STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035263	A. BUILDING _____ B. WING _____	**06/22/2018**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ARCHIE HENDRICKS SENIOR SKILLED NURSING FACILITY	**HCO 1 BOX 9100 SELLS, AZ 85634**

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 0567 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to manage his or her financial affairs.** Based on observation, interviews and record review, the facility failed to manage a personal account of one resident (#27) ensuring the resident has access to petty cash on an ongoing basis. Findings include: On 06/20/18 at 4:26 p.m. interview with Resident 27 indicated he was not aware who to approach if he needs some cash from the facility during weekends. He also stated that he wants to have cash at hand whenever he has appointments outside of the facility which sometimes falls on a Monday. He was not sure if he received any financial statements of his personal funds from the facility. On 6/20/18 at 8:22 a.m. interview with the facility's Medical Billing and Resident Trust Specialist (#15) who had worked in the facility for 5 years in this position revealed that she works Tuesday to Friday from 7a.m. to 6 p.m. Staff #15 was unable to respond when asked how the residents can access cash money from their personal funds if the request was made on weekends. The facility administrator (#21) stated she will follow-up the issue. Staff #15 stated the reisdents usually asks cash amount Mondays through Fridays and not on weekends. Both staff revealed that they do not provide quarterly financial statements to residents because they lose the paper document and resident information need to be provided.
F 0568 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home.** Based on observation, interviews and record review the facility failed to ensure that individual financial records be available to the residents through quarterly statements for 45 residents with personal funds in the facility. Findings include: 06/20/18 4:26 p.m., interview with Resident 27 revealed that he does not receive any quarterly statement of his personal funds from the facility. He also stated that due to his visual impairment he has a family member responsible for his finances. He also stated that he receives a monthly Social Security check that goes to his personal funds managed by the facility. On 6/20/18 at 8:22 a.m. the facility's Medical Billing and Resident Trust Specialist (#15) and administrator (#21) revealed they used to provide quarterly financial statements to residents/or responsible party, however they have stopped doing that practice because some of the residents lose the paper document and they need to protect the confidentiality of the financial records. They also stated that financial statements are always available upon request.
F 0572 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Give residents a notice of rights, rules, services and charges.** Based on record review and resident council interview, the facility did not ensure that the resident had the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. Finding includes: During the resident council interview conducted on 6/19/18, eleven of 11 residents in attendance stated that while there were no rules in the facility that limited visitation rights or required a specific time for when residents could get out of bed in the morning, or get back to bed in the evening, the residents however were unable to verbalize any of their rights as residents in the facility. During the meeting, none of the residents could remember when residents rights were last discussed during any of the monthly council meetings. Review of the resident council meeting minutes for 6/4/18, 5/7/18, 4/9/18, 3/12/18, 2/12/18, 1/17/18, and 12/11/17, revealed the lack of documentation of any discussion about residents rights. In an interview on 6/21/18, an activity staff member (Staff 7) verified that the monthly resident meetings included a list of agenda items put together by the residents; none however, included a discussion about residents rights.
F 0573 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Let each resident or the resident's legal representative access or purchase copies of all the resident's records.** Based on record review and interview, the facility did not ensure that the resident had the right to access personal and medical records pertaining to him or herself. Finding includes: During the resident council interview on 6/19/18, eleven of 11 residents were not aware of their right to be able to request copies of their medical record and to be able to review the contents of their records. Several residents stated that they were surprised that their medical records could actually be available to them, and that it was good to know that they can request copies for their review. Several residents also expressed the interest about what the process was for initiating a request. (Cross-refer to F572)
F 0576 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure residents have reasonable access to and privacy in their use of communication methods.** Based on observation, interviews and record review, the facility failed to have reasonable access to the use of a telephone and a place in the facility where calls can be made without being overheard for one sample resident (#27) Findings include: On 6/19/18 1:17 p.m. interview with Resident 27 revealed that he does not have a telephone in his room. He stated that when there is a phone call for him or if he needs to make a call, he had to go to the nurses' station and make the call. He also stated that there is no privacy with telephone calls in nurses station because all the conversations can be overheard. On 06/21/18 at 11:11 a.m., interview with the social service staff (#117) revealed that after the facility renovation, there

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F 0576 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) was no room out in the lobby to get private phone calls. He also stated that he usually would take Resident 27 in his office to ensure that phone calls were made in private. After the issue was brought to the attention of the facility, a policy was generated to include four facility locations that are available to those residents wanting privacy during communication. Review of the facility policy with a subject entitled Privacy of Communications dated 6/21/18 revealed that each resident room is supplied with a phone: those rooms with two people have two phones. On 6/21/18 at 12:30 p.m. a licensed nurse (#59) failed to show evidence of a telephone in Resident 27's side of the room (Bed B) and confirmed that only bed A had a telephone unit in the room.
F 0577 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Allow residents to easily view the nursing home's survey results and communicate with advocate agencies.** Based observation and interview, the facility did not ensure that the resident had the right to examine the results of the most recent survey of the facility conducted by Federal surveyors and any plan of correction in effect with respect to the facility. Finding includes: During the resident council interview on 6/19/18, several residents stated that they were not aware about the availability of survey results or that the results of the most recent survey conducted at the facility by federal surveyors were available for their review. Further, while one resident (Resident 8) stated during the meeting that the survey results were in a binder in one of the hallways outside the activity room, none of the other residents knew where the binder was located. Several residents in the meeting further stated that they wanted to know what the survey results were about and expressed the interest in reviewing the findings.
F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** Based on interview and record review the facility failed to ensure that their abuse policy contained the required elements related to prevention, protection, training and reporting of allegations of abuse, neglect, exploitation of residents or misappropriation of resident property. This deficient practice had the potential to affect residents with allegations of abuse. Findings: During an interview with the Administrator/Abuse Coordinator and concurrent review of the policy on 6/19/2018 at 11:15 AM, Review of the facility's policy and procedure titled Abuse, Neglect and Exploitation dated (MONTH) 27, (YEAR) with revision date (MONTH) 14, (YEAR) read in pertinent part as follows: .Policy Explanation and Compliance Guidelines: 2. Abuse means .Types of Abuse .H. Mental (Emotional) Abuse includes, but is not limited to, Humiliation, harassment, threats of punishment or deprivation 8. Resident protection after Alleged Abuse, Neglect and Exploitation - The facility will make efforts to protect all residents after alleged abuse, neglect, and/or exploitation. Examples of ways to protect a resident from harm during an investigation of abuse, neglect and exploitation may include, but are not limited to a. Temporary separation from other residents if resident's behavior poses a threat of This section ended there. There were no other examples of protection of residents listed. There was no guidance in the Policies and Procedures for psychosocial support after alleged abuse, neglect, mistreatment and/or exploitation. The Facility must: .4. Perform a complete background check on new employees. Background, reference and credential check should be conducted on employees prior to or at the time of employment by facility administration with applicable state and federal regulations . The state of Arizona and Federal laws require employees be fingerprinted as part of their background check, this is not specified in the facility policies. 5. Have employee training. New employees will also be educated on Abuse during initial orientation. Annual education and training should be provided to all existing employees. Front line supervisors or other department heads should provide education as situations arise. The content of the training was not included in the policy. The facility Administration should report to the state Board of Nursing any knowledge it has of any actions by a court of law which would indicate an employee is unfit for service. The policy did not include requirement to report potential unfit employee to other professional licensing bodies. The policy included Abuse Reporting Checklist this included the following: Make sure that resident is in safe environment (if appropriate). Monitor & remember to document resident's condition, including any medical treatments or nursing interventions . This does not include directions for documentation of any other discipline's interventions. .Notify CMS within two (2) hours if there is serious bodily injury or within 24 hours if there is NO serious bodily injury . This part of the Abuse policy did not include the requirement to report to CMS within 2 hours allegations that involve abuse. (See F609) The regulation for notification reads as follows: .483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials . .Notify Board of Nursing . The policy does not include reporting to other professional licensing/certification bodies. During interviews with staff on 6/19/2018 two of three licensed nurses (LN-C2 and LN-C3) and two of two social service employees (B5 and B6) stated they did not follow up to assure resident protections after an allegation of abuse/neglect was substantiated. When asked what their policy said about this, they all said they did not know. An interview was conducted on 6/21/2018 at in the afternoon with the Education Coordinator, who is responsible for training facility staff related to abuse. We reviewed the training program. The training program did not include training for corrective action/follow up protection for residents for psychosocial support. In addition when asked which staff were included in the training, the Education Coordinator stated direct care staff, CNAs and Nurses. When asked about other staff, such as social services, transportation and therapy she stated they were not included in the training. When asked if therapy, social services or transportation staff were contracted or employees of the facility, she stated they were employees of the facility. Review of 10 employee files revealed that two RNs, a social service staff and a transportation staff did not have documentation of abuse training. On 6/21/2018 at approximately 8:30 AM, the above information was shared with the Abuse Coordinator/Administrator. She acknowledged that the policy did not follow the regulations.
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to notify the Centers for Medicare and Medicaid Services San Francisco Regional Office, Division of Survey and Certification of a fall that occurred when departing [MEDICAL CONDITION] clinic on 04/21/2018. Additionally, the facility failed to investigate what factors may have contributed to the fall,

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F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) mitigating factors and/or variables that may prevent future falls. Failure to investigate the circumstances surrounding the fall may contribute to more falls and/injuries for this resident and/or other residents. Findings include: During a concurrent interview and record review with Staff 61 on 06/20/2018 it was affirmed that resident 18 sustained a minor fall on 04/21/2018 while at departing the [MEDICAL CONDITION] clinic 04/21/2018. The record reflects the resident was evaluated and treated at Sells Hospital then he was returned back to the skilled nursing facility (SNF) on that same dated. Staff 61 validated there was no documentation within the electronic health record or the paper medical record substantiating the resident's responsible party or that the residents physician were notified of the fall that occurred outside the SNF. Staff 61 also validated there was no documentation that the fall had been investigated and that the concern had not been reported to the Centers for Medicare and Medicaid Services.
F 0625 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure 2 of 17 sampled residents (resident number 11 and 353) who were discharged to the hospital were given, or the responsible party of the resident were given, written information regarding the facility bed hold policy. Failure to have a clear understanding of the length of time the bed can be held, the cost associated with the bed hold and/or any other requirements may result in a potential for stress/anxiety associated with the potential return to the facility. Findings include: 1. On 06/19/2018, during a concurrent record review and interview with Staff 61, it was validated the Resident 11 was discharged to local hospital with an anticipated return on 05/ 02/2018. The resident returned to the facility on [DATE] with a new [DIAGNOSES REDACTED]. During the record review with the DON and Staff 51 it was validated there was no written information given to the patient, or the responsible party, regarding the facility bed hold policy such as duration of the bed hold, cost, and/or any additional facility requirements. 2. During a record review concurrent with an interview with Staff 51 on 6/21/2018 at 12:00 p.m., in regards to R353, who was discharge to the hospital on [DATE] with elevated temperature. The Admission Agreement section 2.4 was blank, and Staff 51 validated that the form was incomplete and she was not able to provide any evidence that R353 and responsible party were informed of the bed hold policy. During an interview on 6/21/2018 at 12:30 p.m., with the Staff 117 he acknowledged that the bedhold section 2.4 in the Admission Agreement form was blank and he was not able to provide any evidence that the resident or responsible party was informed of their bed hold policy, duration of bed hold, cost and other regulation requirements.
F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record the facility failed to ensure the comprehensive resident assessment was accurate for 2 of 17 sampled residents (residents 5 and 250). Failure to complete an accurate comprehensive assessment may lead to potential failure to identify all the resident's unmet care needs. Findings include: 1. On 06/19/2018 observations and an interview was completed with Resident 250; he did not have his corrective eyewear in use. Resident 250 was admitted into the facility on [DATE] and some of his [DIAGNOSES REDACTED]. During further investigation and interview on 06/20/2018 Resident 250 stated he had been using corrective eye glasses for the past 5-8 years and that his prescribed glasses were broken during a recent motor vehicle accident. Additionally, he stated that he could not see clearly nor could he read fine print without his glasses. On 06/20/2018 during a concurrent record review and interview with Staff 79 she validated that the resident's comprehensive assessment dated [DATE] indicated that he, the Resident had adequate vision and used NO corrective lenses which was not correct.
F 0655 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Base on record review and interview the facility failed to initiate a baseline care plan for 2 of 17 sampled resident (R150 and R 47). The facility must develop and implement a baseline care plan for each resident to+ includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. Findings include: 1. During a record review concurrent with an interview on 06/21/18 03:57 p.m., with Staff 61 regarding R150 wound care status and plan of care. R150 was readmitted to facility on 6/13/18 with [MEDICAL CONDITION], Hypertension, Chronic Pressure Ulcer, Generalized Muscle Weakness and Liver Disease. On 6/13/18 the nursing admission assessment reveals that the resident had two open skin tear to right buttocks, one measured 1x1x0 CM and the other [MEDICAL CONDITION] CM. The right ankle outer area had a vascular wound that measured [MEDICAL CONDITION] CM. Staff 61 acknowledged that R150 did not have a wound care base line assessment care plan for the right ankle or the right buttock wounds. 2. Record review concurrent with an interview on 06/20/18 at 11:37 a.m., with the Consultant RD, she indicated that she visits the facility on a monthly basis and has limited computer access virtually. The RD further explained that she only monitors the monthly weights and does not evaluated the weekly weights. In addition she stated that the dietary manager and nursing monitors the weekly weights. R 47 was admitted to the facility on [DATE] with Fracture (FX) Femur, FX Ulna, Constipation, [MEDICAL CONDITION], and Muscle Weakness. Resident weight: 6/20/18 - 131. - 5.8% - standing 6/1/18 - 132. - Standing - 5.0 % = 7 lbs lost - according to the clinical record 5/23/18 - 139.8 - W/C 5/16/18 - 139.6 - W/C 5/10/18 - 139.0 - W/C 5/2/18 - 137.6 - W/C When questioned about the resident care plans, she validates that she does not have computer access authority to the care plans and does not review or edit care plans when she visits the facility. According to the RD the monthly monitoring form documents a weight loss of 3.6 % and it is not considered significant. The RD indicated that she will contact IT to gain computer access for the care plans for future evaluations. During an interview concurrent with a record review on 06/20/18 at 12:00 PM with Staff # 26, he acknowledged that there was a discrepancy with the documentation of R 47 weights loss. Staff 26 validated that the baseline care plan was not implement and that his nutritional screening assessment was late per policy. Staff 26 verbalized that he was not aware that the RD was not reviewing the care plans and weekly weights when she visits monthly. During an interview concurrent with a record review on 06/20/18 at 01:44 p.m., with Administrative Staff 61 he stated that the expectation is for the RD to complete the admission assessment timely, review the care plans, review all the weights and make recommendations. Staff 61 stated that he was not aware that the RD was not monitoring the weekly weights, updating or implementing care plans and not conducting assessment timely. When asked what is a timely assessment, he indicated that the initial assessment should be completed within a week of admission. He acknowledged that the resident did lose weight since admission. In addition Staff 61 stated that the weight are reviewed in a meeting weekly and monthly. Further more Staff 61 validated that he was not aware that the RD had only limited computer access to the clinical records. Reviewed the facility policy on 6/20/2018 title Care Plans - Baseline it indicated that a baseline Care plan is implemented to meet the resident immediate needs and should be developed for each resident within 48 hours of admission.

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F 0655 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3)
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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 observation, interviews and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident to meet a resident's medical, nursing and psychosocial needs that are identified in the comprehensive assessment. Findings include: 1. Resident 46 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the facility provided resident matrix revealed that Resident 46 had a facility acquired pressure ulcer. On 6/18/18 at 11 a.m. licensed nurse (LN #76) confirmed the resident has a healing pressure ulcer under the left pannus. She further stated that it started as a blister that developed when the resident was out on pass and his family took him to see a rodeo.On 6/18/18 at 1 p.m., Resident 46 was interviewed and confirmed that he had the blister when he was out on pass due to the hot weather in the rodeo where his family took him. He stated that he felt the itchiness in the left abdomen and started scratching the area. When he returned to the facility the nursing staff observed the blister in the left side of his abdomen. He was told to refrain from scratching or touching the blister. He also stated that the nurses treated the blister after they called the physician. On 6/20/18 tat 12:10 p.m. LN#59 was observed administering the treatment for [REDACTED]. The LN cleansed the area with normal saline and applied two strips of Puracol. The area was dry without any drainage. Review of the last weekly pressure ulcer measurement dated 6/11/18 was 0.4 centimeter (cm) height x 0.6 cm length x 0.9 cm width and zero depth. Review of the resident care plan initiated on 2/4/18 revealed the resident has full thickness wound on the left lower abdomen related to heat exposure. The interventions include comprehensive skin assessment at least weekly by unit nurse; medications and treatments as ordered and notify physician and nurse practitioner (NP) of any noted skin impairment. Another plan of care last revised on 3/10/18 revealed Resident 46 has an actual left pannus (abnormal layer of fibrovascular tissue) related to sun exposure and blister formation. One of the interventions includes Educate caregivers as to causes of skin breakdown; including transfer/positioning requirements; importance of taking care during ambulating/mobility, good nutrition and frequent repositioning. On 6/20/18 interview with LN#59 was conducted. She stated that she had talked to the resident about wearing less constrictive pants particularly around the abdominal area. Also the resident was observed wearing adult diaper underneath the tight pants that contributed to the increased body temperature in the abdominal area. These potential causes of skin breakdown that nursing staff identified as person-centered interventions were not considered in the formulation of a comprehensive care plan to reduce the potential for alteration of skin integrity. 2. Resident 3 was admitted to the facility on [DATE] with several [DIAGNOSES REDACTED]. The medical record also noted that the resident was receiving hospice services. Review of the minimum data set (MDS) following a significant change in condition dated 3/07/18 revealed that Resident 3 had a BIMS (brief interview of mental status) score of 11 indicating some cognitive impairment. The MDS further noted that the resident had no behavior problems, was occasionally incontinent of bladder function, had no prior falls, and that he required extensive assistance for most activities of daily living with 1 or 2-person assistance. Review of the medical record revealed that the resident had several falls including on 4/15/18 at 9:15 p.m. when he sustained a fall in the bathroom while being transferred with a SARA lift (a mechanical transfer device). Accordingly, the resident was being moved (using the lift) after toileting when his knee buckled and he slowly slid to the ground. The resident was not injured. About three hours later, at 12:05 a.m. on 4/16/18, Resident 3 was described in progress notes to have sustained an unwitnessed fall in his room. A certified nurse aide (CNA) who was in the hallway heard a noise in the resident's room and found him on the floor next to the bed. An assessment of the resident revealed no injuries. On 6/12/18 at 11:15 a.m., Resident 3 was found by staff laying in the doorway, and that shortly before, he was observed sitting at the bedside table in a locked wheelchair eating tamales. In an attempt to use the urinal, the resident, according to the progress notes, slid to (sic) far forward and fell to sitting position on floor. The resident was noted to have no injuries. Review of the facility records revealed that while each fall was documented to include a description of the incident, immediate action taken, injuries if present, and any predisposing factors, there was no documentation of attempts to determine the cause of the falls particularly regarding the resident's cognitive status, his physical and functional limitations, and the need for supervision and supportive or assistive devices. The care plan for falls (revised 4/02/18) required that IF no apparent injury, determine and address causative factors of the fall. In addition, there was no indication that the resident's care plan was reviewed and interventions were revised to determine whether they continue to be effective. While the fall on 4/15/18 (noted above), for example, involved the SARA lift, there was no indication that continuing use of the device was evaluated in light of the functional limitations on the resident's lower extremities. The care plan for ADL self-care performance deficit noted continuing use of the SARA lift as he is an extensive transfer and able to participate with transfers by using the Sara Lift. While care plan was initiated on 3/16/17, it was last revised on 6/23/17 before the significant change assessment conducted on 3/07/18. 3. On 06/19/2018 observations and a concurrent interview was completed with Resident 250; he did not have his corrective eyewear in use. Resident 250 was admitted into the facility on [DATE] and some of his [DIAGNOSES REDACTED]. During further investigation and interview on 06/20/2018 Resident 250 stated he had been using corrective eye glasses for the past 5-8 years and that his prescribed glasses were broken during a recent motor vehicle accident. Additionally, he stated that he could not see clearly nor could he read fine print without his glasses. On 06/20/2018 during a concurrent record review and interview with Staff 79 it was validated that the resident's comprehensive assessment dated [DATE] indicated that he, the Resident had adequate vision and used NO corrective lenses. Staff 79 also acknowledged the resident had no care plan associated with his visual limitations, that the resident needed glasses, was aware of the resident's inability to read without glasses and validated that he had a pending appointment to obtain a prescription for new eye glasses. 4. On 06/19/2018, during a concurrent record review and interview with Staff 61, it was validated the Resident 11 was discharged to local hospital on [DATE]. The resident returned to the facility on [DATE] with a new [DIAGNOSES REDACTED]. During the record review with Staff 61 and Staff 79 it was validated the resident returned with a [DIAGNOSES REDACTED]. The existing care plans did not provide specific nursing actions, nursing educational interventions such as signs /symptoms that staff should be cognizant of nor were there any specific interventions delineated to prevent the reoccurrence of the UTI.
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, the facility's interdisciplinary team (IDT) failed to review and revise the resident's care plan related to falls for 1 of 17 sampled residents (Resident 27) who had a fall for two consecutive days. Finding includes: Resident 27 was admitted to the facility from the hospital alert and oriented on 02/02/18 with the following Diagnoses: [REDACTED]. A review of the nursing progress notes created on 2/19/18 revealed that at 1440 Resident 27 was in the shower room following shower and staff was assisting him from shower chair to shower bar, Resident was standing and holding onto shower bar by himself while staff exchanged shower chair for w/c. Resident's knee buckled and he slid with assistance of staff to the floor on his buttocks. No apparent injuries. Review of the nursing progress noted created on 2/20/18 revealed that around 0519, when the resident with gait belt assisted

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F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4) by CNA, was holding the grab bar to transfer to the toilet seat, the resident leaned forward and knelt down on the floor. Two CNAs assisted the resident to sit on the floor. From the floor, the resident was assisted to his wheelchair. Sara lift was used to transfer the resident to the toilet seat. As per resident, he did not know what happened. No apparent injury was seen. Resident denies any pain. Review of the resident care plan initiated on 02/03/18 identified the resident to be at risk for falls related to worsening [MEDICAL CONDITIONS] and weakness. The goal was for the resident not having any late injuries from falls thru next review. One of the interventions includes If you assist Name of resident) to the restroom DO NOT LEAVE unattended. This plan of care was revised on 2/16/18. Interview and concurrent review of the resident's care plans with the MDS coordinator (#79) on 6/20/18 at 10:00 a.m. showed no evidence that facility's IDT has revised the care plan after the first and second falls.
F 0679 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide activities to meet all resident's needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, the facility failed to provide an ongoing program of activities to support residents in their choice of activities designed to meet the interests of and support the residents' physical, mental, and psychosocial well-being of each resident for 1 of 17 sampled residents (#27). Findings include: Resident 27 was admitted to the facility from the hospital alert and oriented on 02/02/18 with the following Diagnoses: [REDACTED]. On 06/18/18 10:15 a.m. during the initial tour, the resident was not in his room but sitting in the activity area in front of the television. On 6/19/18 from 12:45 p.m. and 4:20 p.m. the resident was observed in front of the television with eyes closed and taking naps at intervals. There were no other activities going on and the resident remained sitting in the same location in front of the television. The television show was not meaningful to the resident as he stated that he was not interested in the show. On 8/19/18 at 4:20 pm, interview with Resident 27 was conducted and expressed no desire to join any group activities due to his visual impairment. When asked as to what types of activities that he would be interested in, the resident gave no reply. He pointed out to the audio tapes at his bedside but stated that he needs help to play them. Interview with the director of nursing (DON) Staff #61 on 6/19/18 at 4:40 p.m. revealed there were audio tapes provided to the resident in his room but the resident has refused to use them. On 6/20/18 at 8:10 a.m. Resident 27 was observed in the activity area watching television. He stated his left eye can still see blurred images but he is totally blind in his right eye. 06/20/18 09:46 a.m. interview with the activity coordinator (#7) revealed she has a total of four (4) activity aides that help her implement the activity program. She stated that for residents with sensory deficits, they offer different options such as peg board with clothes pin, board with textures and room visits talking to residents. She also stated that the resident benefits from watching television for auditory stimulation. On 6/20/18 at 10:05 a.m. the Resident 27 remains seated in the activity area watching television. Interview with MDS Coordinator (#79) indicated the resident was cognitively alert and able to make choices and decisions on his own. On the same day at 2 p.m., the resident was observed in the activity area watching [NAME] is Right. 06/21/18 11:04 a.m., interview with the social worker (#117) revealed that Resident 27 was in the period of adjustment. He also stated that Resident 27 used to go to therapy and liked it. His nephew, brother and sister-in-law visit. He had lost his wife recently. He also stated that he works closely with the activities director because she is new and still learning her role as activity coordinator. Review of the admission assessment related to activities dated 2/9/18 revealed activity preferences that were important to Resident 27 such as be around animals such as pets, keep up with the news and participate in religious services or practices. Review of the activities care plan with initiation date of 2/14/18 revealed a problem the resident has little or no activity involvement related to being legally blind. He wishes not to participate and provides his own activities. The goal was for the resident to participate in activities of his choosing but facility will continue to put calendars up in his room and invite him to daily activities. One of the interventioms includes offering one to one activities with the resident three times a week. However, there was no documented evidence of this type of activity and how it benefited the resident. Another interview with activity coordinator (#117) on 6/21/18 at 12:15 p.m. revealed that the Santa Rosa school has provided activities for the resident and the tribal community has helped him in his transition to the facility. The type of activities provided from community resource were not adequately documented in the resident's activities plan of care.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure 3 of 17 sampled residents (Resident 5, 22 and 150) received the care and services necessary to maintain the highest practicable physical, physiological, mental and psychosocial well-being consistent with the resident's comprehensive assessment, plan of care and physician orders. Failure to provide the residents with care and services as ordered and or as outlined in the plan of care could potentially result in negative health care outcomes. Findings include: 1. Resident 5 is an [AGE] year old male who was admitted into the facility on [DATE]. On 03/30/2018 he was discharged to a hospital. On 04/02/2018 he was readmitted into the facility with a [DIAGNOSES REDACTED]. Some of his other multiple [DIAGNOSES REDACTED]. On 06/21/2018 the resident's medical records were further reviewed and the record reflect the resident receives 18units of a long acting insulin daily. Additionally, one of the physician's orders [REDACTED]. The resident's nursing care plan associated with the [DIAGNOSES REDACTED]. The licensed nurses documented the finger stick blood sugar reading on the Medication Administration Records (MAR). On that same date during a concurrent interview and record review of the Nursing Care Plan, MARs and physician orders [REDACTED]. He acknowledged the resident's finger stick blood sugar readings were not documented OR not completed at the below times on the below dates: 6:00 AM finger sticks were not documented or not completed on 04/05/2018 04/09/2018 04/19/2019 04/26/2018 06/14/2018. Additionally, the 4:00 PM finger sticks were not documented or not completed on 04/02/2018 04/05/2018. Staff 61 acknowledged there were some gaps in the provision of care which could also impact the monitoring of the signs and symptoms of low blood sugars or [DIAGNOSES REDACTED]. 2. During a record review concurrent with an interview on 06/21/18 03:57 p.m., with Administrative Staff 61 regarding R150 wound care status and plan of care. R150 was readmitted to facility on 6/13/18 with [MEDICAL CONDITION], Hypertension, Chronic Pressure Ulcer, Generalized Muscle Weakness and Liver Disease. On 6/13/18 the nursing admission assessment reveals that the resident had two open skin tear to right buttocks, one measured 1x1x0 CM and the other [MEDICAL CONDITION] CM. The right ankle outer area had a vascular wound that measured [MEDICAL CONDITION] CM. Reviewed the treatment flow sheet daily documentation and it reveals that no treatments were being performed on the right buttocks and right outer ankle. The physician order [REDACTED]. Staff 61 acknowledged that R150 had not had a wound care assessment by the wound care nurse, the wound care assessment form in the clinical record was blank. He indicated that the expectation is for the wound care

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ARCHIE HENDRICKS SENIOR SKILLED NURSING FACILITY	HCO 1 BOX 9100 SELLS, AZ 85634

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F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 5) nurse to assess all wounds on admission and weekly. Staff 61 also stated that the wound treatment should have been initiated upon admission until resident is evaluated by the wound care nurse or wound doctor. Requested to speak to the wound care nurse, she was not available. Attempted to see the resident wounds and it was not possible during the survey. Reviewed the policy for pressure ulcer / skin assessment on 6/21/2018 and it requires for the skin risk assessment to be completed as soon after admission, no later than 8 hours after admission. Thereafter, weekly for the 1st 4 weeks and or unless there is a significant change in condition or as often required based on the residents condition. The staff is required to use the facility risk assessment tool with every skin assessment.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility did not ensure that the resident's environment was free of accident hazard and that equipment used by the resident was in maintained and in good working order. Finding includes: Resident 39 was admitted to the facility on [DATE] with several [DIAGNOSES REDACTED]. Review of the quarterly minimum data set ((MDS) dated [DATE] revealed that the resident had a BIMS (brief interview of mental status) score of 15 (indicating intact cognitive ability), that she had no mood or behavior problems, and that she required supervision in most activities of daily living. During an initial interview on 6/18/18, Resident 39 stated that she had not recently fallen and that she was able to transfer by herself from her bed to her wheelchair. Review of the medical record however, revealed that the resident was described in progress notes as having had a fall in her room on 5/10/18. The progress notes revealed that during transfer, Resident 39's wheelchair slipped as the left hand brake did not engage. The resident then slid to the floor and was not injured. In another interview on 6/20/18, Resident 39 verified that she did have a fall in her room while she was returning to her bed after using the bathroom. The resident added that as she stood up to transfer back to bed, the wheelchair moved backwards causing her to loose balance and fall on the floor. The resident stated that while was shaken up, she did not sustain any injuries. During the interview, Resident 39 stated that the left hand brake on her wheelchair had been loose but did engage and so she was not concerned. When asked as to when her wheelchair had last undergone a maintenance check, the resident stated that she was not aware; but that after her fall, the wheelchair was repaired. During a separate interview on 6/20/18, a facility maintenance staff (Staff 111) stated that the facility had not been conducting preventive maintenance of late on residents' wheelchairs because of staffing and other competing priorities. Staff 111 stated that repairs were made on wheelchairs only after they were reported broken.
F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to assess and maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise for 1 of 17 sampled residents (R 47). Findings include: Record review concurrent with an interview on 06/20/18 at 11:37 a.m., with the Consultant RD, she indicated that she visits the facility on a monthly basis and has limited computer access virtually. The RD further explained that she only monitors the monthly weights and does not evaluated the weekly weights. In addition she stated that the dietary manager and nursing monitors the weekly weights. R 47 was admitted to the facility on [DATE] with Fracture (FX) Femur, FX Ulna, Constipation, [MEDICAL CONDITION], and Muscle Weakness. Resident weights: 6/20/18 - 131. - 5.8% - standing 6/1/18 - 132. - Standing - 5.0 % = 7 lbs lost - according to the clinical record 5/23/18 - 139.8 - W/C 5/16/18 - 139.6 - W/C 5/10/18 - 139.0 - W/C 5/2/18 - 137.6 - W/C RD was asked if she was aware of R 47 weight loss, she indicated No, because she only looked at monthly weights. The RD also explained that R 47 assessment was done on 5/26/2018 because that was the day of her monthly visit. She explained that the only time she uses the virtual records is if she is notified by management that there is a concern with a resident and a recommendation is needed. The RD also indicated that the dietary tech does a dietary interview/pre-screening with all new admissions, which captures the preferences. Additional record review reveals discrepancy with the computer generated weight form, which documented R 47 monthly weight as a 3.6 % weight lost and the resident chart disclose 5.0 % weight lost. The RD acknowledged that there were significant differences with the documents. According to the monthly monitoring form the weight lost of 3.6 % is not significant per RD. But indicated that the system discrepancy with IT must be addressed because there is duplicate documentation with a different interpretation of the weight lost. When inquired about the facility nutritional risk review form that was not completed in order to evaluate the residents nutritional needs, the RD indicated that she completes a narrative note instead. The RD narrative note did not capture all the standard of practice nutritional risk assessments. Finally, the RD confirmed that the MD and the residents representative was not notified because there is no weight lost according to her monthly weight form. During an interview concurrent with a record review on 06/20/18 at 12:00 PM with Staff 26, he acknowledged that there was a difference with the documentation in regards to R 47 weights loss. He validated that a weight loss care plan was not implement and the nutritional assessment was late. In addition, he validated that he did not report a weight loss to the RD and was not aware that the RD does not evaluates the residents entire weights documentation. The residents clinical record has a warning indicator, indicating that there is a 7 pounds weight loss, but no one is tracking or monitoring that indicator according to Staff 26. During an interview concurrent with a record review on 06/20/18 at 01:44 p.m., with Administrative Staff 61. he stated that the expectation is for the RD to complete the admission assessment timely, review the care plans, review all the weights and make recommendations. Staff 61 stated that he was not aware that the RD was not monitoring the weekly weights, updating or implementing care plans and conducting assessment timely. When asked what is a timely assessment, he indicated that the initial assessment should be completed within a week of admission. He acknowledged that the resident did lose weight since admission and that the RD should have been aware. In addition he stated that the weights are reviewed in a meeting weekly and monthly. Further more Staff 61 validated that he was not aware that the RD only had limited computer access to the clinical records. Reviewed of the facility policy on 6/20/2018 title Initial resident visitation / nutrition screening reveals that the Dietary Manager, Diet Technician, Clinical Manger, or designated associate should visit each resident within approximately 72 hours or in the first week following admission and complete a a dietary interview and prescreen.
F 0726 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, the facility failed to ensure that a licensed nurse have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care in 1 of 17 sampled residents (#5). Findings include:

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F 0726 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 6) On 4/17/18, a Facility Reported Incident (FRI) #AZ 925 was internally investigated and reported accordingly. This report was pertaining to a licensed nurse (LN81) that retrieved loose pills of anti-cancer drugs (Sorafenib) inside a red sharps container, identified the retrieved pills using a medication website, placed the retrieved pills in a medication bottle, labeled the bottle of pills, and administered the retrieved Sorafenib to Resident 5 without prior notification of the physician or the pharmacist. On 6/19/18 at 1:40 pm two (2) licensed nurses (#60 and #46) were interviewed related to this incident and both stated that it was a bad practice. When asked if the pharmacist conducted an in-service training related to handling, administering and disposal of anti-cancer medications, both LN stated they have not received any in-service training after the incident. On 6/19/18 at 1:45 p.m. during a medication cart storage inspection, LN 60 stated that another resident is currently receiving an anti-cancer drug. A punch card from the medication cart was observed labeled (resident's name) with a drug name of [MEDICATION NAME] 500 mg. capsule with a count of 29 capsules left in the bubble pack. When asked how anti-cancer medication are handled, LN 60 stated that they are handled carefully and with gloves on. Red sharps container was also observed attached to the side of each medication cart. LN 60 stated that there is a visible Fill Line marker that is visually inspected and when it reaches the fill line, the nurses would take out the sharps container and put them in the medication room counter for pick up. The second licensed nurse interviewed on 6/19/18 at 2 p.m. (LN 46) has worked in the facility for 6 years. During the interview that was done in the secured medication room (room [ROOM NUMBER]) LN 46 stated that all medications especially IV medications are prepared in that area. There were only two (2) sharps container (1 quart size) observed in the counter next to the sink. Interview with the facility's DON, (LN61) on 6/19/18 at 2 p.m. and 4:20 p.m. revealed that what happened was an unacceptable practice. LN61 stated that the licensed nurse involved has received counseling, however, no formal in-service training has been conducted to all licensed nurses particularly related to safe handling, administering and disposal of anti-cancer drugs. On 06/20/18 at 1:40 p.m. an interview was conducted with (LN 81) who stated it was another nurse LN 80 who disposed the anticancer drugs with discontinued orders from the oncologist. LN 81 also stated that those medications cost $8,000 - $10,000 for a 9-month supply. LN 81 revealed the facility does not have a policy and procedure to dispose medications. Further interview with LN 81 revealed an acknowledgement of the unacceptable practice. LN 81 confirmed that counseling was done, however, to date, there has been no formal in-service training conducted related to safe handling, administration and disposal of anti-cancer medications. On 06/21/18 at 2:41 p.m. interview with Education Coordinator (LN 42) revealed that she conducted LN 81' s' orientation mentorship on 6/22/17 but was unable to explain of the gap of orientation when the date of hire was 4/25/17. LN 42 also confirmed that LN 81 did not attend the nurses competency fair for six (6) hours on 10/20/17. Interview with the DON and LN 81 confirmed the absence of an annual evaluation on file. However LN 42 showed evidence that LN 81 attended meetings of Performance Improvement Program (PIP) for Infection Control. On 06/21/18 3:04 p.m. interview with administrative staff #20 was unable to show proof of licensed staff competencies, however showed the quality assurance (QA) book with a facility plan that identified 12 care topics planned for licensed nurses to be trained for competency. (Cross refer to F755, F880 and F865)
F 0732 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**Post nurse staffing information every day.** Based on observation and interview, the facility did not post the actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care. Finding includes: While the nursing staffing information was posted on an overhead television monitor in the central lobby of the facility in front of the nursing station; and included the date and the number of licensed and unlicensed staff responsible for direct patient care for the different shifts, the actual number of hours worked by the staff, however were not posted, as required.When this was brought to the attention of a licensed nursing staff on 6/20/18, the staff (Staff 47) stated that the IT individual (Staff 107) responsible for posting the information will be notified to add the hours.
F 0745 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide medically-related social services to help each resident achieve the highest possible quality of life.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being for 1 of 17 sampled (R 47). Findings include: During an interview concurrent with a record review on 6/20/18 at 11:02 a.m., with Staff 188 she indicated that during a care plan meeting with the resident and the family on 5/31/2018 it was identified that the resident was hard of Hearing (HOH) and would benefit for a pocket talker (a device used for residents that are HOH in order to enhance the sound in their surroundings). Staff 118 stated that she has not yet ordered the device for the resident, and will do so today. When asked why was the device not ordered she indicated that she had not realized that the resident never receive the pocket talker as planned. During an interview concurrent with a record review on 6/20/18 at 11:32 a.m., with Staff 117 regarding R 47 social service assessment being completed late on 5/21/2018 since the resident was admitted to the facility on [DATE]. He indicated that the expectation is to complete the assessment as soon as possible but definitely within a week of admission. Staff 117 also indicated that he had several attempts and he was not successful in meeting with the resident, but had failed to document each attempt in the clinical records. Reviewed the social service notes and he did not address the residents advance directive and sensory devices needs. When asked about the ordering of the pocket talker for the R 47 he stated that the order is being placed today and he was not aware that the facility had ran out of pocket talker supplies. Requested for a policy on social services and did not receive it to review during the survey.
F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, the facility failed to provide pharmaceutical services including procedures that assure the accurate dispensing and administering of all drugs to meet the needs of 1 of 17 sampled resident (#5). Findings include: Resident 5 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A resident care plan dated 12/26/17 revealed the resident was receiving [MEDICAL CONDITION] related [MEDICAL CONDITION] of the liver. Interventions include: (Resident's name) is at risk for contracting infections due to [MEDICAL CONDITION]. Keep the environment clean and people with infection away. On 4/17/18, a Facility Reported Incident (FRI) #AZ 925 was internally investigated and reported This incident was pertaining to a licensed nurse (LN81) that retrieved loose pills of anti-cancer drugs (Sorafenib) inside a red sharps container, identified the retrieved pills using a medication website, placed the retrieved pills in a medication bottle, labeled the bottle of pills, and administered the retrieved Sorafenib to Resident 5 without prior notification of the physician or the pharmacist. Review of the FRI sent by the facility's DON (LN61) revealed the nurse in the doctor's office stated the medication should never have been stopped. The last prescribed dose was given on 3/1/18. The medications were disposed of in a clean sharps

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F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 7) container on 3/12/18. On 3/15/18, one of the facility nurses (LN81) was preparing an IV medication in the secured medication room. LN81 noticed a sharps container with pills in the bottom that looked similar to [MEDICAL CONDITION] medications Resident 5 was taking. LN81 opened the sharps container and removed the pills. The sharps container also had eight (8) unused IV catheters that were retracted and placed in the sharps container due to expiration. LN81 then proceeded to examine the medications and found the medications to be clean and intact with no visible soiling noted. LN81 placed the medications in a clean medication bottle and labeled the bottle with resident name, the name of the drug and strength. The medication was identified using medication web site. There were five (5) doses given from the medication bottle between 3/15/18 and 3/20/18. There were no adverse effects from the 5 doses given. On 6/19/18 at 1:40 pm two (2) licensed nurses (#60 and #46) were interviewed related to this incident and both stated that it was a bad practice. When asked if the pharmacist conducted an in-service training related to handling, administering and disposal of anti-cancer medications, both LN stated they have not received any in-service training after the incident. On 6/19/18 at 1:45 p.m. during a medication cart storage inspection, LN60 stated that another resident is currently receiving an anti-cancer drug. A punch card from the medication cart was observed labeled (resident's name) with a drug name of [MEDICATION NAME] 500 mg. capsule with a count of 29 capsules left in the bubble pack. When asked how anti-cancer medication are handled, LN60 stated that they are handled carefully and with gloves on. Red sharps container was also observed attached to the side of each medication cart. LN60 stated that there is a visible Fill Line marker that is visually inspected and when it reaches the fill line, the nurses would take out the sharps container and put them in the medication room counter for pick up. The second licensed nurse interviewed on 6/19/18 at 2 p.m. (LN46) has worked in the facility for 6 years. During the interview that was done in the secured medication room (room [ROOM NUMBER]) LN46 stated that all medications especially IV medications are prepared in that area. There were only two (2) sharps container (1 quart size) observed in the counter next to the sink. Interview with the facility's DON, (LN61) on 6/19/18 at 2 p.m. and 4:20 p.m. revealed that what happened was an unacceptable practice. LN61 stated that the licensed nurse involved has received counseling, however, no formal in-service training has been conducted to all licensed nurses particularly related to safe handling, administering and disposal of anti-cancer drugs. On 06/20/18 at 1:40 p.m. an interview was conducted with (LN81) who stated it was another nurse LN 80 who disposed the anticancer drugs with discontinued orders from the oncologist. LN81 also stated that those medications cost $8,000 - $10,000 for a 9-month supply. LN81 revealed the facility does not have a policy and procedure to dispose medications. Further interview with LN81 revealed an acknowledgement of the unacceptable practice. LN81 confirmed that counseling was done, however, to date, there has been no formal in-service training conducted related to safe handling, administration and disposal of anti-cancer medications. (Cross refer to F724 and F880)
F 0760 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based record review and interview, the facility did not ensure that its resident was free of any significant medication error. Finding includes: Resident 39 was admitted to the facility on [DATE] with several [DIAGNOSES REDACTED]. Review of the quarterly minimum data set ((MDS) dated [DATE] revealed that the resident had a BIMS (brief interview of mental status) score of 15 (indicating intact cognitive ability), that she had no mood or behavior problems, and that she required supervision in most activities of daily living. During an interview on 6/18/18, Resident 39 stated that she often had generalized pain especially on her left knee because of arthritis. The resident stated that she was regularly receiving pain medications which was effective and helped her sleep at night. Review of the medical record revealed that Resident 39 had a physician's orders [REDACTED]. The Medication Administration Record [REDACTED] Review of nurses progress notes dated 6/13/18 revealed that a medication error involving Resident 39 had occurred. While the resident's physician, the director of nurses, and administrator were notified, the progress notes did not include any information about the error and what medication was involved. During an interview on 6/21/18, an administrative nursing staff (Staff 61) stated that an investigation report would be provided. Review of the Medication Incident provided revealed that the medication involved the administration of [MEDICATION NAME] HCL 10 mgs by two medication nurses so that the resident was given an extra dose during the scheduled morning medication pass without an order (by the physician) to do so. The note added that the error resulted in the need for increased resident monitoring. Review of the literature revealed that [MEDICATION NAME] exposes users to the risk of opioid addiction, abuse, misuse, and can lead to overdose and death. While the incident report noted that Resident 39 was given an extra dose of the opioid [MEDICATION NAME] because the first dose was not signed off immediately in (the) computer after it was administered, the document did not include any corrective action plan to prevent further occurrence. Further, while the resident's family member was also informed and that the daughter was (satisfied) no issues with (the resident) and not repeat was likely to happen again, no preventive interventions were developed. During a separate interview on 6/21/18, another licensed staff (Staff 47) stated that the resident had two containers of the same medication in the cart: one in a bottle; and the other in a blister pack. This, according to Staff 47, can cause confusion because each container would have a sign-out sheet being that the [MEDICATION NAME] was a controlled narcotic [MEDICATION NAME]. Staff 47 added that the medication nurse should have documented the scheduled morning administration on the MAR (medication administration record) so that the other nurse would have known not to give it again. In another interview on 6/21/18, a licensed nurse (Staff 59) stated that she was responsible for half of the 600-hallway (odd- numbered rooms). When Staff 59 was passing the scheduled morning medications, Resident 39 (assigned to an even-numbered room) approached her and asked if she was due for her morning pain pill. Staff 59, upon checking the electronic MAR, noted that Resident 39's scheduled medications had not been signed off as given. Staff 59, accordingly, went to the other medication cart (designated for the even-side rooms of the hallway), found the resident's [MEDICATION NAME] HCL 10-mg tablets which were in a bottle, and administered one to the resident. Review of the facility's policy and procedure on medication administration required that Administration of medication must be documented immediately after (never before) it is given; which includes the Signature and title of the person administering the medication. The Facility's policy and procedure was not followed.
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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure all drugs and biologicals must be labeled in accordance with currently accepted professional principles and the expiration date when applicable. Failure to label all drugs and biologicals in accordance with standards of practice and/or facility policy may potentially subject a resident to a medication with questionable potency. Findings include:

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	035263	A. BUILDING _____ B. WING _____	06/22/2018

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ARCHIE HENDRICKS SENIOR SKILLED NURSING FACILITY	HCO 1 BOX 9100 SELLS, AZ 85634

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 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 8) On 06/19/2018 the all the medication storage areas were inspected with a licensed nurse. The facility policy dated 11/26/2016 titled Medication (prescribed) Expiration Dates indicates Open multi-dose injectable medication vials will be marked with the date of opening and discarded after 30 days from opening or as recommended by the manufacture. An additional document provided by the facility from MED-PASS, Inc. (Revised (MONTH) 2006) states Eye drop solution containers must be labeled immediately upon opening. The labels must contain the date & time the container was opened. Additionally, from the same aforementioned document, Opened eye drop containers expire 60 days after opening or manufacture's recommendation. Staff 61 validated the medication refrigerator contained an open vial of [MEDICATION NAME] Purified Protein Derivative labeled as being opened on 04/27/2018 which should have been discarded. Staff 61 also verified one of the medication carts also contained an opened vial of [MEDICATION NAME] 100units/10ml vial which had NOT been labeled with an OPEN date. Additionally, Staff 61 validated the medication cart contained an open vial of [MEDICATION NAME] 0.15% eye drop solution which was NOT labeled with an OPEN date.
F 0791 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide or obtain dental services for each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, the facility failed to assist in obtaining routine dental care for 1 of 17 sampled residents. (#5) Findings include: Resident 5 was admitted on [DATE] with [DIAGNOSES REDACTED]. On 06/18/18 03:25 p.m. Resident 5 was observed with missing teeth. During an interview, he stated that he wanted to have his teeth fixed and he has not seen the dentist since admission. He also stated he was having a hard time chewing meat and sometimes the meat served is tough. On 6/18/18 at 12 p.m. dining observation was done. The resident was served corned beef and was chewing slowly. He stated that he was able to chew the meat but had to do it slowly due to missing teeth. He was able to consume 80% of the lunch meal. On 06/21/18 at 11:10 a.m. interview with social worker (#117) confirmed that Resident 5 has been in the facility over a year and has not seen the dentist. Review of the resident care plan for oral care initiated on 12/16/18 and revised on 4/09/18 revealed the resident requires oral inspection daily with oral care after meals and as necessary. There was no plan of care developed for dental services.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation, interviews and record review the facility failed to ensure that food is prepared in sanitary manner, dishes and utensils were cleaned and stored under sanitary conditions, Findings include: On 06/18/18 09:31 a.m. a brief kitchen inspection conducted with the dietary staff (#26) and observed the following: The computer area was dusty and noted to be adjacent to the food preparation. The dishwasher machine was identified by dietary manager #25 as low temperature dishmachine. A dietary aide (#36) who was washing the dishes at the time of inspection was requested to check the sanitation level of the clean dishes. However, dietary aide #36 was unable to locate the litmus strips within the dishwashing area. Dietary manager #25 had to provide the litmus strip to conduct the test. After three (3) attempts of the strip test and coaching by dietary manager #25 on how to conduct the test, dietary staff #36 was able to achieve 50 parts per million (ppm) reading result. Review of the Dishmachine Temperature Log (Form 408) for (MONTH) (YEAR) revealed the concentration of the sanitary solution was checked three times a day with a result of 100 ppm with chlorine sanitizer. A review of facility policy related to Recording of Dishmachine Temperature and ppm revealed the concentration of the sanitary solution during the rinse cycle is 50-100 ppm with Chlorine sanitizer on low temperature dishmachines. On 6/20/18 at 12 p.m. during lunch meal distribution, one of the dietary consultant was present and findings related to staff knowledge of dishwashing procedure on first day of the survey was relayed. The dietary consultant stated that she gave in-service training on Thursday related to dishwashing procedures and the use of sanitizing strips. Review of the In-service training dated 6/14/18 revealed the training covered correct temps and ppms in dishmachine . however, the attendees did not include all dietary staff including dietary aide #36
F 0865 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Have a plan that describes the process for conducting QAPI and QAA activities.** Based on interview the facility failed to make good faith attempts to identify and correct quality deficiencies. Failure to identify and take actions to prevent the reoccurrence of potentially negative incidents/concerns has the potential for injury to residents and/or staff. Findings include: On 06/21/2018, near 14:00, the facility quality assessment and performance improvement (QAPI) program interview was conducted with the Administrator, Chief Operating Officer, Director of Nurses (DON) and other members of the quality team. It was acknowledged during the interview that in (MONTH) (YEAR) there had been a facility concern associated with the safe handling, administration and disposal of chemotherapeutic medications, that the concern had been shared with the facility Medical Director and the discussions would NOT be in the QAPI meeting minutes. The incident had also been referred to the state board of nursing. During the Medication Storage inspection it was validated that the facility currently had a resident that was still receiving oral chemotherapeutic agents. The DON affirmed that he, the facility consulting pharmacist nor the staff development had NOT completed any documented any work-related training on the safe handling, administration & disposal of chemotherapeutic agents.
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, interviews and record review, the facility failed to establish and maintain an infection prevention and control program to provide a safe, and sanitary environment and to help prevent the development and transmission of infections Finding includes: Resident 5 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A resident care plan dated 12/26/17 revealed the resident was receiving [MEDICAL CONDITION] related [MEDICAL CONDITION] of the liver. Interventions include: (Resident's name) is at risk for contracting infections due to [MEDICAL CONDITION]. Keep the environment clean and people with infection away. On 4/17/18, a Facility Reported Incident (FRI) #AZ 925 was sent to CMS. This report was pertaining to a licensed nurse (LN81) that retrieved loose pills of anti-cancer drugs (Sorafenib) inside a red sharps container, identified the retrieved pills using a medication website, placed the retrieved pills in a medication bottle, labeled the botltle of pills, and administered the retieved Sorafenib to Reident 5 without prior notification of the physician or the pharmacist. Review of the FRI sent by the facility's DON (LN61) revealed the nurse in the doctor's office stated the medication should never have been stopped. The last prescribed dose was given on 3/1/18. The meds were disposed of in a clean sharps container on 3/12/18. On 3/15/18, one of the facility nurses (LN81) was preparing an IV medication in the secured med room. LN81 notices a sharps container with pills in the bottom that looked similar to [MEDICAL CONDITION] meds Resident 5 was taking. LN81 opened the sharps container and removed the pills. The sharps container also had eight unused IV catheter that were retracted and placed in the sharps container due to expiration. LN81 then proceeded to examine the meds and found the meds to be clean and intact with no visible soiling noted. LN81 placed the meds in a clean medication bottle and labeled it with resident name and the name of the drug and strength. The medication was identified using medication web site. There were five (5) doses given from the bottle between

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 9) 3/15/18 and 3/20/18. There were no adverse effects from the 5 doses given. Review of the facility's Sharps Disposal policy stated, No one shall open, empty, or manually clean reusable containers, or handle such containers in a manner which would expose him/her to the risk of percutaneous injury. Whoever observes incorrect disposal or handling of contaminated sharps should report the information to the Infection Preventionist (or designee). On 6/19/18 at 1:40 pm two (2) licensed nurses (#60 and #46) were interviewed related to this incident and both stated the reported event was a bad practice. When asked if the Education Coordinator or the Director of Nursing (DON)conducted any in-service training related to handling, administering and disposal of anti-cancer medications, both LNs stated they have not received any in-service training after the incident. On 6/19/18 at 1:45 p.m. during a medication cart storage inspection, LN60 stated that another resident is currently receiving an anti-cancer drug. A punch card from the medication cart was observed labeled (resident's name) with a drug name of [MEDICATION NAME] 500 mg. capsule with a count of 29 capsules left in the bubble pack. When asked how anti-cancer medication are handled, LN60 stated they are handled carefully and with gloves on. Red sharps container was also observed attached to the side of each medication cart. LN60 stated there is a visible Fill Line marker that is visually inspected and when it reaches the fill line, the nurses would take out the sharps container and put them in the medication room counter for pick up. The second licensed nurse interviewed on 6/19/18 at 2 p.m. (LN46) has worked in the facility for 6 years. During the interview that was done in the secured medication room (room [ROOM NUMBER]) LN46 stated that all medications especially IV medications are prepared in that area. There were only two (2) sharps container (1 quart size) observed in the counter next to the sink. Interview with the facility's DON, (LN61) on 6/19/18 at 2 p.m. and 4:20 p.m. revealed that what happened was an unacceptable practice. LN61 stated that the licensed nurse involved has received counseling, however, no formal in-service training has been conducted to all licensed nurses particularly related to safe handling, administering and disposal of anti-cancer drugs. On 06/20/18 at 1:40 p.m. an interview was conducted with (LN81) who stated it was another nurse LN 80 who disposed the anticancer drugs. LN81 also stated that those medications cost $8,000 - $10,000 for a 9-month supply. LN81 revealed the facility does not have a policy and procedure to dispose anti-cancer medications. Review of the facility's policies on Disposal of Medications, Syringes and Needles Section 5.0 revealed the absence of any policy specific to anti-ancer drugs. Review of the facility policy on Medication Storage Section 4.1 #14 revealed that outdated, contaminated, discontinued or deteriorated medications and those containers that are cracked, soiled or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy, if a current order exists. Further interview with LN81 revealed an acknowledgement of the unacceptable practice. LN81 confirmed that counseling was done, however, to date, there has been no formal in-service training conducted related to safe handling, administration and disposal of anti-cancer medications. (Cross refer to F726, F755 and F865)
F 0908 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Keep all essential equipment working safely.** Based on record review and interview, the facility did not ensure and maintain all mechanical and patient care equipment were in safe operating condition. Finding includes: During an interview on 6/21/18 at 11:22 a.m., a maintenance staff member (Staff 111) stated that the facility did not have any preventive maintenance schedule for wheelchairs. Staff 111 added that wheelchairs that are broken or in need of service are to be reported by certified nurse aides (CNAs) to maintenance staff ; only then are they repaired. Staff 111 stated that competing priorities as well as staffing precluded routine preventive maintenance. Review of the medical record revealed that Resident 39 had a fall in her room on 5/10/18 during transfer. Accordingly, the resident's wheelchair slipped as the left hand brake did not engage. The resident then slid to the floor and was not injured. During an interview on 6/20/18, Resident 39 verified that she did have a fall in her room while she was returning to her bed after using the bathroom. The resident added that as she stood up to transfer back to bed, the wheelchair moved backwards causing her to loose balance and fall on the floor. The resident stated that while was shaken up, she did not sustain any injuries. In the interview, Resident 39 added that the left hand brake on her wheelchair was loose but did engage and so she was not concerned until the fall happened. The resident added that she was not aware when her wheelchair had undergone a maintenance check; but added that after her fall, the wheelchair was repaired. (Cross-refer to F689)