STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035290	A. BUILDING _____ B. WING _____	06/14/2019

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ALLEGIANT HEALTHCARE OF PHOENIX, LLC	1880 EAST VAN BUREN STREET PHOENIX, AZ 85006

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 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **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 that a Do Not Resuscitate (DNR) form for one resident (#43) was signed by a witness. The deficient practice could result in residents receiving services which are not in accordance with their wishes. Findings include: Resident #43 was admitted to the facility on (MONTH) 5, 2019, with [DIAGNOSES REDACTED]. Review of the face sheet revealed the name and contact information for the resident's Power of Attorney (POA) for Healthcare.Review of the clinical record revealed a physician order [REDACTED]. Review of the Advance Directives/Medical Treatment Decisions form revealed the resident was a DNR and that verbal consent was obtained from the POA and the form was signed by a Licensed Practical Nurse (LPN) on (MONTH) 5, 2019. Review of the Prehospital Medical Care Directive (Do Not Resuscitate) form revealed verbal consent was obtained from the guardian and a LPN signed the form on (MONTH) 5, 2019, indicating that the form and its consequences had been explained to the signer. Additional review of the form revealed instructions that the form is to be signed by the resident, the resident's identifying information must be completed, the form must be completed and signed in front of a witness, the health care provider must sign the form, and that at least one adult witness or a Notary Public must witness the signing of the form. However, further review of the form revealed the form was not signed by the resident's representative, the resident's identifying information was not completed, and the area designated for the signature of the witness to the resident's directive was blank. Review of the Care Plan Conference Summary dated (MONTH) 25, 2019 revealed the conference meeting was held at the resident's bedside per the resident's request. The form also included the DNR code status was reviewed. An interview was conducted with the Social Services Director (SSD/staff #81) on (MONTH) 13, 2019 at 11:27 AM. The SSD stated that she is responsible for inviting the resident or the POA to meet with the provider and complete the advance directive forms. She stated that a signature is required on the form and that until the POA was able to sign the form, it would be permissible to take verbal direction from the POA as long as there were two witnesses to the verbal directive. The SSD also stated that resident #43 is not DNR status as long as the form remains unsigned. An interview was conducted with the Director of Nursing (DON/staff #27) on (MONTH) 14, 2019 at 9:25 AM. The DON stated that it would be acceptable to have two nurses witness verbal consent for DNR and have the responsible party come to the facility and sign the forms as soon as possible. The DON also stated that the DNR documents can be mailed to the responsible party for their signature and returned to the facility signed. During an interview conducted with an LPN (staff #30) on (MONTH) 14, 2019 at 10:41 AM, the LPN stated that if resident #43 had a change of condition and the nurse called 911 for transfer to the hospital, the emergency medical responders would not honor the Prehospital Medical Care Directive (Do Not Resuscitate) form because it lacked the appropriate signatures. During an interview conducted with a LPN (staff #39) on (MONTH) 14, 2019 at 10:48 AM, the LPN stated that it was necessary to have two signatures for verbal consent. The facility's policy regarding Advance Directives revealed advance directives will be respected in accordance with state law and facility policy. The policy also included the Nurse Supervisor will be required to inform emergency medical personnel of a resident's advance directive regarding treatment options and provide such personnel with a copy of such directive when transfer from the facility via ambulance or other means is made.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident and staff interviews, and policy review, the facility failed to ensure a comprehensive person-centered care plan was developed for one sampled resident (#198) regarding respiratory care and for one sampled resident (#77) regarding activities. The deficient practice could result in resident #198 not receiving respiratory care and resident #77 not being provided activities consistent with the resident's choice and abilities. The census was 93. Findings include: -Resident #198 was admitted to the facility on (MONTH) 27, (YEAR), with [DIAGNOSES REDACTED]. The resident was discharged (MONTH) 17, (YEAR). Review of the physician's orders [REDACTED]. An admission Minimum Data Set (MDS) assessment dated (MONTH) 3, (YEAR) revealed a score of 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident was cognitively intact. The assessment included the resident was receiving [MEDICAL CONDITION] treatments and oxygen. Review of the nursing progress notes for (MONTH) through (MONTH) (YEAR), revealed the resident was receiving oxygen and using the [MEDICAL CONDITION] machine. Review of the Medication Administration Record [REDACTED]. However, review of the comprehensive care plan did not reveal any care plan that addressed the respiratory care. During an interview conducted with the Director of Nursing (DON/staff #27) on (MONTH) 14, 2019 at 11:37 a.m., the DON stated that she expects a care plan to be in place as soon as possible for a resident with respiratory needs. -Resident #77 was admitted to the facility on (MONTH) 8, 2019, with [DIAGNOSES REDACTED]. Review of the admission MDS assessment dated (MONTH) 15, 2019, revealed a BIMS score of 13 which indicated the resident was cognitively intact. The assessment also revealed that it was very important to the resident to have books and magazines to read, listen to music, be around pets/animals, to keep up with the news, to do group activities, to get fresh air if weather is good, and participate in religious services. Review of the Activity assessment dated (MONTH) 15, 2019, revealed the resident liked to read books and magazines and watch

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 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) Television. However, review of the care plan did not reveal any care plan regarding activities that listed the resident's goals and preferences for activities. During an interview conducted with the resident on (MONTH) 10, 2019 at 9:14 a.m., the resident stated that she likes to read magazines but that she has not been provided any. The resident was observed sitting in the room watching television. No magazines or books were observed in the room. On (MONTH) 12, 2019, at 1:10 p.m., an interview was conducted with the Activities Director (staff #72). Staff #72 stated that she did not know why a care plan was not developed for activities. She stated that the activity care plan should have been completed by now. An interview was conducted with the DON (staff #27) on (MONTH) 12, 2019 at 1:48 p.m. The DON stated that a complete person-centered comprehensive care plan including one for activities should be completed within 21 days of admission. Review of the facility's policy titled Care Planning - Interdisciplinary Team revealed the care planning/interdisciplinary team is responsible for the development of an individualized comprehensive care plan for each resident. The policy also revealed a comprehensive care plan for each resident is developed within seven days of completion of the MDS assessment. The policy further revealed the care plan is based on the resident's comprehensive assessment.
F 0660 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Plan the resident's discharge to meet the resident's goals and needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and review of policy and procedures, the facility failed to ensure discharge planning included developing a discharge care plan for one sampled resident (#98). The deficient practice has the potential to result in an ineffective transition to post-discharge care and increases the risk factors leading to preventable readmission. Findings include: Resident #98 was admitted on (MONTH) 16, 2019, with [DIAGNOSES REDACTED]. The resident was discharged (MONTH) 12, 2019. Review of the physician's orders [REDACTED]. The baseline care plan dated (MONTH) 16, 2019, revealed the only information regarding discharge was that the goal was to discharge to the community. An initial social service evaluation form dated (MONTH) 18, 2019 did not address the resident's discharge plan. Review of a Social Service progress note dated (MONTH) 18, 2019, revealed the family requested a care plan meeting immediately to discuss discharge plans. The Care Plan Conference Summary dated (MONTH) 22, 2019, revealed the plan was for the resident to be discharged to home. The admission Minimum Data Set (MDS) assessment dated (MONTH) 23, 2019, revealed there was no active discharge plan in place for the resident to return to the community. A nurse practitioners progress note dated (MONTH) 27, 2019, revealed the resident would benefit from acute rehabilitation as she is making good progress and should be evaluated by an acute rehabilitation. A discharge narrative progress note dated (MONTH) 12, 2019 revealed the resident was transferred to an acute rehabilitation facility. A discharge MDS assessment dated (MONTH) 12, 2019, revealed the resident's discharge was a planned discharge and that the resident was discharged to an inpatient rehabilitation facility. However, review of the clinical record and the comprehensive care plan did not reveal a discharge care plan had been developed. An interview was conducted with the Director of Social Services (staff #81) on (MONTH) 14, 2019 at 8:44 a.m. Staff #81 stated discharge planning starts at admission. Staff #81 stated that the discharge care plan should have a goal to help ensure a safe discharge. Staff #81 also stated that baseline care plans are to be completed within 48 hours of admission and comprehensive care plans are to be completed within 21 days of admission. An interview was conducted on (MONTH) 14, 2019 at 9:09 a.m. with the Director of Nursing (DON/staff #27). The DON stated that a baseline care plan should be developed within 48 hours of admission. The DON also stated that a person-centered comprehensive care plan should include a discharge care plan with goals and interventions and should be developed within 21 days of admission. Review of the facility's policy titled Discharge Planning revealed discharge planning is to ensure safe transition to discharge destination. The policy also included the Interdisciplinary team, resident, and family establishes discharge planning goals/preferences.
F 0686 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **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 1 of 2 sampled residents (#198) was consistently provided pressure ulcer treatments. The deficient practice could result in delayed wound healing or worsening of the pressure ulcer. Findings include: Resident #198 was admitted to the facility on (MONTH) 27, (YEAR), with [DIAGNOSES REDACTED]. An Admission Clinical Evaluation dated (MONTH) 27, 2019, included the resident had an open area to the rear right thigh. A Weekly Pressure Ulcer report dated (MONTH) 28, (YEAR), revealed the resident had a stage 3 pressure ulcer to the rear right thigh that was present upon admission. A physician's orders [REDACTED]. On (MONTH) 30, (YEAR), the order was changed to every 2 days. A care plan initiated (MONTH) 2, 2019 revealed the resident had increased nutritional needs related to a stage 3 pressure ulcer. An admission Minimum Data Set (MDS) assessment dated (MONTH) 3, (YEAR) revealed a score of 15 on the Brief Interview for Mental Status which indicated the resident had intact cognition. The assessment included the resident had one unhealed stage 3 pressure ulcer that was present upon admission. However, review of the Treatment Administration Record (TAR) for (MONTH) (YEAR) revealed no documentation that the treatment was provided on (MONTH) 5, 7, 13, 19, 21, and 25, (YEAR). Review of the TAR dated (MONTH) (YEAR) revealed no documentation that the treatment was provided on (MONTH) 5, 19, and 30, (YEAR). An interview was conducted with a Licensed Practical Nurse (LPN/staff #141) on (MONTH) 14, 2019 at 10:11 a.m. The LPN stated that the wound nurse provides most of the pressure ulcer treatments. She stated that the floor nurse would do a pressure ulcer treatment as needed i.e. a dressing became soiled or dislodged. During an interview conducted with the wound nurse (#130) on (MONTH) 14, 2019 at 10:16 a.m., she stated wound treatments are done by the wound nurse and documented in the electronic record. An interview was conducted with the Director of Nursing (DON/staff #27) on (MONTH) 14, 2019 at 11:13 a.m. The DON stated that the expectation is that the pressure ulcer treatments be documented after the treatment has been provided. Review of an undated facility policy titled, Wound Assessment Documentation-Facility Procedure included, The Registered/Licensed Practical Nurse must assess, manage and document wounds upon admission or occurrence of wound. The nurse must apply the Principles of Wound Care Management based on evidence researched practices as outlined in this manual. The policy also included the wound care nurse does the complex treatments and conducts assessments and documents admission and weekly wound assessments. The policy further included the floor nurses performs non-complex treatments and as needed complex treatments when the wound nurse is not available.
F 0688 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, staff interviews, and policy and procedure, the facility failed to ensure

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F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) splints were applied to one sampled resident (#48) as ordered by the physician. The deficient practice could result in a reduction in range of motion. Findings include: Resident #48 was admitted to the facility on (MONTH) 14, 2019, with [DIAGNOSES REDACTED]. Review of the care plan initiated on (MONTH) 14, 2019 revealed the resident was at risk for chronic pain related to contracture. Interventions included massage and positioning. The quarterly Minimum Data Set assessment dated (MONTH) 23, 2019 revealed the resident had severely impaired cognition skills for daily decision making. The assessment included the resident had range of motion impairment in the upper and lower extremities on both sides and was totally dependent for all activities of daily living. Review of the clinical record revealed a physician's orders [REDACTED]. Review of the clinical record revealed a prescription for a wrist hand brace was signed by the physician on (MONTH) 1, 2019. Review of the Treatment Administration Records for April-June 2019 revealed no documentation regarding splints. Further review of the clinical record revealed no documentation that the splints were applied as ordered by the physician. During an observation conducted on (MONTH) 10, 2019 at 9:35 AM, the resident was observed with an inflatable carrot orthoses in the right hand and nothing in the left hand. A second carrot orthoses was observed on the bedside table. During another observation conducted on (MONTH) 11, 2019 at 2:01 PM, the resident's hands were observed with nothing in them. Two carrots orthoses were observed on top of the resident's dresser. An observation of the resident was conducted on (MONTH) 12, 2019 at 12:51 PM. The carrot orthoses were observed on the dresser and nothing was observed in the resident's hands. An interview was conducted with a Licensed Practical Nurse (LPN/staff#114) on (MONTH) 12, 2019 at 12:57 PM. The LPN stated that she was not aware of any orders for splints for resident #48. She stated that she places cushions (carrots) in the resident's hands as a comfort measure. Staff #114 stated that there was no order for the cushions so it is not documented anywhere. An interview was conducted with the Executive Director (ED/staff #215) on (MONTH) 12, 2019 at 1:44 PM. The ED stated that the RNA (Restorative Nursing Aid) would be the one to document about the splints. The ED stated that the order was not entered correctly resulting in the order not populating for the RN[NAME] The ED further stated that is why the documentation could not be found and that the splints had not been applied by the RN[NAME] An interview was conducted with the Director of Rehab (staff #242) on (MONTH) 12, 2019 at 2:09 PM. She stated that when resident #48 was admitted her hands were so badly contracted that they wanted to use something that would not cause her more harm. She stated a low level splint was ordered for the resident, which were the carrots. A follow up interview was conducted with staff #242 and an orthotic company representative on (MONTH) 13, 2019 at 12:15 PM. The company representative stated that the resident's hands were very contracted and the plan was to gradually open the hands. He stated that he recommended the carrots. Staff #242 stated that therapy staff do not document anything about splints. Staff #242 stated the splints are given to the nursing staff and that the nursing staff will obtain a physician's orders [REDACTED]. Review of the facility's policy and procedure regarding splint/brace revealed splints and braces are worn on the recommendation of the occupational or physical therapist and on the order of the physician. Often, they are put on and taken off according to a schedule. They are used to prevent contractures or deformities in resident whose medical condition leaves them prone to such developments. They may also be used to prevent existing contractures from worsening. The policy also instructed to document the assistance/application of the splint or brace in the electronic medical record.
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide safe and appropriate respiratory care for a resident when needed.** **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 1 of 3 sampled residents (#198) who needed respiratory care was provided such care, consistent with professional standards of practice. The deficient practice could result in respiratory complications. Findings include: Resident #198 was readmitted to the facility on (MONTH) 24, (YEAR), with [DIAGNOSES REDACTED]. The resident was discharged (MONTH) 6, (YEAR). -Regarding the [MEDICAL CONDITION] issue: An Admission Clinical Evaluation dated (MONTH) 24, (YEAR), included the resident was using a [MEDICAL CONDITION] device. A health status note dated (MONTH) 24, (YEAR), included the resident had the [MEDICAL CONDITION] in place. A provider note dated (MONTH) 26, 27, and 28, (YEAR) revealed the plan was to continue the [MEDICAL CONDITION] throughout the day and at night as tolerated. A health status note dated (MONTH) 29, (YEAR), included the resident was using the [MEDICAL CONDITION]. A provider note dated (MONTH) 11 and 17, (YEAR) included to continue the [MEDICAL CONDITION] throughout the day and at night as tolerated. A nurse practitioner note dated (MONTH) 31, (YEAR) included the resident stated she had been short of breath at night and that her [MEDICAL CONDITION] device had not been put on and she wanted to ensure orders were written for the [MEDICAL CONDITION] at night. The note also included that this issue was discussed with staff including the respiratory staff. The note revealed the plan was for staff to apply the [MEDICAL CONDITION] at night and as needed when sleeping and to continue the [MEDICAL CONDITION] throughout the day and at night as tolerated. A nurse practitioner note dated (MONTH) 5, (YEAR) included for staff to apply the [MEDICAL CONDITION] at night and as needed when sleeping and to continue the [MEDICAL CONDITION] throughout the day and at night as tolerated. However, review of the clinical record revealed no evidence there was a physician's orders [REDACTED]. Further review of the clinical record did not reveal documentation that the [MEDICAL CONDITION] was consistently applied at night and throughout the day as needed. -Regarding the [MEDICATION NAME] treatment: A physician's orders [REDACTED]. Review of the Medication Administration Record [REDACTED]. Review of the MAR for (MONTH) (YEAR) revealed no documentation the resident received the [MEDICATION NAME] solution from (MONTH) 1, (YEAR) through (MONTH) 12, (YEAR). An interview was conducted with a Respiratory Therapist (RT/staff #38) on (MONTH) 14, 2019 at 9:25 a.m. The RT stated that nursing normally applies a resident's home [MEDICAL CONDITION] machine. The RT stated that respiratory therapy is involved with the maintenance of the [MEDICAL CONDITION] machine and would only document in the progress notes if something was abnormal. He also stated that nursing knows to notify respiratory therapy if they need any help. An interview was conducted with a Licensed Practical Nurse (LPN/staff #141) on (MONTH) 14, 2019 at 10:11 a.m. The LPN stated that respiratory therapy is the one who handles and documents on residents' home [MEDICAL CONDITION] machines. The LPN also stated that when a resident is readmitted from the hospital, the nurses check to see if there are new orders from their discharge to be put into the computer. An interview was conducted with the Director of Nursing (DON/staff #27) on (MONTH) 14, 2019 at 10:28 a.m. The DON stated that if a resident uses a [MEDICAL CONDITION] machine, it should be documented. A facility's policy regarding [MEDICAL CONDITION] machines titled Non-Invasive Ventilation revised (MONTH) 2019 instructed to 1. Verify orders and patient status by reviewing chart. The policy also revealed the vital signs, BBS, and settings are to be documented on the flow sheet. A facility's policy titled Medication Administration revised (MONTH) 2019, included the purpose of the policy was To provide Respiratory Therapists/Nursing staff guidelines regarding administration of respiratory therapy related medications. The procedure included, Each dose of medication will be administered following the FDA standards and is to be properly recorded in the patient's medication record.

F 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.**

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F 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interview, and policy review, the facility failed to ensure food items in 2 refrigerators were labeled and dated. The deficient practice could result in a potential for food borne illness. Findings include: An initial kitchen observation was conducted on [DATE] at 08:15 AM with a Dietary Aide (staff #250). A plastic bag containing hash browns and a plastic bag containing sausages were observed without a label or an opened date in the small kitchen refrigerator. During this same observation, a plastic bag containing dinner roles was also observed without a label or an opened date in the large kitchen refrigerator. An interview was conducted on [DATE] at 12:13 PM with the Director of Dietary Services (staff #245). Staff #245 stated that he inspects the refrigerators and freezers for expired, unlabeled food and beverages daily when he arrives every morning. He stated that sometimes plastic bags of food are taken out of the labeled box in the large refrigerator and moved to the small refrigerator. He stated that the staff forget to label and date the bag before putting it in the small refrigerator. He stated that some of the dinner rolls were served last night, and the hash browns and sausage links were served that morning. The Director of Dietary Services stated that food that is not labeled or dated in the refrigerator is not an acceptable practice. Review of the facility's policy regarding food storage for cold foods revealed all time/temperature control foods, frozen and refrigerated, will be appropriately stored in accordance with guidelines of the FDA Food Code. The policy also included all foods will be in covered containers or wrapped, labeled and dated, and arranged in a manner to prevent cross contamination.