over her uncleaned gloved right hand. She did not change gloves prior to donning the sterile glove. She picked up the sterile suction catheter with her right hand and suctioned the resident. The RT then checked the resident's oxygen saturation level and listened to his breath sounds. The RT removed her gloves and washed her hands before leaving the room. In an interview conducted with the RT (staff #123) on (MONTH) 23, 2019 at 9:36 AM, staff #123 stated that the facility procedure does not include changing gloves after removing the unclean cannula and before inserting the clean inner cannula. She also stated that the procedure calls for placing the sterile glove over the used glove when suctioning a [MEDICAL CONDITION]. During an interview conducted on (MONTH) 23, 2019 at 10:20 AM with the Director of Respiratory Therapy (staff #77), staff #77 stated that the therapists do not change gloves between the removal of the old inner cannula and the insertion of the new one because it is not a sterile procedure. She stated that they only touch the outside of the cannula. She also stated that it is appropriate to place the sterile glove over the used glove before suctioning through a [MEDICAL CONDITION]. Review of the facility's policy titled Airway Care revised (MONTH) (YEAR) revealed the purpose of [MEDICAL CONDITION] care is to prevent infection and maintain a patent airway. The policy included [MEDICAL CONDITION] care will be performed every shift and as needed by respiratory therapy. The policy also included standard precautions will be used at all times when providing [MEDICAL CONDITION] care. The facility's policy titled Suctioning Artificial Airway dated (MONTH) 2012 revealed [MEDICAL CONDITION] suctioning should be performed with special consideration for the potential complications associated with the procedure including infection. The suctioning procedure directs that sterile technique should be employed and that the Center for Disease Control (CDC) Guidelines for Standard Precautions should be adhered to. Review of the CDC Guidelines for Preventing Health-Care--Associated Pneumonia, 2003, revealed it is strongly recommended for implementation and strongly supported by well-designed experimental, clinical, or epidemiologic studies that standard precautions be followed. This includes decontaminating hands with soap and water or antibacterial rub, whether or not gloves are worn, after contact with mucous membranes, respiratory secretions, or objects contaminated with respiratory

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	035193	A. BUILDING _____ B. WING _____	**08/23/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ALLEGIANT HEALTHCARE OF MESA	**3130 EAST BROADWAY ROAD MESA, AZ 85204**

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 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 7) secretions. Change gloves and decontaminate hands between contacts with a contaminated body site and the respiratory tract of, or respiratory device on, the same patient.