STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035234	A. BUILDING _____ B. WING _____	11/30/2018

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ARIZONA STATE VETERAN HOME-PHX	4141 NORTH S HERRERA WAY PHOENIX, AZ 85012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0600 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, facility documentation and policies review, the facility failed to ensure one resident (#31) was free from physical abuse by one resident (#316), and failed to ensure that additional interventions were in place to protect other residents from abuse. Findings include: -Resident #31 was admitted to the facility on (MONTH) 22, (YEAR), with [DIAGNOSES REDACTED]. A nursing note dated (MONTH) 23, (YEAR) included that resident #31 was pushed by another resident (#316). The nurse observed the resident's back was against the door. Resident #316 was redirected and counseled not to put his hand to anybody that could result to injury. The note also included that both residents were assessed and there were no injuries. A physician's note dated (MONTH) 26, (YEAR) included that resident #31 was pushed by another resident on (MONTH) 23, (YEAR). Review of the Event Report dated (MONTH) 1, (YEAR) revealed the resident was a victim of aggression and was pushed by peer with no injury. -Resident #316 was admitted to the facility on (MONTH) 1, (YEAR), with [DIAGNOSES REDACTED]. The resident was discharged from the facility on (MONTH) 21, (YEAR). Review of a nursing progress note dated (MONTH) 4, (YEAR) revealed resident #316 threatened to whoop his room mate ass if he did not turn his light out. The note included that resident #316 was alert and oriented times two and was very upset. The roommate agreed to be moved to another room. A behavior care plan dated (MONTH) 5, (YEAR) identified that the resident has socially inappropriate/disruptive behavioral symptoms as evidenced by verbal threats. The goal included that the resident would not harm self or others secondary to socially inappropriate/disruptive behavior. Interventions included to place resident in a specially designated therapeutic unit, praise resident when behaviors are appropriate, remove resident from group activities when behavior is unacceptable and when resident becomes socially inappropriate/disruptive, move to a quiet, calm environment. According to an activities care plan dated (MONTH) 8, (YEAR), included resident has ongoing socially inappropriate and disruptive behaviors. A nursing progress note dated (MONTH) 13, (YEAR) included the resident instigated a verbal altercation with another resident and was verbally abusive to a resident calling him a dumb ass and telling him to shut up. Per the note, the incident happened during an activity when resident #316 became upset when another resident made a comment on a newspaper article. The note included that the verbal altercation almost turned into a physical altercation when the other resident got up from the chair and approached resident #316. Resident #316 continued to antagonize other residents even after staff redirection.The behavior care plan was updated to reflect that the resident had a verbal altercation with another resident on (MONTH) 13, (YEAR). However, there were no additional interventions which were implemented at this time. A nursing note dated (MONTH) 15, (YEAR) included the resident continued with repetitive conversations and questions, got easily agitated and was verbally aggressive if not getting his way. A nursing note dated (MONTH) 16, (YEAR) revealed the resident continued with behaviors and got easily agitated when re-directed. A nursing note dated (MONTH) 23, (YEAR) included that staff had witnessed resident #316 push another resident (#31) in the dining area. Review of the Incident/Accident Report dated (MONTH) 23, (YEAR) revealed that resident #316 was physically aggressive and pushed another resident in the dining room, after watching a concert. When asked why, resident #316 stated that he was just trying to help. The report included that resident #316 was alert and oriented. A statement from the recreation therapist (staff #136) included that as the concert was ending, she heard resident #316 yell I just wanted to help! She did not see what happened because she was at the adjoining dining room, however, she heard resident #316 cursing at the resident. (#31). No injuries were noted. Further review of the behavioral care plan revealed that on (MONTH) 23, (YEAR), resident #316 pushed another resident who landed against the surface of a closed door. Interventions included to allow distance in seating other residents around resident #316, assess whether the behavior endangers the resident and/or others and intervene if necessary, avoid over stimulation (e.g. noise, crowding, other physically aggressive residents), maintain a calm, slow, understandable approach with the resident, observe and report socially inappropriate/disruptive behaviors when around others, seat resident where constant or near constant observation is possible, obtain a psych consult/psychosocial therapy, and when resident begins to be socially inappropriate/disruptive provide comfort measures for basic needs (e.g. pain, hunger, toileting). Nursing notes dated (MONTH) 9, (YEAR) included that resident #316 yelled at another resident using inappropriate language. The resident was redirected but unsuccessful and removed other resident from the area. A nursing note dated (MONTH) 15, (YEAR) revealed that resident #316 was verbally and physically aggressive with another resident. Per the documentation, resident #316 overturned the wheelchair of another resident and yelled at the other resident stating, I will kill you and I'll f--- your mother and wife too. The note included that resident #316 had the potential to harm other residents, due to a volatile temper, poor impulse control and a history of violence. Continued review of the behavior care plan revealed it was updated to reflect that the resident assaulted another resident in the dining room on (MONTH) 15, (YEAR). However, the care plan did not include any new interventions. Review of the clinical record from (MONTH) 16, through (MONTH) 21, (YEAR) (date of discharge) revealed the resident continued to be verbally and physically aggressive toward staff and other residents, and there were no new interventions which were put into place to address the resident's ongoing aggressive behaviors, in order to prevent further abuse to other residents. An interview with the recreation therapist (staff #136) was conducted (MONTH) 30, (YEAR) at 11:07 a.m. She stated that she could not remember the incident on (MONTH) 23, (YEAR) but could recall that resident #316 had several incidents with other residents. An interview with a nurse supervisor (staff #138) was conducted on (MONTH) 30, (YEAR) at 8:21 a.m. Staff #138 stated that she was the nurse on duty the day the incident between resident #31 and #316 happened (March 23). She said there was a concert in the dining room when she heard a commotion, so she ran to the dining room and saw resident #31 up against the wall. She said resident #316 told her that he was just helping resident #31. She said she started an investigation and found that resident #31 was pushed a little bit by resident #316, and because resident #31 had an unsteady gait, he could easily be put off balance. She said resident #316 has known behaviors such as a tendency to boss others around, meddles

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) with activities of other residents and likes to push beds and wheelchairs to help. She stated that resident #316 stayed at the facility for a couple of months only and is no longer at the facility for safety reasons. She stated at the time the incident happened, she did not think it was abuse because it was the first incident between the two residents and resident #31 and #316 have known behaviors. During an interview with the Director of Nursing (DON/staff #78) conducted on (MONTH) 30, (YEAR) at 1:34 p.m., she stated that she is not aware of the incident between resident #31 and #316, because she was not employed at the facility when this incident happened. In an interview with the Administrator (staff #1) conducted on (MONTH) 30, (YEAR) at 1:39 p.m., she stated that she does not know anything about the incident between resident #31 and #316 that happened in (MONTH) because she was not employed at the facility at that time. Review of the facility's Abuse policy revealed that all residents have the right to be free from verbal, sexual, physical, emotional and mental abuse. The policy included the resident will be protected during the investigation process. The facility's policy on Resident Rights also included that resident have the right to be free from abuse, neglect, misappropriation of property and exploitation. Review of the facility's policy regarding Resident-to-Resident Altercations revealed staff will separate residents involved in an altercation and will institute measures to calm the situation. The policy included to review the events with the Nursing Supervisor and the Director of Nursing, and possible measures to try to prevent additional incidents. The policy also included to document in the resident's clinical record all interventions and their effectiveness.
F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, staff interviews, facility documentation and policy review, the facility failed to follow their policy regarding Abuse, by failing to report an incident of physical abuse involving two residents (#31 and #316) to the State Agency and Adult Protective Services (APS). Findings include: -Resident #31 was admitted to the facility on (MONTH) 22, (YEAR), with [DIAGNOSES REDACTED]. A nursing note dated (MONTH) 23, (YEAR) included that resident #31 was pushed by another resident (#316). The nurse observed the resident's back was against the door. Resident #316 was redirected and counseled not to put his hand to anybody that could result to injury. The note also included that both residents were assessed and there were no injuries. -Resident #316 was admitted to the facility on (MONTH) 1, (YEAR), with [DIAGNOSES REDACTED]. Review of the Incident/Accident Report dated (MONTH) 23, (YEAR) revealed that resident #316 was physically aggressive and pushed another resident in the dining room, after watching a concert. When asked why, resident #316 stated that he was just trying to help. The report included that resident #316 was alert and oriented. A statement from the recreation therapist (staff #136) included that as the concert was ending, she heard resident #316 yell I just wanted to help! She did not see what happened because she was at the adjoining dining room, however, she heard resident #316 cursing at the resident. (#31).Per the report, the physician, responsible party and the nursing supervisor were notified of the incident. This report was also signed by the assistant director of nursing, administrator and the medical director. However, there was no evidence that the incident of abuse was reported to State Agency or Adult Protective Services (APS). In an interview with a registered nurse (RN/staff #139) conducted on (MONTH) 29, (YEAR) at 1:35 p.m., she stated when she receives a report that a resident pushed another resident, she will consider the incident as abuse. She said she will write an incident report and report the incident to the Director of Nursing and/or administrator who will be responsible to report the incident to the local agencies as required. During an interview with the Director of Nursing (staff #78) conducted on (MONTH) 30, (YEAR) at 1:34 p.m., she stated that the nurse who receives the report or who witnesses an incident, the supervisor and herself will conduct the investigations and the results of the investigations will be submitted to the administrator, who will then be responsible to report it to the State agency and APS. She said all resident to resident altercations and allegations of abuse are to be reported to the State Agency and APS by the administrator within 2 hours. She further stated that she did not know why the incident between resident #31 and #316 was not reported to the State Agency and APS. An interview with the administrator (staff #1) was conducted on (MONTH) 30, (YEAR) at 1:39 p.m. She stated that she reports resident to resident altercations and any type of abuse allegations to the State agency and APS within 2 hours of the incident. She said she was not employed at the facility when the incident between resident #31 and #316 happened and did not know why it was not reported. Review of the Abuse policy revealed that all incidents or suspicions of abuse, neglect, and mistreatment will be reported to the proper authorities. The policy included that the administrator and/or his/her designee will submit the report of the incident to the State Agency and APS, as soon as possible, but never later than 24 hours after the incident. The facility's Abuse policy did not include that allegations of abuse or incidents of abuse must be reported to the State Agency and APS within two hours after the allegation is made.
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 clinical record reviews, staff interviews, facility documentation and policy and procedures, the facility failed to ensure that an allegation of physical abuse involving two residents (#31 and #316) was reported to the State Agency and Adult Protective Services, and failed to ensure that an injury of unknown source for one resident (#19) was reported to the State Agency. Findings include: -Resident #31 was admitted to the facility on (MONTH) 22, (YEAR), with [DIAGNOSES REDACTED]. A nursing note dated (MONTH) 23, (YEAR) included that resident #31 was pushed by another resident (#316). The nurse observed the resident's back was against the door. Resident #316 was redirected and counseled not to put his hand to anybody that could result to injury. The note also included that both residents were assessed and there were no injuries. -Resident #316 was admitted to the facility on (MONTH) 1, (YEAR), with [DIAGNOSES REDACTED]. Review of the Incident/Accident Report dated (MONTH) 23, (YEAR) revealed that resident #316 was physically aggressive and pushed another resident in the dining room, after watching a concert. When asked why, resident #316 stated that he was just trying to help. The report included that resident #316 was alert and oriented. A statement from the recreation therapist (staff #136) included that as the concert was ending, she heard resident #316 yell I just wanted to help! She did not see what happened because she was at the adjoining dining room, however, she heard resident #316 cursing at the resident. (#31).Per the report, the physician, responsible party and the nursing supervisor were notified of the incident. This report was also signed by the assistant director of nursing, administrator and the medical director. However, there was no evidence that the incident of abuse was reported to State Agency or Adult Protective Services (APS). In an interview with a registered nurse (RN/staff #139) conducted on (MONTH) 29, (YEAR) at 1:35 p.m., she stated when she receives a report that a resident pushed another resident, she will consider the incident as abuse. She said she will write an incident report and report the incident to the Director of Nursing and/or administrator who will be responsible to report the incident to the local agencies as required. During an interview with the Director of Nursing (staff #78) conducted on (MONTH) 30, (YEAR) at 1:34 p.m., she stated that the nurse who receives the report or who witnesses an incident, the supervisor and herself will conduct the investigations and the results of the investigations will be submitted to the administrator, who will then be responsible to report it to the State agency and APS. She said all resident to resident altercations and allegations of abuse are to be reported to the State Agency and APS by the administrator within 2 hours. She further stated that she did not know why the incident between resident #31 and #316 was not reported to the State Agency and APS. An interview with the administrator (staff #1) was conducted on (MONTH) 30, (YEAR) at 1:39 p.m. She stated that she reports resident to resident altercations and any type of abuse allegations to the State agency and APS within 2 hours of the

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F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) incident. She said she was not employed at the facility when the incident between resident #31 and #316 happened and did not know why it was not reported. Review of the Abuse policy revealed that all incidents or suspicions of abuse, neglect, and mistreatment will be reported to the proper authorities. The policy included that the administrator and/or his/her designee will submit the report of the incident to the State Agency and APS, as soon as possible, but never later than 24 hours after the incident. The facility's Abuse policy did not include that allegations of abuse or incidents of abuse must be reported to the State Agency and APS within two hours after the allegation is made. -Resident #19 was admitted to the facility on (MONTH) 30, 2013, with [DIAGNOSES REDACTED]. Review of the quarterly MDS (Minimum Data Set) assessment dated (MONTH) 21, (YEAR), revealed a Brief Interview for Mental Status (BIMS) score of 10, which indicated that the resident had a moderate impairment for decision making. A nursing progress note dated (MONTH) 18, (YEAR) included the resident had a bruise to the side of his right eye. Review of the facility's investigation dated (MONTH) 18, (YEAR) revealed that while providing care, a nurse noticed a bruise to the side of the resident's right eye. The report included a statement from a certified nursing assistant who reported that she provided care for the resident on (MONTH) 17. She stated that she put the resident down using the Hoyer lift, changed his brief and did not see a bruise on the resident's eye at the end of her shift, which ended at 10:30 p.m. She said that sometimes the resident moves his hand toward his face when he is being changed. The facility was unable to determine how the bruise occurred. The facility was unable to provide any documentation that the injury of an unknown source was reported to the State Agency. During an interview conducted on (MONTH) 30, (YEAR) at 12:35 p.m., the Administrator (staff #1) stated that an internal investigation had been completed regarding the bruise on the resident's right eye. Staff #1 said that she did not think that the resident had been abused, so she did not think the incident was reportable to the State Agency. Staff #1 stated that she was not aware that an injury of unknown origin could be possible abuse. Review of the facility's Abuse policy revealed that all incidents or suspicions of abuse, neglect, mistreatment or the misappropriation of funds will be investigated and will be reported to the proper authorities. The policy included that all episodes of witnessed or suspected abuse, mistreatment or exploitation will be reported to the State Agency within 24 hours after the incident. However, the policy did not address that violations involving abuse, neglect, exploitation or mistreatment, including injuries of an unknown source must be reported immediately to the State Agency, but not later than 2 hours after the allegation is made.
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, staff interviews, facility documentation and policy review, the facility failed to ensure that an allegation of physical abuse for one resident (#31) was thoroughly investigated. Findings include: Resident #31 was admitted to the facility on (MONTH) 22, (YEAR) with [DIAGNOSES REDACTED]. The Incident/Accident Report dated (MONTH) 23, (YEAR) included that staff witnessed another resident pushed resident #31 in the dining room after watching a concert. There were no injuries noted. Per the report, the physician, responsible party, and the nursing supervisor were notified of the incident. The report also included one witness statement. During an interview conducted with a registered nurse (RN/staff #139) on (MONTH) 29, (YEAR) at 1:35 p.m., she stated that when she is notified that a resident pushed another resident, she considers the incident abuse. The RN stated that she will write an incident report and gather witness statements and will notify the DON (Director of Nursing) and/or the administrator of the incident. An interview was conducted with a licensed practical nurse (LPN/staff #168) on (MONTH) 30, (YEAR) at 11:21 a.m. He stated that regarding resident to resident altercations, he will conduct an investigation related to the details of the incident and will collect witness statements from staff or anyone who witnessed the incident. The LPN also stated that he will then report the incident to his supervisor, DON, administrator, police, APS and Ombudsman. During an interview conducted with the DON (staff #78) on (MONTH) 30, (YEAR) at 1:34 p.m., she stated that the nurse who was initially notified of the incident, the supervisor, and herself will conduct the investigation. The DON stated that the results of the investigation will be submitted to the administrator who will then be responsible to report the results to the State agency, APS and Ombudsman. The facility's policy on Abuse included that all incidents or suspicions of abuse, neglect, and mistreatment will be investigated by the facility and will be reported to the proper authorities. The policy included the administrator and/or his/her designee will investigate the incident in the following ways: interviewing all persons who may have knowledge of the incident; reviewing medical records or other written reports; taking any other action believed to be helpful in establishing the facts of the incident. The policy also included the results of the investigation must be reported to AZDHS and other certification agency within 5 business days of the incident. The facility's policy regarding Resident-to-Resident Altercations included that All altercations, including those that may represent resident-to-resident abuse, shall be investigated and reported to the Nursing Supervisor, the Director of Nursing, and to the Administrator. The policy included to report incidents, findings, and corrective measures to appropriate agencies as outlined in the abuse reporting policy.
F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policies review, the facility failed to ensure services met professional standards of quality regarding the use of Velcro leg straps for one resident (#17). Findings include: Resident #17 was admitted (MONTH) 7, (YEAR) with [DIAGNOSES REDACTED]. A quarterly Minimum Data Set (MDS) assessment dated (MONTH) 29, (YEAR) revealed a Brief Interview of Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. The MDS assessment also included the resident required extensive assistance for all activities of daily living (ADLs), including repositioning. The current care plan revealed the resident was at high risk for skin breakdown, had a history of [REDACTED]. During an interview conducted on (MONTH) 26, (YEAR) at 9:53 a.m. with the resident, the resident was observed to have Velcro leg straps holding his legs together while sitting in the wheel chair. Review of the clinical record revealed no evidence of an order for [REDACTED]. An interview was conducted on (MONTH) 28, (YEAR) at 10:59 a.m. with a Certified Nursing Assistant (CNA/staff #167) who stated that the Velcro leg straps were provided by the therapy department. Staff #167 stated that the Velcro straps prevent the resident's legs from falling off of the foot pedals of the wheel chair. The CNA stated that the straps are repositioned around the resident's legs as directed by the resident. Staff #167 stated the resident is aware that he has the straps to keep his legs aligned in the wheel chair. Staff #167 stated the resident will request to have the straps put on and will request to have the straps taken off. The CNA stated the straps are removed when the resident is in bed. An interview was conducted on (MONTH) 28, (YEAR) at 1:31 p.m. with a Registered Nurse (RN/staff #168) who stated that resident #17's legs will side out of his wheel chair and that the Velcro leg bands are applied to keep his legs together and to prevent sliding. The RN stated that the CNAs apply and remove the leg bands. The RN also stated that there should be a physician's orders [REDACTED]. Staff #168 further stated that the resident does not request to have the band removed. The RN stated that there is no required documentation regarding the leg straps. Review of the clinical record now reveals an order entered by a Licensed Practical Nurse (LPN/staff #172) on (MONTH) 29, (YEAR) at 8:19 a.m. for Velcro leg straps to the lower extremities per the vets request for leg spasms and positioning. An interview was conducted on (MONTH) 29, (YEAR) at 10:58 a.m. with an Occupational Therapist (staff #169) who stated that the Velcro leg bands around the legs of resident #17 did not come from the therapy department and that she is unaware of how the resident got them. Staff #169 stated that she has evaluated the resident and offered different ways to elevate his legs in his wheel chair instead of using the Velcro bands, but that the resident refused the other ways and asked to keep the Velcro leg bands instead.

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F 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) An interview was conducted on (MONTH) 29, (YEAR) at 11:10 a.m. with the Director of Rehab (staff #161) who stated that he is aware of the Velcro leg bands that resident #17 has for his legs. Staff #161 stated that the therapy department does not recommend the bands because of the possibility of complications arising from using them. He stated that the therapy department does not provide the bands to residents. Staff #161 stated that there would need to be frequent skin inspections to assess the skin under the band. He stated that he had an undocumented conversation with resident #17 regarding the use of the Velcro legs bands and offered an alternative, but that the resident was very particular and wanted to continue to use the leg bands. During an interview conducted on (MONTH) 29, (YEAR) at 3:03 p.m. with the resident, the resident stated that he has had the Velcro leg bands for about two years and that he wears them to prevent his legs from being open when in his wheel chair. Resident #17 stated that he tells the CNA staff when to put the bands on and when to remove them. Resident #17 stated that he received the bands about two years ago and has used them every day since. During an interview conducted on (MONTH) 29, (YEAR) at 3:12 p.m. with a CNA (staff #170), the CNA stated that the resident will request the Velcro leg bands to be applied every morning to keep his legs together in his wheel chair, but that she does not have to document the bands were applied. Staff #170 stated that the only communication regarding the leg bands is done through shift report and the resident self-directing his care. An interview was conducted on (MONTH) 30, (YEAR) at 10:43 a.m. with a physician (staff #171) who stated that the Velcro leg bands for resident #17 are medically necessary to prevent leg contractures. Staff #171 stated that the resident has had the leg bands for years. The physician stated that a physician's orders [REDACTED]. An interview was conducted on (MONTH) 30, (YEAR) at 12:53 p.m. with staff #172 who stated the Velcro leg straps are a standard nursing order and that she added the order yesterday. She stated a physician's orders [REDACTED]. Staff #172 stated that a staff member asked her about the leg bands for resident #17 yesterday because the staff did not know what the leg bands were for. She stated that she was unaware of the leg bands but investigated the use of them and then added the order to the resident's clinical record. The facility's policy Care Plan, Comprehensive Person-Centered included the comprehensive, person-centered care plan will describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The policy also included the care plan will reflect the resident's expressed wishes regarding care and treatment goals. The facility's policy titled Maintain Skin Integrity revealed the purpose of this procedure is to provide information regarding identification of the pressure ulcer/injury risk factors and interventions for specific risk factors. The policy included to review the resident's care plan and identify risk factors as well as the interventions designed to reduce or eliminate those considered modifiable. The policy also include skin assessments should include areas of impaired circulation due to pressure from positioning or medical devices.
F 0686 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policies and procedures, the facility failed to ensure physician orders [REDACTED].#17) with a pressure ulcer. Findings include: Resident #17 was admitted (MONTH) 7, (YEAR) with [DIAGNOSES REDACTED]. The quarterly Minimum Data Set assessment dated (MONTH) 29, (YEAR) included the resident had a pressure ulcer. Review of the current care plan revealed the resident had an intergluteal crest unstageable pressure ulcer with an approach to apply dressings per the physician's orders [REDACTED]. A physician's orders [REDACTED]. During a wound treatment observation conducted on (MONTH) 29, (YEAR) at 2:30 p.m., a Registered Nurse (wound nurse/staff #166) was observed to use wound cleaner instead of normal saline to clean the intergluteal crest wound. Review of the wound cleaner used to clean the wound revealed the following ingredients: aloe barbadensis leaf juice, [MEDICATION NAME], imidazolidinyl urea, [MEDICATION NAME], potassium sorbate, sodium benzoate, sodium [MEDICATION NAME] sulfate, sodium metabisulfite, tocopheryl acetate, and water. A review of normal saline ingredients revealed the following: Saline solution is a mixture of salt and water. Normal saline solution contains 0.9 percent sodium chloride (salt), which is similar to the sodium concentration in blood and tears. An interview was conducted on (MONTH) 29, (YEAR) at 2:50 p.m. with staff #166. Staff #166 stated that wound cleaner and normal saline were essentially the same thing, so the treatment was done correctly. Later that day, staff #166 stated that she spoke with the Director of Nursing (staff #78) who stated that wound cleaner and normal saline were two different things and that the physician's orders [REDACTED]. A review of the facility's policy titled Pressure Ulcer/Skin Breakdown- Clinical Protocol revealed that the physician will order pertinent wound treatments, including pressure reduction surfaces, wound cleansing and debridement approaches, dressings, and application of topical agents. A review of the facility's policy titled Maintain Skin Integrity included to review the resident's care plan and identify the risk factors as well as the interventions designed to reduce or eliminate those considered modifiable.
F 0692 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record reviews, staff and resident interviews and review of policies and procedures, the facility failed to ensure physician orders were implemented for one resident (#64) and failed to ensure nutritional parameters were maintained for one resident (#164). Findings include: -Resident #64 was admitted to the facility on (MONTH) 22, (YEAR), with [DIAGNOSES REDACTED]. In addition, the resident received [MEDICAL TREATMENT] treatments three times a week. A physician's order dated (MONTH) 26, (YEAR) documented the resident was to be on a fluid restriction of 1500 milliliter (ml) daily related to [MEDICAL TREATMENT]. A current care plan identified the resident was on a fluid restriction and an approach was for nursing to provide all beverages. Review of the Certified Nursing Assistant (CNA) daily fluid intakes for (MONTH) (YEAR) revealed there was no documentation that the resident was on a 1500 ml daily fluid restriction. Review of the (MONTH) (YEAR) Medication Administration Record (MAR) revealed there was no documentation of the resident's daily fluid intake amounts. Further review of the clinical record revealed there was no documentation that the resident's daily fluid intake amounts had been monitored or documented to ensure that the 1500 ml fluid restriction had been implemented as ordered. An interview was conducted with a Licensed Practical Nurse (staff #165) on (MONTH) 30, (YEAR) at 12:24 p.m. She stated that per the physician orders, the resident was on a 1500 ml daily fluid restriction. She said the restriction information is suppose to be documented on the MAR, however, she said that the fluid restriction information was not on the MAR for resident #64. She stated that she has never documented this resident's daily fluid amounts, because she was not aware of the fluid restriction. An interview was conducted with the Assistant Director of Nursing (staff #156) on (MONTH) 30, (YEAR) at 12:47 p.m. She stated the fluid restriction orders are to be transcribed onto the MAR, so all of the nurses know about the fluid restriction. Staff #156 said that the CNA's are to chart every shift the amount of fluids the resident has consumed on the daily fluid intake flowsheet. Staff #156 stated there is a unit nurse who is responsible to make sure the nurses and CNA's documentation is entered every day. She stated she could not explain why the nurses and CNA's did not know of the fluid restriction. Due to the lack of documentation, staff #156 stated that staff would not know the actual amount of fluids that the resident had consumed daily. According to the facility policy regarding Fluid Restrictions, the purpose was to provide the resident with the amount of fluids necessary to maintain optimum health, which may include restricting fluids. The policy included to verify that there is a physician's order, review the care plan and/or your daily assignment sheet to assess for special needs, follow

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F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) specific instructions concerning fluid restrictions and be accurate when recording fluid intake. Regarding documentation the policy included to document the amount of fluids consumed by the resident during the shift, the type of fluid consumed, (i.e., tea, milk, coffee, soup, etc.) and the signature and title of the person recording the data. Report other information in accordance with facility practice and professional standards of practice. A second facility policy regarding fluid restrictions included that when the physician orders a fluid restriction, the amount of fluid allowed per 24 hour period will be specified. The food service department will provide no fluids on the tray. Nursing will be responsible for obtaining all fluids for meals or between meals and recording these intakes. -Resident #164 was admitted to the facility on November, 8, (YEAR), with [DIAGNOSES REDACTED]. Regarding weights: A physician's order dated (MONTH) 9, (YEAR) included the resident was to have weekly weights x 4 on Sundays. Review of the clinical record revealed the resident weighed 240.7 lbs on (MONTH) 9, (YEAR). Further review of the clinical record revealed that the resident's weight had not been retaken the next day, as per their policy. According to a nutritional status care plan dated (MONTH) 15, (YEAR), the resident was overweight related to excessive intake, as evidenced by a Body Mass Index (BMI) >35. Approaches included to monitor weight (reweigh as needed), meal intakes and nutrition related lab values. The Initial Nutrition assessment dated (MONTH) 16, (YEAR) documented a BMI of 38.8 (obese), current oral intake = 83% and the estimated fluid needs >1640 ml fluid/day. Per the assessment, weekly weights have been ordered and will continue with current interventions. Monitor and evaluate weight, labs, diet texture tolerance and meal/fluid intakes. Review of the weight record revealed the resident weighed 179.2 lbs on (MONTH) 18, (YEAR), which was nine days after the admission weight. Despite a significant decrease in the resident's weight (approximately 61 lbs), there was no evidence that the resident was re-weighed or that the dietician was notified. A nutrition note was completed on (MONTH) 28, (YEAR). The note included that a weight variance report reflected a significant weight loss of -34.3% in 9 days. An error is suspected and a reweigh has been requested. Current oral intake is 38% and will continue to monitor for nutrition related concerns. Review of the weight record revealed the resident weighed 176.8 lbs on (MONTH) 28, (YEAR). Further review of the clinical record revealed there was no documentation from dietary that the resident was on a planned weight loss program. An interview was conducted with a LPN (staff #151) on (MONTH) 30, (YEAR) at 8:53 AM, who stated that residents are weighed on admission and then monthly. She stated if there is a different order like daily weights, it will pop up on the computer. She said the nurse will then direct the CNA to get a weight, which will be documented by the nurse and the CN[NAME] Staff #151 stated the previous weight will be compared with the current weight and if there is a significant change, the doctor will be notified. Staff #151 was unaware of why resident #164 was not re-weighed after the significant difference was noted.An interview was conducted with a family member on (MONTH) 30, (YEAR) at 10:36 AM. The family member stated that he had not noticed any weight loss and was sure he would be able to tell if the resident had lost any weight. An interview was conducted on (MONTH) 30, (YEAR) at 1:52 PM, with the Registered Dietary Technician (staff#163). Staff #163 stated that nursing is in charge of obtaining weights and that residents are weighed on admission and then monthly. Staff #163 was unsure why this resident had not been re-weighed, but assumed the original weight was an error. Staff #163 also stated that although the initial nutrition assessment was based on the weight of 240. 7 lbs, it probably wouldn't change due to the fact that the resident was still overweight. She stated the weight loss is not a concern if residents are overweight. An interview was conducted with the Director of Nursing (DON/staff #78) on (MONTH) 30, (YEAR) at 2:11 PM. She stated that the facility has nutritional meetings every week and the dietician makes recommendations. She said the nurse will then transcribe it as an order and staff are expected to follow it. She stated that when a CNA reports weight loss to the nurse, the nurse is expected to notify the dietician right away. The DON stated the dietician then evaluates the cause of the weight loss and makes recommendations as needed. She said for residents with obesity as a [DIAGNOSES REDACTED]. She said when there are weight discrepancies or a huge difference from a previous weight, it is expected that the resident will be re-weighed and the dietician will be notified. When the DON was asked about the weight discrepancy with resident #164 she stated, It's just one of the things that I have to fix. Review of the policy regarding Weight Assessment and Intervention revealed that nursing staff will obtain resident weights on admission, the next day and weekly for two weeks thereafter. Any weight change of 5% or more since the last weight assessment will be retaken the next day for confirmation. If the weight is verified, nursing will immediately notify the Dietitian in writing. Verbal notification must be confirmed in writing. The Dietitian will respond within 24 hours of receipt of written notification. The threshold for significant unplanned and undesired weight loss will be based on the following criteria: 1 month-5% weight loss is significant; greater than 5% is severe. Regarding the fluid restriction: A physician's order dated (MONTH) 11, (YEAR) included the resident was to be on a 1250 ml per day fluid restriction related to [MEDICAL CONDITION]. Review of the admission Minimum Data Set (MDS) assessment dated (MONTH) 15, (YEAR) revealed the resident had short and long term memory problems. The MDS also included the resident was on a mechanically altered diet and required supervision with eating and had no difficulty with swallowing. The nutritional status care plan dated (MONTH) 15, (YEAR) identified the resident was on a fluid restriction. One of the approaches was for nursing to provide all beverages. The Initial Nutrition assessment dated (MONTH) 16, (YEAR) documented estimated fluid needs of greater than 1640 ml fluid/day. Interventions included to monitor and evaluate weight, labs, diet texture tolerance and meal/fluid intake. The nutrition assessment did not address that the resident was on a 1250 ml fluid restriction. A review of the MAR revealed that from (MONTH) 14-29, (YEAR), the resident received 240 ml-760 ml per day. Further review of the clinical record revealed there was no documentation that the physician ordered fluid restriction was consistently implemented. An interview was conducted on (MONTH) 29, (YEAR) at 8:35 AM, with a LPN (staff #151). Staff #151 stated that fluid intakes are documented at the end of the shift. Staff #151 stated the CNA's write on the meal ticket the amount of fluids consumed for each meal. She stated the fluids from each meal are then added together and combined with the amount given for medication pass and documented in the computer. An interview was conducted with a CNA (staff #80) on (MONTH) 30, (YEAR) at 10:10 AM. Staff #80 stated the resident's meal tickets will indicate if they are on fluid restriction. Staff #80 said they keep track of how much the residents drink on the meal ticket and then verbally tell the nurse. She also stated that residents on fluid restriction should not have a water pitcher in their room. An observation was conducted on (MONTH) 30, (YEAR) at 10:17 AM, in the resident's room. The resident was observed to have a pitcher on the bedside table marked ice only, however, the pitcher was half full of water. At this time, resident #164 stated that he did not know if he was on a fluid restriction. On (MONTH) 30, (YEAR) at 11:35 AM, the resident was observed in the dining room at lunch time. The resident was served beverages by a CNA previous to the meal, which consisted of orange juice and coffee. A second cup of coffee was also served to the resident by another CNA (staff #123). During the meal, the resident was also given a carton of milk by a nurse. After the meal, the resident's meal ticket was reviewed and there was no documentation as to the amount of fluids which were consumed by the resident. Per the meal ticket, the diet was regular mechanical soft and there was no indication of a fluid restriction. An interview was conducted with a CNA (staff #123) on (MONTH) 30, (YEAR) at 12:13 PM. Staff #123 was unable to explain how staff are notified of a fluid restriction or how fluid consumption is documented. He stated that they just write down the meal percentages. He stated that there was no one in the dining room on a fluid restriction. Staff #123 further stated that the cups are 240 ml. An interview was conducted with a Registered Dietician (staff #159) on (MONTH) 30, (YEAR) at 1:52 PM. Staff #159 stated for those on a fluid restriction, dietary does not do a breakdown of fluids per meal. Staff #159 said that residents are

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F 0692 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 5) allowed free choice to drink their ordered amount of fluids at any time of the day. Staff #159 stated that nursing is responsible for keeping track and documenting the amount of fluids consumed per shift. An interview was conducted with the Director of Nursing (staff #78) on (MONTH) 30, (YEAR) at 2:11 PM. Staff #78 stated that the nurses know the fluid restrictions of the residents at the facility. She stated when a resident is admitted , the nurse gets the orders for fluid restrictions from the reports. She stated the nurses calculate fluid intake daily for residents on fluid restriction and document it at the end of the shift. She stated the residents on a fluid restriction do not get a pitcher of water. She also stated she does not know who ensures that other staff like activities and the CNA's know how much to give the resident for fluids between meals. Review of the facility policy for Encouraging and Restricting Fluids revealed that when a resident has been placed on restricted fluids, the water pitcher and cup will be removed from the room. The policy included that an intake and output record will be maintained in the resident's room. The type of liquid consumed and the amount (in ml's) of fluids consumed by the resident during the shift should be recorded in the resident's medical record. According to the policy regarding Fluid Restriction Orders, nursing will be responsible for obtaining all fluids for meals or between meals and recording these intakes.
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, staff interviews, and policy review, the facility failed to ensure controlled medications were not returned to the broken seal card and secured with tape. Findings include: A medication storage observation was conducted on (MONTH) 27, (YEAR) at 2:20 PM with a Licensed Practical Nurse (LPN/staff #73). A medication card for [MEDICATION NAME] 5 mg (milligrams) was observed with the seal broken with the medication secured with a strip of tape. A medication card for [MEDICATION NAME] 15 mg was also observed with the seal broken with the medication secured with a strip of tape. An interview was immediately conducted with staff #73, who stated that she had taped the medications back in the cards this morning because the residents had refused the medications. The LPN stated that she was not sure if their policy allowed controlled medications to be placed back into the card. After reviewing their policy, she stated that narcotics should not be placed back into the card but that they should be properly wasted. An interview conducted with the Assistant Director of Nursing (ADON/staff #156) on (MONTH) 29, (YEAR) at 1:11 PM. Staff #156 that stated narcotics should never be put back into the bubble pack. The ADON stated that if the resident refuses the narcotic medication, the narcotic medication needs to be destroyed. The facility's policy Control Substances revealed that when a resident refuses a non-unit dose medication (or it is not given), or a resident receives partial tablets or single dose [MEDICATION NAME] (or it is not given), the medication shall be destroyed and may not be returned to the container.
F 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observations, staff interviews, and policy review, the facility failed to ensure that food was stored in accordance with professional standards for food safety. Findings include: During the initial kitchen observation conducted on (MONTH) 11, (YEAR) at 8:45 a.m., several cantaloupes were observed in a metal container stored in the dry storage room. The dietary employee (staff #157) stated that it is the facility's practice to remove produce from the kitchen when it is overripe. Upon closer inspection, the cantaloupes were soft to the touch and two of the cantaloupes had a gray and black area with fuzzy light grayish white growth on top of the gray and black areas. The area on each cantaloupe was approximately 2 inches long by 2 inches wide. Staff #157 acknowledged that it was mold on the two cantaloupes and promptly removed them from the dry storage room. During this same kitchen observation, a metal container of cooked pork ribs along with a metal container of processed salami was observed in the walk-in freezer uncovered. Staff #157 stated that the cold air in the freezer makes the Saran Wrap break. Staff #157 then removed the two items from the walk-in freezer. An interview was conducted with the Assistant Director of Dining Services (staff #158) on (MONTH) 28, (YEAR) at 9:15 a.m. Staff #158 stated that produce is supposed to be turned every three days and that over ripe produce should be removed. Another interview was conducted with staff #158 on (MONTH) 30, (YEAR) at 8:26 a.m. He stated that he had reviewed the facility's policy on food storage and that open food products are to be stored in a Zip Lock bag or covered with a lid. Staff #158 stated that if food is covered with Saran Wrap, it must then be covered in aluminum foil. Review of the facility's Food Storage and Date Marking policy revealed that leftover food is to be stored in covered containers or wrapped carefully and securely. The policy included that frozen foods should be properly wrapped or covered to ensure wholesomeness and stored to allow adequate air circulation. The policy also included that all stock must be rotated and that rotating stock is essential to assure the freshness and highest quality of all foods.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** Based on observations, staff interviews, and policy review, the facility failed to ensure that one glucometer was disinfected after use. Findings include: During an observation conducted on (MONTH) 28, (YEAR) at 9:32 AM, a Register Nurse (RN/staff #164) was observed to check a resident's blood glucose level. After the procedure, the RN was observed cleaning the glucometer with an alcohol prep pad and placing it back in the medication cart. An observation was conducted on (MONTH) 30, (YEAR) at 12:32 PM. A Licensed Practical Nurse (LPN/staff #165) was observed taking a glucometer into a resident's room and retuning the glucometer to the medication cart drawer without disinfecting the glucometer. An interview was immediately conducted with staff #165, who stated that she had used the glucometer and that she should have cleaned the glucometer. The LPN stated that the glucometer should be cleaned after every use. She also stated that the glucometer is cleaned with an alcohol swab or a Dispatch wipe. An interview was conducted with a Registered Nurse (RN/staff#163) on (MONTH) 28, (YEAR) at 8:26 AM. Staff #163 stated that the glucometer is cleaned with an alcohol prep pad. Staff #163 also stated she did not know the facility's policy regarding cleaning glucometers but that she always uses alcohol to clean the glucometer. An interview with was conducted on (MONTH) 29, (YEAR) at 1:11 PM with the Director of Nursing (DON/staff #78) and the Assistant Director of Nursing (ADON/staff #156). The DON stated that glucometers should be cleaned after each resident use with the disinfectant wipe, Dispatch that is on the medication cart. The ADON stated that it is not acceptable to use an alcohol prep pad to clean glucometers after each resident use. The facility's policy titled Decontaminating and Labeling Equipment revealed . Glucometers will be cleaned after each use with a disinfecting wipe (Dispatch) a bleach wipe that has a concentration 1:10 to 1:100 dilute bleach solution .