STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035171	A. BUILDING _____ B. WING _____	**03/21/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ALTA MESA HEALTH AND REHABILITATION	**5848 EAST UNIVERSITY DRIVE MESA, AZ 85205**

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 0561 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, resident and staff interviews, facility documentation and policy review, the facility failed to ensure 2 of 13 sampled residents (#2 and #11) had the right to choose when they wake up and when they get out of bed in the mornings. This deficient practice has the potential to alter sleep patterns that could affect the overall health and well-being of residents. Findings include: -Resident #11 was admitted on (MONTH) 25, 2019, with [DIAGNOSES REDACTED]. Review of the care plan dated (MONTH) 28, 2019, revealed the resident had self-care performance deficits and required extensive assistance of one staff for dressing. The admission MDS (Minimum Data Set) assessment dated (MONTH) 1, 2019, revealed a score of 14 on the BIMS (Brief Interview for Mental Status), which indicated the resident was cognitively intact. The MDS assessment also included the resident needed extensive assistance of one staff for dressing. During an interview conducted with the resident on (MONTH) 18, 2019 at 9:26 a.m., the resident stated that she is awaken, gotten out of bed, dressed and then is put back to bed by the CNA's (Certified Nursing Assistant) as early as 3:00 a.m. The resident stated that this upsets her because now she is wide awake, breakfast is not served until 7:00 a.m. to 7:30 a.m., and that it makes for a long day. On (MONTH) 20, 2019 at 1:41 p.m., a follow-up interview was conducted with resident #11. Resident #11 stated that the night CNA had gotten her and her roommate up before 3:00 a.m., as recently as last night or the night before. Resident #11 stated that the CNA told her and her roommate that the CNAs were getting residents pre-dressed so the day shift would not have to dress them. -Resident #2 was admitted on (MONTH) 10, 2013, with [DIAGNOSES REDACTED]. A review of the care plan dated (MONTH) 28, (YEAR), revealed the resident had self-care performance deficits and needed extensive assistance of one staff for dressing. A quarterly MDS assessment dated (MONTH) 9, (YEAR), revealed a BIMS score of 12, indicating the resident had moderate cognitive impairment. The MDS assessment also included the resident needed extensive assistance of one staff for dressing. An interview was conducted with resident #2 on (MONTH) 20, 2019 at 1:43 p.m. Resident #2 stated that she did not like the CNA's getting her and her roommate up as early as 3:00 a.m. and dresses them and then puts them back to bed. She also stated that she did not report this to anyone. An interview was conducted with the DON (Director of Nursing/staff #29) on (MONTH) 21, 2019 at 8:25 a.m. Staff #29 stated that she had spoken to residents #2 and #11 and that they stated the CNA's get them up early to dress them and then puts them back to bed. She stated that she would take care of that. On (MONTH) 21, 2019 at 9:21 a.m., an interview was conducted with a CNA (staff #27). Staff #27 stated that the DON had put up a get up early list which listed the residents that were to be dressed by the night shift. A review of the get up list revealed resident #2 and resident #11 were on that list. The list also included, Effectively immediately this is the resident get up schedule. ALL N[NAME] (night) shift CNA staff are expected to follow this schedule NO EXCEPTIONS. If a resident refuses to get up or dressed, please try to swap out that place with another resident. The DON's name was typed under the instructions. An interview was conducted with the Administrator (staff #13) on (MONTH) 21, 2019 at 10:00 a.m. Staff #13 reviewed the get up list and stated that she was not aware of the list. She stated that she did not think it was appropriate to get residents up early and put them back to bed. A follow up interview was conducted with staff #29 on (MONTH) 21, 2019 at 1:33 p.m. Staff #29 stated that the get up list had been the process for many years. The DON stated that it was almost impossible for the day shift CNA's to get everyone up and ready for breakfast, so the night shift staff would get residents up and assist them with dressing around 5:00 a.m. Staff #29 stated that residents and families had discussed wake-up times during the care plan conferences. However, no documentation was provided that this practice had been agreed upon by families or residents. The facility's policy regarding residents' rights revealed the resident has a right to a dignified existence, self-determination, and communication with and access to persons or services inside and outside of the facility. The policy included the facility must protect and promote the rights of each resident including the right to reside and receive services in the facility with reasonable accommodation of the individual needs and preferences, except when to do so would endanger the health or safety of the resident or other residents. The policy also included the resident has the right to choose schedules (including sleeping and waking times) consistent with his or her interests.
F 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, staff and resident interviews, facility documentation and policy review, the facility failed to ensure one resident (#8) was free from abuse by another resident (#126). The deficient practice could result in further abuse of residents. Findings include: -Resident #8 was admitted to the facility on (MONTH) 3, (YEAR), with [DIAGNOSES REDACTED]. A quarterly Minimum Data Set (MDS) assessment dated (MONTH) 10, (YEAR), revealed the resident had moderate cognitive impairment, and required supervision to limited assistance of one person for most activities of daily living. A care plan dated (MONTH) 18, (YEAR) included the resident used anti-anxiety medications related to anxiety. An incident progress note dated (MONTH) 25, (YEAR) included that resident #8 was slapped in the face by another resident (#126), who came into her room during the previous shift (evening shift on (MONTH) 24). Per the note, no injuries were noted to resident #8 and she did not appear to be in distress about the incident. Another note dated (MONTH) 25, (YEAR) included the resident's family member was notified that she was assaulted by another resident. -Resident #126 was admitted to the facility on (MONTH) 30, (YEAR), with [DIAGNOSES REDACTED].

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 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) An admission note dated (MONTH) 30, (YEAR) included the resident was observed wandering in the hall. Progress notes dated (MONTH) 1, (YEAR) indicated the resident was found wandering the halls several times, attempted to go outside and was issued a wanderguard. Review of the Mood/Behavior notes dated (MONTH) 3, 4, 5, 12 and 13, (YEAR) revealed documentation that the resident was wandering into other resident rooms. A care plan dated (MONTH) 14, (YEAR) included the resident had impaired cognitive function, dementia, or impaired thought processes related to a history of [MEDICAL CONDITION]. The care plan noted that the resident makes statements that she wants to leave the facility. Interventions included the resident has a wanderguard in place due to wandering, and provide diversionary activities such as; one on on conversations, sitting or strolling outside and playing the piano in the chapel. A care plan dated (MONTH) 15, (YEAR) revealed the resident displays a behavior of going into other residents' rooms. Interventions included to divert the resident's attention, move her to an alternate location as needed and to intervene as necessary to protect the rights and safety of others. According to the Mood/Behavior notes dated (MONTH) 17 and 18, (YEAR), resident #126 was wandering into other resident rooms. A note dated (MONTH) 19, (YEAR) revealed that social services and the Director of Nursing (DON) met with the resident's Power of Attorney (POA) regarding the resident's behaviors. The POA was informed that if the behaviors continue to increase with psych services in place, the facility would look into alternative placement, such as memory care for the resident. A Mood/Behavior note dated (MONTH) 21, (YEAR) included that resident #126 was stopped from going into another resident's room and in the process, slapped a LPN in the face open handed. An incident note dated (MONTH) 24, (YEAR) included the resident was attempting to go out of the facility through an emergency exit door, when a CNA blocked her and the resident hit the CNA in the arm. The note further included that later the same CNA redirected this resident out of another resident's room, and the resident slapped the CNA on the face. Review of a Mood/Behavior note dated (MONTH) 26, (YEAR) included the resident was exhibiting exit seeking behaviors and wandering into several rooms. A Mood/Behavior note dated (MONTH) 2, (YEAR) included the resident was wandering into other resident rooms and set off an emergency exit alarm. Multiple progress notes dated (MONTH) 3, (YEAR) documented that resident #126 had attempted to leave the building on several occasions and when redirected, became aggressive by trying to hit a CNA, and that the resident was cursing and raising her voice. The notes also included the resident was found in several occupied resident rooms. A communication note dated (MONTH) 7, (YEAR) included the psych nurse practitioner visited resident #126 and adjusted her medications due to an increase in behaviors, as evidenced by wandering and exit seeking. A Mood/Behavior note dated (MONTH) 11, (YEAR) included the resident had been yelling and swearing at staff and other residents, as well as taking clothes from another resident's room. A Mood/Behavior note dated (MONTH) 12, (YEAR) included the resident was rummaging through another resident's room. An incident note on the same day included the resident went into another resident's room and tried to take a jewelry box. Review of a Mood/Behavior note dated (MONTH) 13, (YEAR) revealed the resident was exit seeking on two occasions during the shift, and wandered into several other resident rooms. The note also included the resident raised her voice a couple of times, but did not get violent. A care conference note dated (MONTH) 15, (YEAR) included concerns regarding an increase in behaviors for resident #126, which was discussed with the POA, a friend and the case manager. The need for a behavioral unit/memory care was also discussed. The note included that social services will update family of upcoming discharge date . Review of a Mood/Behavior note dated (MONTH) 17, (YEAR) revealed the resident had wandered into several resident's rooms and was redirected with difficulty. The resident was very verbal and was combative. The heath status note dated (MONTH) 17, (YEAR) revealed the resident was continuing to have behaviors throughout the shift, including going in and out of other resident's rooms, being verbally aggressive with staff, being difficult to redirect and attempting to strike out twice at a staff member. The note included that attempts to redirect had some effect for short periods of time. Per the note, resident #126 was found in another resident's room and when the other resident asked her to leave, she started cussing at the nurse and the resident. A Mood/Behavior note dated (MONTH) 18, (YEAR) included the resident was going in and out of other resident's rooms. A note dated (MONTH) 20, (YEAR) revealed the resident was exhibiting exit seeking behaviors, which set off the front door alarm and visited another resident's room looking for her boyfriend. The Mood/Behavior note dated (MONTH) 21, (YEAR) included the resident was wandering into several resident rooms. A note dated (MONTH) 22, (YEAR) included that social services and the DON spoke with the resident's friend to tell him the search continued to find memory care placement for resident #126. A Mood/Behavior note dated (MONTH) 23, (YEAR) included the resident was having several bouts of aggressive behavior and was screaming, and was attempting to go into different rooms. A physician's note dated (MONTH) 23, (YEAR) included the resident had been disruptive and has also been wandering. The note included a psych evaluation had been ordered. Review of a facility's investigation revealed that on (MONTH) 24, (YEAR) around 8:00 p.m., a licensed practicable nurse (LPN/staff #31) who was on duty was notified by resident #8 that resident #126 slapped her on the face. Per the report, resident #126 stopped in front of resident #8's door and wanted to come inside the room, but resident #8 would not let her in as they were not roommates, and resident #126 slapped her on the face, and then continued walking down the hall. The report included that resident #126 was discharged from the facility later that evening around 10:00 p.m. The investigation included the incident was not witnessed by staff or other residents. A health status note dated (MONTH) 24, (YEAR) included that resident #126 was being sent to the hospital for aggressive behavior and combativeness, as she had slapped resident #8. In an interview with resident #8 on (MONTH) 18, 2019 at 9:09 a.m., she stated that there was a resident about a year ago, who hit her in the right eye. She stated she didn't remember the name of the resident, but she is no longer in the facility. Resident #8 stated that she was in the doorway and resident #126 came to her room looking for her keys and wanted to get in her room, but she wouldn't let her pass, so resident #8 hit her. Resident #8 stated that after the incident, she put on her call light and told the LPN who was working that evening about the incident. An interview with staff #31 was conducted on (MONTH) 20, 2019 at 2:45 p.m. She stated that she was the nurse working that evening. She stated resident #8 put on her call light and when she answered it, resident #8 told her that resident #126 had slapped her, because she would not let resident #126 into her room. Staff #31 stated that she immediately informed the Director of Nursing (DON/staff #29) of the incident. An interview with staff #29 was conducted on (MONTH) 20, 2019 at 8:45 a.m., who stated that resident #126 had been having some behaviors and psych was involved. She stated resident #126's POA was very involved and the facility was working with him and the provider to get her behaviors managed. Review of a policy titled, Abuse and Neglect dated (MONTH) (YEAR) included The resident has the right to be free from abuse .Residents must not be subjected to abuse by anyone, including, but not limited to, location employees, other residents, consultants or volunteers, employees of other agencies serving the resident, family members or legal guardians, friends or other individuals. The purpose of the policy was to identify and remedy any abusive situations and to prevent further injuries. The policy further included that with allegations of resident to resident abuse, the residents will be separated immediately and both ensured a safe environment.
F 0602 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Protect each resident from the wrongful use of the resident's belongings or money.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, staff interviews, review of facility documentation and policies and procedures, the facility failed to ensure that three resident's (#2, #76 and #226) medications were not misappropriated. Findings include: -Resident #2 was admitted on (MONTH) 10, 2013, with [DIAGNOSES REDACTED]. The physician's orders [REDACTED]. A review of the resident's MAR (Medication Administration Record) for (MONTH) (YEAR), revealed the resident received [MEDICATION NAME]-[MEDICATION NAME] 5-325 mg per the physician's orders [REDACTED].

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F 0602 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) -Resident #76 was admitted (MONTH) 10, (YEAR), with [DIAGNOSES REDACTED]. A review of the resident's clinical record revealed a physician's orders [REDACTED]. This order was discontinued on (MONTH) 10, (YEAR). A physician's orders [REDACTED]. This order was discontinued on (MONTH) 14, (YEAR) and replaced with an oral/liquid medication. Review of the resident's MAR for (MONTH) (YEAR), revealed the resident received these medications from (MONTH) 1-18, (YEAR). Review of the facility's investigative documentation regarding the misappropriation of medications for resident #2 and #76, revealed that on (MONTH) 18, (YEAR) a RN (Registered Nurse/staff #15) and a LPN (Licensed Practical Nurse/staff #16) reported that a 30 pill card of MS and the corresponding control sheet for resident #76 was missing from the medication cart, as well as a 30 pill card of [MEDICATION NAME]-[MEDICATION NAME] and the corresponding control sheet for resident #2. A binder belonging to a RN (staff #66) was found and contained the empty bubble pack for the MS, the corresponding control sheet for resident #76 and the control sheet for the [MEDICATION NAME]-[MEDICATION NAME] for resident #2. The bubble pack for the [MEDICATION NAME]-[MEDICATION NAME] was not found. Further review of the facility's investigative report included a written statement from staff #66 dated (MONTH) 19, (YEAR). Staff #66 reported that she had found an empty card of MS ER 15 mg tablets in the bottom of the 300 hall med cart and that there was a corresponding count sheet, which noted that the card was new with 30 tablets delivered. She reported that there was also a count sheet for [MEDICATION NAME]-[MEDICATION NAME] 5-325 mg, which noted that the corresponding card contained 30 tablets, however the card was not found. The statement included the removal of the card and sheets and that she placed them in a clipboard which holds paperwork, with the intent of bringing them to the DNS (Director of Nursing services/staff #29) upon her return, as she was out of town on a work-related meeting. Staff #66 stated that the clipboard was accidentally left in the CNA (Certified Nursing Assistant) fridge room, where it was apparently found and gone through, and then brought to the attention of Human Resources. Staff #66 reported that she had mentioned to another nurse that the sheets in the narcotic record should be counted, because she felt like maybe some sheets have come up missing and they should be counting them anyway. Per the statement, staff #66 was unsure who to bring this issue to as the management team was away, but was told the DNS would be back on (MONTH) 19, (YEAR). An interview was conducted with the DNS (staff #29) on (MONTH) 19, 2019 at 1:01 p.m. Staff #29 was not able to remember if she was away from the building when the incident was originally reported. Staff #29 said that staff #16 had reported the missing narcotics card and control sheets, as she had been the one who had signed them in the night before. Staff #29 stated that an empty medication card and the corresponding control sheet, as well as another control sheet had been found in a binder belonging to staff #66. Staff #29 stated that when she interviewed staff #66, staff #66 stated that she had found the empty medication card and blank control sheets in the bottom drawer of the 300 hallway medication cart. Staff #29 stated that staff #66 was taken for drug testing which was negative, and that staff #66 was suspended pending completion of the investigation. The investigation was inconclusive as to whether staff #66 had misappropriated the medications, however, the medications were missing. Neither resident #2 or #76 missed any doses of their medications, as the result of this incident. On (MONTH) 20, 2019 at 9:54 a.m. a telephone interview was attempted with staff #66, however; the telephone number had been disconnected. -Resident #226 was admitted to the facility on (MONTH) 20, (YEAR), with [DIAGNOSES REDACTED]. Review of the clinical record revealed a physician's orders [REDACTED]. Review of the MAR for (MONTH) (YEAR) revealed that resident #226 received all scheduled doses of [MEDICATION NAME] as ordered for the month. Review of the pharmacy documentation revealed that on (MONTH) 23, (YEAR), a delivery of [MEDICATION NAME] 10 mg containing 90 tablets for resident #226 was delivered to the facility at 10:14 p.m. The pharmacy documentation showed it was received and signed for by a RN (staff #66). Review of the facility's investigative documentation revealed that on the morning of (MONTH) 24, (YEAR) during the narcotic count at shift change, a bubble pack containing eight [MEDICATION NAME] for resident #226 was missing. Staff #66 who was working the night shift was unable to explain what happened to the medication to the oncoming nurse (staff #30). Staff #30 conducted a search for the missing medication and found the empty bubble pack of [MEDICATION NAME] sitting next to staff #66's belonging in the chart room. Staff #30 then called the Director of Nursing (staff #29) at approximately 7:00 a.m. to notify her of the missing narcotics. Staff #29 instructed staff #30 to contact the Administrator (staff #68). Further review of facility's investigative documentation revealed an in-person interview was conducted with staff #66, by the Administrator and Human Resources (HR/staff #17). Staff #66 stated that the evening RN (staff #15) on (MONTH) 23, (YEAR) told her that the [MEDICATION NAME] for resident #226 was running low and would need to be reordered. Staff #66 stated she removed the card of eight [MEDICATION NAME] from the cart and placed it in the chart room (which is an unlocked room for nurses and CNA's to chart) at that time. Staff #66 stated the [MEDICATION NAME] arrived from the pharmacy immediately afterwards so the medication did not need to be reordered, and that she did not give the card which she had removed from the narcotic box another thought. Staff #66 stated she did not know why she left the medication in the chart room all night. The investigative report included a telephone interview was conducted by the Administrator with the evening RN (staff #15). Staff #15 stated that she did not see staff #66 remove any medications from the medication cart and that she did not see any medications in the chart room. Staff #15 stated she did tell staff #66 that the [MEDICATION NAME] for resident #226 was running low, but it arrived from the pharmacy before she left her shift that evening. The report also included a telephone interview with each of the Certified Nursing Assistants (CNA/staff #4 and CNA/staff #69) working on the night shift. Both CNA's stated that they had not seen any medications in the chart room that night. The facility's investigative documentation also revealed the Administrator had reviewed video footage from the building security cameras from (MONTH) 23, (YEAR)-May 24, (YEAR). The video footage showed the narcotic count between staff #66 and staff #30 on the morning of (MONTH) 24, (YEAR). When staff #30 looks away, staff #66 reaches into the trash can attached to the medication cart and removes what appears to be a bubble pack. The video footage showed that when staff #30 walks away, staff #66 takes the bubble pack into the chart room. All other staff are accounted for on the video and no suspicious activity was noted. All three of the night shift staff (#66, #4 and #69) were drug tested with negative results. Staff #66 was suspended pending the investigation and was later terminated on (MONTH) 29, (YEAR). Continued review of the investigative report revealed that the facility could not state for certain what happened to the missing medications, as no concrete proof could be found. An interview was conducted with the DNS (staff #29) on (MONTH) 19, 2019 at 1:01 p.m. Staff #29 stated that according to the documentation, staff #66 should have never pulled the card for reorder since the medication had already been delivered. A telephone interview was attempted on (MONTH) 20, 2019 at 9:54 a.m. with staff #66, however; the phone number had been disconnected and no other numbers were available. Review of the facility's policy and procedure for Abuse and Neglect dated (MONTH) (YEAR), revealed the purpose was to ensure there is an effective system in place which prevents mistreatment, neglect, exploitation, abuse of residents and misappropriation of resident property. The policy included the resident has the right to be free from abuse, neglect, misappropriation of the resident property and exploitation. Residents must not be subjected to abuse by anyone, including but not limited to employees, other residents, consultants, volunteers, family members, friends or other individuals.
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, facility documentation and policy review, the facility failed to ensure that a complete and through investigation was completed for 1 of 4 sampled residents (#8) regarding an allegation of abuse. The deficient practice could result in incomplete and inaccurate investigations being conducted. Findings include: Resident #8 was admitted to the facility on (MONTH) 3, (YEAR), with [DIAGNOSES REDACTED]. An incident progress note dated (MONTH) 25, (YEAR) included that resident #8 was slapped in the face by another resident during the previous shift (evening shift on (MONTH) 24). Per the note, resident #8 did not sustain any injuries and she did

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F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) not appear to be in distress about the incident. Another note dated (MONTH) 25, (YEAR) included the resident's family member was notified that resident #8 was assaulted by another resident. Review of a facility's investigation revealed that on (MONTH) 24, (YEAR) around 8:00 p.m., a licensed practicable nurse (LPN/staff #31) who was on duty was notified by resident #8 that another resident slapped her on the face. Per the report, the other resident stopped in front of resident #8's door and wanted to come inside the room, but resident #8 would not let her in as they were not roommates, so the other resident slapped resident #8 on the face. The report included the other resident was discharged from the facility later that evening around 10:00 p.m. The investigation also included the incident was not witnessed by staff or other residents. Further review of the facility's investigative documentation revealed that it was not thorough, as there were no interviews with other residents who were in the vicinity when the incident occurred, there were no interviews with other staff, and there was no documentation that an interview was attempted or completed with the resident who hit resident #8 in the face. The report also did not include the name of the LPN, who resident #8 reported the allegation to on (MONTH) 24. In an interview with the DON (staff #29) on (MONTH) 20, 2019 at 8:45 a.m., she stated if there is an allegation of resident to resident abuse, all residents involved are interviewed, even if they are confused. Staff #29 said that other residents in the area of the incident are also interviewed and any witness statements are taken from staff or visitors, who may have witnessed the event. She stated that she thought there were additional interviews done for this investigation, but none were provided. In an interview with the Administrator (staff #13) on (MONTH) 21, 2019 at 12:45 p.m., she stated that additional interviews were not able to be located for this incident. Review of a policy titled Abuse and Neglect dated (MONTH) (YEAR), revealed the facility will have evidence that all alleged or suspected violations of abuse are thoroughly investigated. The investigation may include interviewing employees, residents or other witnesses to the incident. The policy included to interview all involved (employee, resident and family) individually, not as a group, so that their descriptions of the incident can be compared to determine any inconsistencies. Consider having each person write his or her memory of the event. If possible, get signed and dated statements from any witnesses.
F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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 and policy and procedure, the facility failed to ensure that professional standards were followed during medication administration, by crushing an extended release medication. The deficient practice could result in an increased risk of side effects, as the medication is released all at once instead of over an extended period of time (dose dumping). Also during medication administration, the nurse left medications at a resident's bedside. The deficient practice could result in resident's not taking all of their medications. Findings include: A medication pass observation was conducted with a Licensed Practical Nurse (LPN/staff #31) on (MONTH) 20, 2019 at 8:30 a.m. The LPN was observed to crush a 250 mg (milligram) tablet of extended release [MEDICATION NAME] (anticonvulsant) and mix the medication in apple sauce. The LPN then administered the medication to a resident. An interview was immediately conducted with staff #31, who stated that she believed the solid [MEDICATION NAME] tablets could be crushed, just not the capsules. The LPN was then observed preparing medications for another resident. She entered the resident's room, took his blood pressure and set the medication cup on the bedside table. The medication cup had 10 pills inside and included a narcotic medication. The LPN then exited the room and left the cup of pills on the bedside table. The resident was not observed taking the pills. An interview was immediately conducted with staff #31. She stated it was not the facility policy to leave medications in the room. She stated she should have stayed in the room, while he took them. An interview was conducted with the Director of Nursing (DON/staff #29) on (MONTH) 20, 2019 at 11:42 a.m. The DON stated that medications cannot be left in a resident's room. The DON said the nurse must remain with the resident until the medications are taken. She said the resident did not have a self-administration assessment. She also stated that if a medication is coated it cannot be crushed. The DON proceeded to look up [MEDICATION NAME] in the Wolter-Kluwer Nursing 2019 Drug Handbook, which stated that delayed or extended release [MEDICATION NAME] tablets cannot be crushed. Review of a policy and procedure for Medication Administration revealed do not leave medications at the bedside or at the table unless there is a specific physician order [REDACTED]. If the resident has not been assessed for safety of self-administration and there is not a physician order [REDACTED].
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** Based on observations, staff interviews and policy and procedure, the facility failed to ensure that 1 of 2 medication carts was locked when unattended. The deficient practice could result in misappropriation of resident medication. Findings include: An observation was conducted with a Licensed Practical Nurse (LPN/staff #31) on (MONTH) 20, 2019 at 8:03 a.m. The LPN prepared medication for a resident and then walked away from the medication cart into the dining room to administer the medication. The medication cart was left unlocked and unattended in the hallway. On (MONTH) 20, 2019 at 9:05 a.m., another observation was conducted of staff #31 preparing medication for a resident. The LPN then entered a resident's room to administer the medication and left the medication cart unlocked and unattended in the hallway. An interview was immediately conducted with the LPN. She stated that she is aware that her medication cart should be locked, but she had forgotten to do it. An interview was conducted with the Director of Nursing (DON/staff #29) on (MONTH) 20, 2019 at 11:42 a.m. The DON stated the medication cart must be locked at all times, unless the nurse is attending to the cart. Review of a policy for Dispensing and Storage of Medication revealed that medications will be stored in a locked medication cart, drawer or cupboard. Only the person passing medications and the director of nursing services will be permitted to have access to the keys to the medication storage areas.
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.** Based on observation, staff interviews and policy and procedures, the facility failed to ensure that a plastic bag containing rice was sealed and a bag of cookie dough was properly labeled in the kitchen freezer. Findings include: -An observation during a kitchen tour was conducted with the facility's Food and Nutrition Director (staff #12) on 3/18/19 at 9:07 a.m. During the observation, a box with a plastic bag of uncooked rice was found open to air in the freezer, and there was a plastic bag of cookie dough which was not labeled or dated. An interview was conducted with staff #12 on 3/20/19 at 1:12 p.m. Staff #12 stated that the box of rice in the freezer should have been sealed air tight and the cookie dough should have been labeled and dated. An interview was conducted with the Food Service Manager (staff #67) on 3/20/19 at 1:30 p.m. Staff #67 stated that the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035171	A. BUILDING _____ B. WING _____	**03/21/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ALTA MESA HEALTH AND REHABILITATION	**5848 EAST UNIVERSITY DRIVE MESA, AZ 85205**

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 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 4) freezers are given a mini-inspection several times a day and are fully checked weekly. He stated that the box of rice should have been properly sealed and the cookie dough should have been labeled and dated. A review of the facility's Policy and Procedure revised in (MONTH) of (YEAR), revealed that food storage stock items are to be individually dated and labeled, with a delivery date and best-by date etc., if removed from it's original container. The policy also included that foods which have been opened are to be placed in an enclosed container, and dated, labeled and stored properly.
F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, resident, family and staff interviews and policy review, the facility failed to accurately document Restorative Nursing services provided to 3 of 10 residents (#9, #11 and #13). Findings include: -Resident #9 was admitted (MONTH) 9, 2019, with a [DIAGNOSES REDACTED]. A review of the resident's clinical record revealed physician's orders [REDACTED]. However, review of the resident's clinical record revealed no documentation of the resident receiving RNA services in (MONTH) through (MONTH) 20, 2019. During an interview with a family member of resident #9 on (MONTH) 19, 2019 at 12:00 p.m., the family member stated that RNA services are provided to the resident, though sometimes she refuses. -Resident #11 was admitted (MONTH) 25, 2019, with a [DIAGNOSES REDACTED]. A review of the clinical record revealed physician's orders [REDACTED]. Continued review of the clinical record revealed there was no documentation of the resident receiving RNA services in (MONTH) through (MONTH) 20, 2019. During an interview with resident #11 on (MONTH) 21, 2019 at 11:15 p.m., resident #11 stated that RNA does come in and provide services three times a week. -Resident #13 was admitted (MONTH) 15, (YEAR), with a [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. Review of the resident's clinical record revealed no documentation of the resident receiving RNA services in (MONTH) through (MONTH) 20, 2019. An interview was conducted with a CNA (Certified Nursing Assistant/staff #27) on (MONTH) 21, 2019 at 11:00 a.m., who stated that she sees the RNA (CNA/staff #3) in with resident #13 a few times a week as well as other residents. On (MONTH) 20, 2019 at 2:27 p.m., the RNA book was reviewed. The RNA book included orders for RNA services, but did not include any documentation of the services residents were receiving. On (MONTH) 21, 2019 at 8:41 a.m., an interview was conducted with the RNA (CNA/staff #3). Staff #3 stated that she documents the RNA services in the resident's EMR (Electronic Medical Record). Staff #3 demonstrated where and how the RNA services were documented, however, there were only three residents on the screen (not residents #9, #11 or #13). Staff #3 stated that she provided RNA services to all of the resident's per the orders in the RNA book, but she could not document on resident #9, #11 or #13, because they were not set-up in the EMR and she didn't have access to do that. Staff #3 said the DON (Director of Nursing) was the one responsible for doing that and she had told the DON that residents needed to be set-up. An interview was conducted with the DON (staff #29) on (MONTH) 21, 2019 at 8:47 a.m., regarding documentation of RNA services. Staff #29 stated she has asked the RNA (staff #3) repeatedly about if she was documenting RNA and she stated she was. The DON then had staff #3 demonstrate how RNA services were documented. Staff #3 demonstrated that she was able to document on three residents, but stated that she did not have access to add residents. The DON then stated that she didn't know how to set up the RNA services in the EMR and would have to obtain assistance. A review of the facility's Maintenance of Active Medical Records policy revealed that the facility will maintain medical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible, and systematically organized. Electronic documentation will be maintained electronically . A review of the Restorative Nursing Documentation policy revealed step by step instructions for authorized staff to set-up RNA services in the facilities Electronic Medical Records.