STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035130	A. BUILDING _____ B. WING _____	02/07/2019

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ARCHSTONE CARE CENTER	**1980 WEST PECOS ROAD CHANDLER, AZ 85224**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policy, the facility failed to ensure one resident (#126) advanced directive was accurately documented in the clinical record. Findings include: Resident #126 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the [DATE] admission face sheet indicated the resident was identified as his responsible party. A physician order [REDACTED].>Review of a document titled Advanced Directive Decisions dated [DATE] revealed the resident's decision was Do Not Resuscitate and Do Not Hospitalize. The section to be completed by the physician was blank. Review of the Social History assessment dated [DATE] completed by social services revealed the resident was his own responsible party. The assessment revealed the section Do Not Resuscitate Order (see DNR form) was marked CPR and the Advance Directive section was marked yes. The admission Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact. Further review of the clinical record did not reveal a Prehospital Medical Care Directive or that an Advanced Directive had been completed. An interview was conducted on [DATE] at 12:53 PM with the Admissions Manager (staff #115), who that stated the Advanced Directive Decisions form is completed at the time of admission Staff #115 stated that the form is put into a binder at the nurse's station and that the physician will sign it. Staff #115 further stated that if the resident is a Do Not Resuscitate (DNR) status, the orange Prehospital Medical Care Directive form is completed, the physician will sign it, and the status is updated in the clinical record. However, the Admission Manager was unable to locate the form for this resident in the binder at the nurse's station. On [DATE] at 01:23 PM, the resident declined an interview regarding his Advanced Directive status. An interview was conducted on [DATE] at 01:45 PM with the Director of Nursing (DON/staff #110), who stated the Advanced Directives processes are started during the admission process as part of the admission paperwork. The DON stated that if the resident wishes to be a DNR status, the orange Prehospital Medical Care Directive form is to be completed along with the required signatures. Staff #110 also stated that the Social Worker completed the Social History Assessment for this resident and that for the choices of CPR (Cardiopulmonary resuscitation) and no CPR under the DNR section, the Social Worker selected CPR and selected Yes under the Advanced Directive section. During an interview conducted on [DATE] at 01:10 PM with the Social Worker (SW/staff #114), the SW stated that when she completed the Social History Assessment form this resident, the resident chose CPR, but also wanted the Power of Attorney (POA) to make the decision. Staff #114 stated that by marking the CPR selection under Do Not Resuscitate it applied to the performance of CPR only and that the Advanced Directive section meant the resident or the resident's POA would initiate Advanced Directives. The Social Worker stated that she had spoken with the resident's POA on a previous date and then again on [DATE] and that it was clarified that the resident was a Full Code status. However she did not have any documentation of the communications with the resident's PO[NAME] The facility's policy titled Advanced Directives included the policy statement that, Advanced Directives will be respected in accordance with state law and facility policy. The policy revealed that Upon admission, the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he if she chooses to do so .If the resident is incapacitated and unable to receive information about his or her right to formulate an advance directive, the information may be provided to the resident's legal representative . The policy included that information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record. The policy also included the Director of Nursing or designee will notify the Attending Physician of advance directives so that appropriate orders can be documented in the resident's clinical record and plan of care.
F 0637 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Assess the resident when there is a significant change in condition** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and the Resident Assessment Instrument (RAI) manual, the facility failed to ensure that a significant change in status Minimum Data Set (MDS) assessment was completed within the required timeframe for one resident (#75). Findings include: Resident #75 was admitted on (MONTH) 7, (YEAR) with [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. Review of the care plan revealed the resident was admitted to hospice services on (MONTH) 5, (YEAR). A physician's progress note dated (MONTH) 5, (YEAR) included the resident's admission to hospice services. However, review of clinical record revealed no significant change in status MDS assessment was completed in (MONTH) (YEAR). An interview was conducted on (MONTH) 6, 2019 at 12:18 p.m. with the MDS Registered Nurse (RN/staff #28) who stated that when a resident is admitted to hospice services, it is considered a significant change of condition and a significant change in status MDS assessment is required to be completed. Staff #28 also stated that they follow the RAI manual for MDS assessment requirements and schedules. An interview was conducted on (MONTH) 7, 2019 at 10:59 a.m. with the Director of Nursing (DON/staff #110) who stated that her expectation is for staff to complete the MDS assessments accurately and in a timely manner. Staff #110 stated that if a resident is admitted to hospice services, that would be a significant change of condition and completion of a significant change in status MDS assessment would be required. The DON stated the MDS assessment policy is to follow the RAI manual. The RAI manual instructs a Significant Change in Status Assessment (SCSA) is required to be performed when a terminally ill resident enrolls in a hospice program. The manual included the Assessment Reference Date (ARD) must be within 14 days from the effective date of the hospice election. The manual also instructs that a SCSA must be performed regardless of whether an assessment was recently conducted for the resident.

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 0637 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1)
F 0695 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, staff interviews, and policy review, the facility failed to ensure that oxygen was administered per physician's order for one resident (#229). Findings include: Resident #229 was admitted on (MONTH) 24, 2019 with [DIAGNOSES REDACTED]. The physician's orders dated (MONTH) 29, 2019 included for oxygen at 2 liters per minute (LPM) via nasal cannula to maintain oxygen saturation at 90% every 8 hours as needed (PRN) for shortness of breath. The admission Minimum Data Set assessment dated (MONTH) 31, 2019 revealed a Brief Interview of Mental Status score of 15, indicating the resident was cognitively intact. The assessment also included the resident was provided oxygen therapy. During an observation conducted of the resident on (MONTH) 4, 2019 at 10:51 a.m., the resident was observed with oxygen via nasal cannula at 3.5 LPM. An observation was conducted of the resident on (MONTH) 6, 2019 at 11:18 a.m. The resident was observed receiving oxygen via nasal cannula at 3.5 LPM. An interview was conducted on (MONTH) 6, 2019 at 11:25 a.m. with a Licensed Practical Nurse (LPN/staff #76) who stated that some oxygen orders will have a LPM range, so adjusting the oxygen flow would be following the physician order. Staff #76 stated that if a physician order is specific for LPM, then the expectation is that order should be followed for that resident. During an observation conducted of the resident #229 on (MONTH) 7, 2019 at 10:35 a.m., the resident was observed with oxygen via nasal cannula at 3.5 LPM. Immediately following this observation, an interview was conducted with a Registered Nurse (RN/staff #61), who stated that the resident has been using oxygen daily since admission. Staff #61 stated that the physician's order is for the resident to have oxygen at 2 LMP prn and that the order should be followed. After observing the resident was receiving oxygen at 3.5 LPM, the RN stated that the oxygen should be at 2 LPM and not 2 LPM. Staff #61 immediately decreased the oxygen to 2 LPM. An interview was conducted on (MONTH) 7, 2019 at 10:59 a.m. with the Director of Nursing (DON/staff #110). The DON stated that the expectation is that the nurses follow physician orders. The facility's policy titled Oxygen Administration revealed the purpose is to provide guidelines for safe oxygen administration. The policy included to verify that there is a physician's order for oxygen and to review the order for oxygen administration. The policy also included to adjust the oxygen delivery device so that the proper flow of oxygen is being administered.
F 0757 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policy and procedures, the facility failed to ensure one resident's (#231) drug regimen was free of unnecessary drugs, by failing to ensure that pain medication was administered within the pain parameters per the physician's orders [REDACTED].>Findings include: Resident #231 was admitted on (MONTH) 31, 2019 with [DIAGNOSES REDACTED]. A review of physician's orders [REDACTED]., and [MEDICATION NAME] (narcotic) HCI tablet 10 mg by mouth every 4 hours as needed for pain 9-10. Review of the Mediation Administration Record (MAR) for (MONTH) 2019 revealed [MEDICATION NAME] 10 mg was administered for a pain level of 2 on (MONTH) 3, 2019 at 1:01 a.m. and 9:32 p.m. An interview was conducted on (MONTH) 6, 2019 at 11:25 a.m. with a Licensed Practical Nurse (LPN/staff #76) who stated that as needed (PRN) pain medication will have a specific pain scale attached to the order. The LPN stated that the resident's pain level will determine which PRN medication is to be administered to the resident. Staff #76 stated that the expectation is that nurses follow the physician's orders [REDACTED].>During an interview conducted on (MONTH) 7, 2019 at 10:59 a.m. with the Director of Nursing (DON/staff #110) the DON stated that the expectation is that staff follow the physician's orders [REDACTED]. The facility's policy titled Pain-Clinical Protocol revealed the staff will use a consistent approach and a standardized pain assessment instrument appropriate to the resident's cognitive level. The policy included the physician will order appropriate medication interventions to address the resident's pain. The policy also included pain medications should be selected based on pertinent treatment guidelines.

F 0761 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**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 observations, review of clinical records, staff interviews, and policy review, the facility failed to ensure that expired medications were not available for use for two residents (#17 and #14) and failed to ensure that the expired medications were not administered to one resident (#14). Findings include: -Resident #17 was admitted to the facility on [DATE] and readmitted on [DATE]. During a medication storage observation conducted on 02/05/19 at 2:15 PM of a medication cart on Station 2 the following medications for resident #17 were observed: -One bubble pack of Calcium antacid chewable tablets 500 milligram (mg) (packaged as two tablets per bubble) with 26 doses remaining with an expiration date of 10/06/18. -Two bubble packs of [MEDICATION NAME] (antidiarrheal) 2 mg tablets with one pack containing 30 remaining doses with an expiration date of 10/06/18 and one pack containing 10 remaining doses with an expiration date of 09/09/18. -One bubble pack of [MEDICATION NAME] ([MEDICATION NAME]) 325 mg tablets (packaged as two tablets per bubble) with 24 doses remaining with an expiration date of 10/06/18. -Two bubble packs of [MEDICATION NAME][MEDICATION NAME] ([MEDICATION NAME]) 25 mg tablets with one pack containing 2 remaining doses with an expiration date of 09/19/18 and one pack with 28 remaining doses with an expiration date of 10/06/18. Review of the resident's Medication Administration Records (MAR) revealed the resident last received the medications prior to (MONTH) (YEAR). -Resident #14 was admitted to the facility on [DATE]. During a medication storage observation conducted on 02/06/19 at 02:03 PM of a medication cart on Station 1, one bubble pack of [MEDICATION NAME] 500 mg tablets with 62 tablets remaining was observed with an expiration date of 11/08/18. Review of the physician orders [REDACTED]. Review of the MARs for (MONTH) and (MONTH) 2019 revealed documentation that the resident was administered the medication as ordered. During an interview conducted on 02/06/19 at 02:03 PM with a Licensed Practical Nurse (LPN/staff #76), the LPN stated that she had administered Tylenol from that pack to the resident that morning. An interview was conducted on 02/07/19 at 09:32 AM with the Director of Nursing (DON/staff #110). The DON stated that the night shift nurse is responsible for checking the carts every night for any expired medications and to ensure that opened medications are dated when opened. The facility's policy titled Storage of Medications revealed Medication and biologicals are stored safety, securely, and properly following manufacturer's recommendations or those of the supplier. The policy included Outdated, contaminated or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from inventory, disposed of according to procedures for medication disposal .and reordered from the pharmacy .if a current order exists.

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F 0761 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2)