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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
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 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.

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 0695 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) 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.