| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 035176 | A. BUILDING _____ B. WING _____ | 10/10/2019 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| BEATITUDES CAMPUS | 1712 WEST GLENDALE AVENUE PHOENIX, AZ 85021 |

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 0600<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on facility documentation and video recording, staff and visitor interviews, and clinical record and policy reviews, the facility failed to ensure one of three sampled residents (#43) was free from sexual abuse. The deficient practice could result in others residents being sexually abused.<br>Findings include:<br>Resident #43 was admitted to the facility on (MONTH) 11, (YEAR) with [DIAGNOSES REDACTED].<br>A quarterly Minimum Data Set (MDS) assessment dated (MONTH) 2, 2019 revealed the resident's cognitive skills for daily decision making was moderately impaired.<br>Review of the facility's investigation report revealed the Director of Nursing (DON/staff #79) was notified on (MONTH) 3, 2019 that a visitor had touched a resident (#43) inappropriately in the dining room on (MONTH) 28, 2019. The incident was witnessed by two certified nursing assistants (CNAs/staff #34 and staff #96). The CNAs immediately removed resident #43 from the situation. A video recording of the area was reviewed on (MONTH) 3, 2019 and confirmed the incident. The visitor was then told to leave the campus immediately and not return until the facility contacted him. The visitor was escorted off the campus by security. The report included resident #43 is alert and oriented to self only, pleasant with cares, ambulates freely on the unit, and is friendly and outgoing.<br>The investigation report included a statement from CNA #34 and CNA #96 written by the DON signed by the CNAs dated (MONTH) 3, 2019. On Saturday, (MONTH) 28, 2019 while CNA #96 was feeding residents their breakfast in the dining room she saw a visitor's hands on resident #43's butt. The visitor was rubbing resident #43's butt, went down her leg and came back up the middle part of her leg. CNA #96 asked CNA #34 to look. CNA #34 turned around and saw what the visitor was doing. CNA #34 got up and removed resident #43 away from the visitor. CNA #96 asked CNA #34 if she reported the incident to the nurse. When CNA #96 saw the nurse (staff #110), she asked if CNA #34 reported the incident regarding resident #43 to her and that staff #110 stated CNA #34 did tell her but that since resident #43 did not resist there was nothing they could do.<br>A statement written by the Licensed Practical Nurse (LPN/staff #110) dated (MONTH) 3, 2019 revealed that on (MONTH) 28, 2019 at approximately 9:30 a.m., CNA #34 asked her if a resident on the unit was allowed to fondle resident #43. The statement included resident #43 and another resident on the unit were always touching each other and appear consensual and that she thought CNA #34 was referring to this resident and was not aware the CNA was talking about a visitor. If she had realized it was a visitor, she would have dropped everything and notified everyone. She was in the middle of passing medications and did not actually see any of this activity. The statement included that she only found out this morning (October 3, 2019) that it was a visitor when she was told she would be receiving a call from the DON (staff #79) regarding the incident.<br>The report included documentation by the social worker dated (MONTH) 3, 2019 that an attempt was made to interview resident #43 about the incident but that the resident was unable to understand or answer the questions.<br>The report also included a statement from the DON (staff #79) dated (MONTH) 3, 2019, that she was notified by the unit clerk (staff #5) that CNA #34 had told her that a visitor had been seen touching resident #43 inappropriately on Saturday, (MONTH) 28th, 2019. Because there are cameras in the dining room, the video was reviewed and the visitor was seen using his hand to touch resident #43 in a very inappropriate way. The administrator (staff #102) was contacted and security was contacted to escort the visitor from the building.<br>During an observation conducted of the resident on (MONTH) 7, 2019 at 9:14 a.m., the resident was observed sitting on a couch smiling, listening, and holding a doll. The resident was unable to be interviewed.<br>Per the administrator (staff #102) on (MONTH) 8, 2019 at 12:14 p.m., the LPN (staff #110) had been terminated.<br>An interview was conducted via phone with the LPN (staff #110) on (MONTH) 8, 2019 at 12:56 p.m., She stated that she was passing medications the morning of Saturday, (MONTH) 28, 2019, when staff #34 approached her and said he is patting on her (resident #43) again. The LPN stated resident #43 and another resident sometimes hold hands and walk down the hall and that she thought staff #34 was referring to that resident. She stated staff #34 did not say the he was a visitor. Staff #110 stated if staff #34 would have said it was a visitor, she would have immediately called security and had the visitor removed, and notified the DON (staff #79) and the administrator (staff #102). The LPN stated that she did see the visitor sitting at a table with other residents. She also stated that resident #43 and the male resident she holds hands with were both gone, so she thought the aides (#34 and #96) had taken care of the situation, like before. She stated she had never heard of that visitor having that kind of behavior in the past. The LPN stated the visitor in the past had complained to her that resident #43 kept coming up to him and pestering him and asked if resident #43 could be moved to a different area. She stated she had abuse training and that she had been terminated from the facility.<br>In an interview conducted with CNA #96 on (MONTH) 8, 2019 at 1:40 p.m., she stated she is familiar with resident #43 and that she witnessed the incident on (MONTH) 28, 2019. She stated she was sitting at a table in the dining room assisting residents with breakfast when she saw a visitor rub resident #43's butt with his hands; go down her leg and up her inner thigh. CNA #96 stated she asked her CNA #34 to look. She said CNA #34 got up and removed resident #43 away from the visitor to a different area. She stated CNA #34 then informed the nurse (staff #110) of the incident. She stated she later went to the nurse (staff #110) to ask if CNA #34 told her about the incident and that staff #110 stated yes but that they could not do anything because resident #43 did not resist. She stated resident #43 is unable to consent to the incident that occurred. CNA #96 stated she had never seen the visitor do anything like that before and that she has not seen the visitor since the incident. CNA #96 stated that in the abuse training that she received, the facility's procedure is to follow the chain of command when reporting abuse and that she is to report any allegations of abuse to the floor nurse.<br>In an interview conducted with CNA #34 on (MONTH) 8, 2019 at 1:50 p.m., she stated she is familiar with resident #43 and she witnessed the incident that occurred on (MONTH) 28, 2019. She stated she and CNA #96 were sitting at a table in the dining room assisting residents with breakfast. She stated CNA #96 had a better view of the visitor and resident #43. She said CNA #96 saw something that she brought to her attention. CNA #34 stated resident #43 had gotten up from the table where she was eating and was standing next to the visitor. She stated it was normal behavior for resident #43 to walk up to others and be friendly. She stated that she observed the visitor put his hand up and down resident #43's inner thigh and then pat her on the bottom. CNA #34 stated resident #43 did not react in a distressed manner, but that she is not alert and oriented enough to give consent or to know what the visitor was doing was wrong. She stated she took resident #43 to another part of the dining room. She said the visitor was looking around to see if anyone had seen what he was doing and that he was acting like he was guilty of something. She stated after she removed resident #43, she told the nurse (staff #110) that the visitor of another resident was touching resident #43 inappropriately. CNA #34 stated staff #110 told her there was nothing |

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| F 0600<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | (continued... from page 1)<br>they could do because resident #43 was not resisting and that staff #110 did not appear too concerned. She stated she did not know what staff #110 did after that. CNA #34 stated that when she returned to work on (MONTH) 3, 2019, the visitor was on the unit which was upsetting to her and that she told the unit clerk (staff #5) about it during breakfast. She stated staff #5 reported it to the DON (staff #79). She stated she had never seen the visitor touch any other residents inappropriately and has not seen him in the facility since.<br>A video recording of the incident was viewed with the administrator (staff #102) on (MONTH) 8, 2019 at 2:36 p.m. The visitor was sitting at a table in the dining room and resident #43 was standing to the left of the visitor at 9:04 a.m. The visitor touched the resident's front crotch area with his left hand, then starts touching her upper buttocks, started touching lower and then rubs and pats her buttocks and squeezes them a bit. At 9:05 a.m. staff #34 gets up from the table and escorts resident #43 away from the visitor. At 9:06 a.m., staff #34 is seen speaking with the nurse (staff #110) who is at her cart near the dining room.<br>After viewing the video recording, the administrator stated that she considers this incident to be sexual assault and that it was awful that administration was not made aware of this right away when it happened. She stated that when staff #34 returned to work on (MONTH) 3, 2019 and saw the visitor, she became upset and reported the incident to the unit clerk who reported it to the DON, who reported it to her. The administrator said the DON immediately went to the unit and told the visitor that an allegation had been made and that he needed to leave the facility. Staff #102 said the DON called security and security escorted the visitor out of the facility and told him that he was not to come back on campus and that they would be in contact with him. She stated the abuse allegation was substantiated.<br>An interview was conducted via phone with the visitor on (MONTH) 10, 2019 at 12:48 p.m. The visitor stated that his family member has been a resident for about a year and a half and that he used to come and visit about 6-8 hours every day. The visitor stated he has not been able to visit and that he misses his family member. He stated he does not understand why he is unable to come back to the facility. The visitor stated that he was always cordial with the other residents and was never inappropriate with any residents at the facility. The visitor also stated he was told a complaint had been made against him and he needed to leave the facility immediately. He stated he could not remember the exact day, but it happened while he was eating breakfast with his family member.<br>In an interview conducted with the administrator (staff #102) on (MONTH) 10, 2019 at 3:36 p.m., she stated for any allegations of abuse, nursing staff are to immediately call her or the DON and one of them will come in and start the process of reporting within the 2 hour time frame. She stated the first thing the nurse should do is to make sure the resident is safe. The administrator stated that if staff are unable to contact her or the DON, the floor nurses know the process and the process is posted at the nurses stations. Staff #102 said the expectation is that staff report allegations of abuse immediately. She stated that in this case, the CNAs (#34 and #96) reported the incident to the nurse (staff #110) and that they were under the impression the nurse was going to do something about it.<br>Review of facility's policy titled, Freedom from Abuse, Neglect, and Exploitation dated 7/2019 revealed, It is the policy of the facility to maintain an environment where residents are free from abuse .all residents, staff, families, visitors, volunteers and resident representatives are encouraged and supported in reporting any suspected acts of abuse, neglect, misappropriation of resident property, or exploitation. The policy included Each resident has the right to be free from abuse .of any type by anyone. Additionally, the policy includes, Residents have the right to engage in consensual activity. However, anytime the facility has reason to suspect that a resident may not have the capacity to consent to sexual activity; the facility must ensure the resident is evaluated for capacity to consent. Residents without the capacity to consent to sexual activity may not engage in sexual activity. The policy describes sexual abuse as, non-consensual sexual contact of any type with a resident. Generally, sexual contact is non-consensual if the resident .appears to want the contact to occur, but lacks the cognitive ability to consent.<br>Another facility policy titled, Visitors dated (MONTH) 28, (YEAR) includes, Our facility permits residents to receive visitors subject to the resident's wishes and the protection of the rights of other residents in the facility. |
| F 0607<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Develop and implement policies and procedures to prevent abuse, neglect, and theft.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on clinical record review, facility documentation, staff interviews, and policy review, the facility failed to implement their abuse policy regarding reporting for 3 residents (#54, #5, and #43), investigation for 2 residents (#54 and #5), and protection of residents for one resident (#43). The deficient practice could result in allegations not being reported within the required time frame, investigations not being thoroughly investigated, and residents not being protected from abuse.<br>Findings include:<br>-Resident #54 was admitted on (MONTH) 30, 2019 with [DIAGNOSES REDACTED].<br>An admission Minimum Data Set (MDS) assessment dated (MONTH) 6, 2019 revealed the resident had no problems with memory or recall ability and was independent with cognitive skills for daily living.<br>Review of facility documentation revealed that on (MONTH) 20, 2019 resident #54 reported to a Registered Nurse (RN/staff #58 ) that a Certified Nursing Assistant (CNA/staff # 136) had washed her butt and feet and then used the same washcloth to wash her face and that the CNA hit her in the lip causing it to bleed.<br>Continued review of the report revealed resident #54, staff #136, and the Director of Nursing (DON/staff #79) were interviewed but did not include interviews with other staff or residents who may have had knowledge of the incident.<br>The report revealed the police and Adult Protective Services (APS) were notified but did not reveal documentation the State Survey Agency was notified within the required time frame.<br>Review of the State data base system revealed no evidence the State Survey Agency was notified of the incident within the required time frame.<br>An interview was conducted with the administrator (staff #102) on (MONTH) 10, 2019 at 3:36 p.m. The administrator stated all allegations of abuse are to be reported to the DON or to her immediately. She stated the allegations are to be reported to the State Survey Agency no later than 2 hours after the allegation is made. The administrator also stated that a thorough investigation would include interviews with other residents that staff #136 provided care to and interviews with other staff regarding staff #136 and who may have knowledge of the incident. She stated that a complete and thorough investigation needs to be conducted when there is an allegation of abuse.<br>-Resident #5 was admitted to the facility on (MONTH) 1, 2010 with [DIAGNOSES REDACTED].<br>Review of the annual MDS assessment dated (MONTH) 29, 2019 revealed the resident had severely impaired cognitive skills for daily decision making.<br>Review of a nursing note dated (MONTH) 22, 2019 revealed the resident's family reported the resident had a bruise with a raised area measuring about 2-3 cm (centimeters) diagonally across the resident's right forehead that was not present the previous night. The note included the occurrence and time of the bruise was unknown and that it was being investigated. The note also included the resident had been to the beauty salon that day and that a message was sent to the beauty shop to see if they could provide information about the bruise.<br>The incident tracking record completed by a registered nurse (RN/staff #28) dated (MONTH) 22, 2019 included the following information:<br>-Date of incident - (MONTH) 22, 2019<br>-Time of incident - 1:00 p.m.<br>-Incident Category - Skin<br>-Description of the Incident - Bruise and raised area measuring about 2-3 cm (centimeters) diagonally across the resident's right forehead was found by resident's family and occurrence and time of bruise was unknown<br>-Resident's description - Calm and cooperative with no evidence or signs of pain.<br>-Witnessed - No<br>-Staff Action at the time of incident - Area was assessed and documented; and, no further actions were necessary in terms of the wound because area was intact.<br>-Type of injury - Bruise/contusion<br>-Did the resident go to the hospital - No<br>Investigation/Follow-up: |

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| F 0607<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | (continued... from page 2)<br>-Interventions - Educated staff on importance of ADL (Activities of Daily Living) care that's timed and performed according to the patient's needs and on the importance of immediately reporting of any skin issues.<br>-Investigation Outcome - State Reportable (blank)<br>No evidence was revealed a thorough investigation was conducted to include staff, family, resident or witness statements/interviews and the results of the investigation.<br>There was also no evidence that the injury of unknown source was reported to the State Agency and APS within the required time frame for reporting.<br>An interview was conducted on (MONTH) 9, 2019 at 1:58 p.m. with the RN (staff #28) who received the report of the resident's bruise. She stated an injury of unknown origin is an injury that no one can say how it happened. The RN said she did not think the bruise was an injury of unknown source because the family told her the bruise might be a result of the resident leaning against the elevated right shoulder part of the wheelchair. The RN stated that she notified the physician, DON (staff #79) and the wound nurse but did not report the incident to the State Survey Agency and other local agencies because she did not think it was an injury of unknown source.<br>During an interview conducted on (MONTH) 10, 2019 at 3:37 p.m. with the administrator (RN/staff #102), she stated allegations of abuse including injury of unknown origin must be reported to her or the DON immediately and must be reported to local agencies within 2 hours of the incident if it is serious. She stated bruising is considered an injury of unknown source if no one cannot say how it happened and must be reported to her and the DON immediately. She stated if she and/or the DON are unavailable, the staff knows the process in reporting and that they should not wait to report the incident to the appropriate agencies. She stated all allegations of abuse including injury of unknown origin will be investigated and the results of the investigation will be submitted to the State Agency. The administrator further stated that the injury of unknown source was not reported to her and that she has to assume it was not reported to the DON as well because of the lack of investigation. She also stated that she did not know anything about the bruise or whether the incident was reported to the State Survey Agency and APS.<br>Attempts were made to conduct an interview with the DON (staff #79) on (MONTH) 10, 2019 but were unsuccessful because staff #79 was unavailable.<br>The facility's policy titled, Freedom from Abuse, Neglect and Exploitation Policy and Procedure revealed the facility will ensure reports of abuse, neglect and injuries of unknown source are promptly reported and thoroughly investigated. The Department Manager/Supervisor receiving the initial report will be responsible for initiating the investigation to include but not limited to who was involved, residents, staff, and witness statements of the event. The results of the investigation will be recorded and attached to the report. The policy also revealed abuse, neglect, and injuries of unknown source will be reported no later than 2 hours after the allegation is made to the State Survey Agency and APS.<br>-Resident #43 was admitted to the facility on (MONTH) 11, (YEAR) with [DIAGNOSES REDACTED].<br>A quarterly Minimum Data Set (MDS) assessment dated (MONTH) 2, 2019 revealed the resident's cognitive skills for daily decision making was moderately impaired.<br>Review of the facility's investigation report revealed the Director of Nursing (DON/staff #79) was notified on (MONTH) 3, 2019 that a visitor had touched a resident (#43) inappropriately in the dining room on (MONTH) 28, 2019. The incident was witnessed by two certified nursing assistants (CNAs/staff #34 and staff #96). The CNAs immediately removed resident #43 from the situation and reported the incident to the Licensed Practical Nurse (LPN/staff #110). A video recording of the area was reviewed on (MONTH) 3, 2019 and confirmed the incident. The visitor was then told to leave the campus immediately and not return until they contacted him. The visitor was escorted off the campus by security. The report included resident #43 is alert and oriented to self only, pleasant with cares, ambulates freely on the unit, and is friendly and outgoing.<br>Continued review of the report revealed the LPN (staff #110) was being terminated and had been reported to the State Board for failure to report an allegation of abuse and for failing to protect the residents from further potential abuse by failing to ensure the alleged perpetrator did not have access to resident #43 and/or other vulnerable residents.<br>Further review of the report revealed the allegation of abuse was not reported to the State Survey Agency and APS until (MONTH) 3, 2019, 5 days after the allegation was made.<br>An interview was conducted via phone with the LPN (staff #110) on (MONTH) 8, 2019 at 12:56 p.m., She stated that she was passing medications the morning of Saturday, (MONTH) 28, 2019, when staff #34 approached her and said he is patting on her (resident #43) again. The LPN stated resident #43 and another resident sometimes hold hands and walk down the hall and that she thought staff #34 was referring to that resident. She stated staff #34 did not say the he was a visitor. Staff #110 stated that if staff #34 would have said it was a visitor, she would have immediately called security and had the visitor removed, and notified the DON (staff #79) and the administrator (staff #102).<br>In an interview conducted with CNA #96 on (MONTH) 8, 2019 at 1:40 p.m., she stated she was sitting at a table in the dining room assisting residents with breakfast when she saw a visitor rub resident #43's butt with his hands; go down her leg and up her inner thigh. CNA #96 stated she asked her CNA #34 to look. She said CNA #34 got up and removed resident #43 away from the visitor to a different area. She stated CNA #34 then informed the nurse (staff #110) of the incident. She stated she later went to the nurse (staff #110) to ask if CNA #34 told her about the incident and that staff #110 stated yes but that they could not do anything because resident #43 did not resist.<br>In an interview conducted with CNA #34 on (MONTH) 8, 2019 at 1:50 p.m., she stated she and CNA #96 were sitting at a table in the dining room assisting residents with breakfast. She said CNA #96 saw something that she brought to her attention. CNA #34 stated resident #43 had gotten up from the table where she was eating and was standing next to the visitor. She stated it was normal behavior for resident #43 to walk up to others and be friendly. She stated she observed the visitor put his hand up and down resident #43's inner thigh and then pat her on the bottom. She stated she took resident #43 to another part of the dining room. She stated that after she removed resident #43, she told the nurse (staff #110) that the visitor of another resident was touching resident #43 inappropriately. CNA #34 stated staff #110 told her there was nothing they could do because resident #43 was not resisting and that staff #110 did not appear too concerned. She stated she did not know what staff #110 did after that. CNA #34 stated that when she returned to work on (MONTH) 3, 2019, the visitor was on the unit which was upsetting to her and that she told the unit clerk (staff #5) about it during breakfast. She stated staff #5 reported it to the DON (staff #79).<br>During an interview conducted with the unit clerk (staff #5) on (MONTH) 10, 2019 at 9:00 a.m., staff #5 stated that staff #34 told her the morning of (MONTH) 3, 2019 that there was an incident with resident #43 and a visitor and that she had reported it the LPN (staff #110). Staff #5 stated that she did not believe the LPN (staff #110) reported the incident to administration so she reported it to the DON (staff #79) who initiated an investigation.<br>In an interview conducted with the administrator (staff #102) on (MONTH) 10, 2019 at 3:36 p.m., she stated for any allegations of abuse, nursing staff are to immediately call her or the DON and one of them will come in and start the process of reporting within the 2 hour time frame. She stated the first thing the nurse should do is to make sure the resident is safe. The administrator stated that if staff are unable to contact her or the DON, the floor nurses know the process and the process is posted at the nurses stations. Staff #102 said the expectation is that staff report allegations of abuse immediately. She stated that in this case, the CNAs (#34 and #96) reported the incident to the nurse (staff #110) and that they were under the impression the nurse was going to do something about it.<br>The facility's policy titled Freedom from Abuse, Neglect and Exploitation Policy and Procedure revealed that immediately upon receiving a report of alleged abuse the alleged perpetrator will immediately be removed and the resident protected. The policy also revealed abuse, neglect, and injuries of unknown source will be reported no later than 2 hours after the allegation is made to the State Survey Agency and APS. |
| F 0609<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on clinical record review, facility documentation, staff interviews, and policy review, the facility failed to ensure allegations of abuse for two residents (#54 and #43) and an allegation of injury of unknown source for one resident (#5) were reported to the State Survey Agency and Adult Protective Services (APS) within the required time frame. The deficient |

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| F 0609<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | (continued... from page 3)<br>practice could result in allegations not being reported within the required time.<br>Findings include:<br>-Resident #54 was admitted on (MONTH) 30, 2019 with [DIAGNOSES REDACTED].<br>An admission Minimum Data Set (MDS) assessment dated (MONTH) 6, 2019 revealed the resident had no problems with memory or recall ability and was independent with cognitive skills for daily living.<br>Review of facility documentation revealed that on (MONTH) 20, 2019, resident #54 reported to a Registered Nurse (RN/staff #58 ) that a Certified Nursing Assistant (CNA/staff # 136) had washed her butt and feet and then used the same washcloth to wash her face and that the CNA hit her in the lip causing it to bleed.<br>The report revealed the police and Adult Protective Services (APS) were notified but did not reveal documentation the State Survey Agency was notified within the required time frame.<br>Review of the State data base system revealed no evidence the State Survey Agency was notified of the incident within the required time frame.<br>No evidence was revealed the State Survey Agency was notified no later than 2 hours after the allegation was made.<br>An interview was conducted with the administrator (staff #102) on (MONTH) 10, 2019 at 3:36 p.m. The administrator stated all allegations of abuse are to be reported to the DON or to her immediately. She stated the allegations are to be reported to the State Survey Agency no later than 2 hours after the allegation is made.<br>-Resident #5 was admitted at the facility on (MONTH) 1, 2010 with [DIAGNOSES REDACTED].<br>Review of the annual MDS assessment dated (MONTH) 29, 2019 revealed the resident had severely impaired cognitive skills for daily decision making.<br>Review of a nursing note dated (MONTH) 22, 2019 revealed the resident's family reported the resident had a bruise with a raised area measuring about 2-3 cm (centimeters) diagonally across the resident's right forehead that was not present the previous night. The note included the occurrence and time of the bruise was unknown and that it was being investigated. The note also included the resident had been to the beauty salon that day and that a message was sent to the beauty shop to see if they could provide information about the bruise.<br>The incident tracking record completed by a registered nurse (RN/staff #28) dated (MONTH) 22, 2019 included the following information:<br>-Date of incident - (MONTH) 22, 2019<br>-Time of incident - 1:00 p.m.<br>-Incident Category - Skin<br>-Description of the Incident - Bruise and raised area measuring about 2-3 cm (centimeters) diagonally across the resident's right forehead was found by resident's family and occurrence and time of bruise was unknown<br>-Resident's description - Calm and cooperative with no evidence or signs of pain.<br>-Witnessed - No<br>-Staff Action at the time of incident - Area was assessed and documented; and, no further actions were necessary in terms of the wound because area was intact.<br>-Type of injury - Bruise/contusion<br>-Did the resident go to the hospital - No<br>Investigation/Follow-up:<br>-Interventions - Educated staff on importance of ADL (Activities of Daily Living) care that's timed and performed according to the patient's needs and on the importance of immediately reporting of any skin issues.<br>-Investigation Outcome - State Reportable (blank)<br>However, no evidence was revealed that the injury of unknown source was reported to the State Agency and APS.<br>An interview was conducted on (MONTH) 9, 2019 at 1:58 p.m. with the RN (staff #28) who received the report of the resident's bruise. She stated an injury of unknown origin is an injury that no one can say how it happened. The RN said she did not think the bruise was an injury of unknown source because the family told her the bruise might be a result of the resident leaning against the elevated right shoulder part of the wheelchair. The RN stated that she notified the physician, DON (staff #79) and the wound nurse but did not report the incident to the State Survey Agency and other local agencies because she did not think it was an injury of unknown source.<br>During an interview conducted on (MONTH) 10, 2019 at 3:37 p.m. with the administrator (RN/staff #102), she stated allegations of abuse including injury of unknown origin must be reported to her or the DON immediately and must be reported to local agencies within 2 hours of the incident if it is serious. She stated bruising is considered an injury of unknown source if no one cannot say how it happened and must be reported to her and the DON immediately. She stated if she and/or the DON are unavailable, the staff knows the process in reporting and that they should not wait to report the incident to the appropriate agencies. The administrator further stated that the injury of unknown source was not reported to her and that she has to assume it was not reported to the DON as well because of the lack of investigation. She also stated that she did not know anything about the bruise or whether the incident was reported to the State Survey Agency and APS.<br>Attempts were made to conduct an interview with the DON (staff #79) on (MONTH) 10, 2019 but were unsuccessful because staff #79 was unavailable.<br>-Resident #43 was admitted to the facility on (MONTH) 11, (YEAR) with [DIAGNOSES REDACTED].<br>A quarterly Minimum Data Set (MDS) assessment dated (MONTH) 2, 2019 revealed the resident's cognitive skills for daily decision making was moderately impaired.<br>Review of the facility's investigation report revealed the Director of Nursing (DON/staff #79) was notified on (MONTH) 3, 2019 that a visitor had touched a resident (#43) inappropriately in the dining room on (MONTH) 28, 2019. The incident was witnessed by two certified nursing assistants (CNAs/staff #34 and staff #96). The CNAs immediately removed resident #43 from the situation and reported the incident to the Licensed Practical Nurse (LPN/staff #110). A video recording of the area was reviewed on (MONTH) 3, 2019 and confirmed the incident. The visitor was then told to leave the campus immediately and not return until they contacted him. The visitor was escorted off campus by security. The report included resident #43 is alert and oriented to self only, pleasant with cares, ambulates freely on the unit, and is friendly and outgoing.<br>Further review of the report revealed the allegation of abuse was not reported to the State Survey Agency and APS until (MONTH) 3, 2019, 5 days after the allegation was made.<br>An interview was conducted via phone with the LPN (staff #110) on (MONTH) 8, 2019 at 12:56 p.m., She stated that she was passing medications the morning of Saturday, (MONTH) 28, 2019, when staff #34 approached her and said he is patting on her (resident #43) again. The LPN stated resident #43 and another resident sometimes hold hands and walk down the and that she thought staff #34 was referring to that resident. She stated staff #34 did not say the he was a visitor. Staff #110 stated if staff #34 would have said it was a visitor, she would have immediately called security and had the visitor removed, and notified the DON (staff #79) and the administrator (staff #102).<br>In an interview conducted with CNA #96 on (MONTH) 8, 2019 at 1:40 p.m., she stated she was sitting at a table in the dining room assisting residents with breakfast when she saw a visitor rub resident #43's butt with his hands; go down her leg and up her inner thigh. CNA #96 stated she asked CNA #34 to look. She said CNA #34 got up and removed resident #43 away from the visitor to a different area. She stated CNA #34 then informed the nurse (staff #110) of the incident. She stated she later went to the nurse (staff #110) to ask if CNA #34 told her about the incident and that staff #110 stated yes but that they could not do anything because resident #43 did not resist.<br>In an interview conducted with CNA #34 on (MONTH) 8, 2019 at 1:50 p.m., she stated she and CNA #96 were sitting at a table in the dining room assisting residents with breakfast. She said CNA #96 saw something that she brought to her attention. CNA #34 stated resident #43 had gotten up from the table where she was eating and was standing next to the visitor. She stated it was normal behavior for resident #43 to walk up to others and be friendly. She stated she observed the visitor put his hand up and down resident #43's inner thigh and then pat her on the bottom. She stated she took resident #43 to another part of the dining room. She stated that after she removed resident #43, she told the nurse (staff #110) that the visitor of another resident was touching resident #43 inappropriately. CNA #34 stated staff #110 told her there was nothing they could do because resident #43 was not resisting and that staff #110 did not appear too concerned. She stated she did not know what staff #110 did after that. CNA #34 stated that when she returned to work on (MONTH) 3, 2019, the visitor was on the unit which was upsetting to her and that she told the unit clerk (staff #5) about it during breakfast. She stated staff #5 reported it to the DON (staff #79). |

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| | 035176 | A. BUILDING _____ B. WING _____ | 10/10/2019 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| BEATITUDES CAMPUS | 1712 WEST GLENDALE AVENUE PHOENIX, AZ 85021 |

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| F 0609<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | (continued... from page 4)<br>During an interview conducted with the unit clerk (staff #5) on (MONTH) 10, 2019 at 9:00 a.m., staff #5 stated that staff #34 told her the morning of (MONTH) 3, 2019 that there was an incident with resident #43 and a visitor and that she had reported it the LPN (staff #110). Staff #5 stated that she did not believe the LPN (staff #110) reported the incident to administration so she reported it to the DON (staff #79) who initiated an investigation.<br>In an interview conducted with the administrator (staff #102) on (MONTH) 10, 2019 at 3:36 p.m., she stated for any allegations of abuse, nursing staff are to immediately call her or the DON and one of them will come in and start the process of reporting within the 2 hour time frame. The administrator stated that if staff are unable to contact her or the DON, the floor nurses know the process and that the process is posted at the nurses stations. Staff #102 said the expectation is that staff report allegations of abuse immediately. She stated in this case, the CNAs (#34 and #96) reported the incident to the nurse (staff #110) and that the CNAs were under the impression the nurse was going to do something about it.<br>The facility's policy titled, Freedom from Abuse, Neglect and Exploitation Policy and Procedure revealed the facility will ensure reports of abuse, neglect and injuries of unknown source are promptly reported. The policy also revealed abuse, neglect, and injuries of unknown source will be reported no later than 2 hours after the allegation is made to the State Survey Agency and APS. |
| F 0610<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Respond appropriately to all alleged violations.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on clinical record review, facility documentation, staff interviews, and policy review, the facility failed to ensure thorough investigations were conducted for 2 residents (#54 and #5) and failed to protect one resident (#43) from further potential abuse. The deficient practice could result in further abuse and investigations not being thoroughly investigated.Findings include:<br>-Resident #54 was admitted on (MONTH) 30, 2019, with [DIAGNOSES REDACTED].<br>An admission Minimum Data Set (MDS) assessment dated (MONTH) 6, 2019 revealed the resident had no problems with memory or recall ability and was independent with cognitive skills for daily living.<br>Review of facility documentation revealed that on (MONTH) 20, 2019 resident #54 reported to a Registered Nurse (RN/staff #58 ) that a Certified Nursing Assistant (CNA/staff # 136) had washed her butt and feet and then used the same washcloth to wash her face and that the CNA hit her in the lip causing it to bleed.<br>Continued review of the report revealed resident #54, staff #136, and the Director of Nursing (DON/staff #79) were interviewed but did not include interviews with other staff or residents who may have had knowledge of the incident.<br>An interview was conducted with the administrator (staff #102) on (MONTH) 10, 2019 at 3:36 p.m. The administrator stated that a thorough investigation would include interviews with other residents that staff #136 provided care to and interviews with other staff regarding staff #136 and who may have knowledge of the incident.<br>-Resident #5 was admitted to the facility on (MONTH) 1, 2010 with [DIAGNOSES REDACTED].<br>Review of the annual MDS assessment dated (MONTH) 29, 2019 revealed the resident had severely impaired cognitive skills for daily decision making.<br>Review of a nursing note dated (MONTH) 22, 2019 revealed the resident's family reported the resident had a bruise with a raised area measuring about 2-3 cm (centimeters) diagonally across the resident's right forehead that was not present the previous night. The note included the occurrence and time of the bruise was unknown and that it was being investigated. The note also included the resident had been to the beauty salon that day and that a message was sent to the beauty shop to see if they could provide information about the bruise.<br>The incident tracking record completed by a registered nurse (RN/staff #28) dated (MONTH) 22, 2019 included the following information:<br>-Date of incident - (MONTH) 22, 2019<br>-Time of incident - 1:00 p.m.<br>-Incident Category - Skin<br>-Description of the Incident - Bruise and raised area measuring about 2-3 cm (centimeters) diagonally across the resident's right forehead was found by resident's family and occurrence and time of bruise was unknown<br>-Resident's description - Calm and cooperative with no evidence or signs of pain.<br>-Witnessed - No<br>-Staff Action at the time of incident - Area was assessed and documented; and, no further actions were necessary in terms of the wound because area was intact.<br>-Type of injury - Bruise/contusion<br>-Did the resident go to the hospital - No<br>Investigation/Follow-up:<br>-Interventions - Educated staff on importance of ADL (Activities of Daily Living) care that's timed and performed according to the patient's needs and on the importance of immediately reporting of any skin issues.<br>-Investigation Outcome - State Reportable (blank)<br>No evidence was revealed a thorough investigation was conducted to include staff, family, resident or witness statements/interviews and the results of the investigation.<br>During an interview conducted on (MONTH) 10, 2019 at 3:37 p.m. with the administrator (RN/staff #102), she stated all allegations of abuse including injury of unknown origin will be investigated and the results of the investigation will be submitted to the State Agency. The administrator further stated that the injury of unknown source was not reported to her and that she has to assume it was not reported to the DON as well because of the lack of investigation. She stated the DON notifies her of any incidents and that the DON is good about investigating the incidents. She also stated that she did not know anything about the bruise.<br>Attempts were made to conduct an interview with the DON (staff #79) on (MONTH) 10, 2019 but were unsuccessful because staff #79 was unavailable.<br>The facility's policy titled, Freedom from Abuse, Neglect and Exploitation Policy and Procedure revealed the facility will ensure reports of abuse, neglect and injuries of unknown source are promptly reported and thoroughly investigated. The Department Manager/Supervisor receiving the initial report will be responsible for initiating the investigation to include but not limited to who was involved, residents, staff, and witness statements of the event. The results of the investigation will be recorded and attached to the report.<br>-Resident #43 was admitted to the facility on (MONTH) 11, (YEAR) with [DIAGNOSES REDACTED].<br>A quarterly Minimum Data Set (MDS) assessment dated (MONTH) 2, 2019 revealed the resident's cognitive skills for daily decision making was moderately impaired.<br>Review of the facility's investigation report revealed the Director of Nursing (DON/staff #79) was notified on (MONTH) 3, 2019 that a visitor had touched a resident (#43) inappropriately in the dining room on (MONTH) 28, 2019. The incident was witnessed by two certified nursing assistants (CNAs/staff #34 and staff #96). The CNAs immediately removed resident #43 from the situation and reported the incident to the Licensed Practical Nurse (LPN/staff #110). A video recording of the area was reviewed on (MONTH) 3, 2019 and confirmed the incident. The visitor was then told to leave the campus immediately and not return until they contacted him. The visitor was escorted off the campus by security. The report included resident #43 is alert and oriented to self only, pleasant with cares, ambulates freely on the unit, and is friendly and outgoing.<br>Continued review of the report revealed the LPN (staff #110) was being terminated and had been reported to the State Board for failure to report an allegation of abuse and for failing to protect the residents from further potential abuse.<br>During an interview conducted with CNA #34 on (MONTH) 8, 2019 at 1:50 p.m., the CNA stated she observed the visitor put his hand up and down resident #43's inner thigh and then pat her on the bottom. She stated she took resident #43 to another part of the dining room. She stated that after she removed resident #43, she told the nurse (staff #110) that the visitor of another resident was touching resident #43 inappropriately. CNA #34 stated staff #110 told her there was nothing they could do because resident #43 was not resisting and that she did not know what staff #110 did after that. CNA #34 stated that when she returned to work on (MONTH) 3, 2019, the visitor was on the unit which was upsetting to her and that she told the unit clerk (staff #5) about it during breakfast. She stated staff #5 reported it to the DON (staff #79).<br>An interview was conducted with the administrator (staff #102) on (MONTH) 8, 2019 at 2:36 p.m. The administrator stated that |

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| BEATITUDES CAMPUS | 1712 WEST GLENDALE AVENUE PHOENIX, AZ 85021 |

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| F 0610<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | (continued... from page 5)<br>when staff #34 returned to work on (MONTH) 3, 2019 and saw the visitor, she became upset and reported the incident to the unit clerk who reported it to the DON, who reported it to her. The administrator said the DON immediately went to the unit and told the visitor that an allegation had been made and that he needed to leave the facility. Staff #102 said the DON called security and security escorted the visitor out of the facility and told him that he was not to come back on campus and that they would be in contact with him.<br>In another interview conducted with the administrator on (MONTH) 10, 2019 at 3:36 p.m., the administrator stated that when there is an allegation of abuse, the first thing the nurse should do is to make sure the resident is safe. She stated that the process to be implemented when there is an allegation of abuse is posted at the nurses stations and that the floor nurses know the process.<br>The facility's policy titled Freedom from Abuse, Neglect and Exploitation Policy and Procedure revealed that immediately upon receiving a report of alleged abuse the alleged perpetrator will immediately be removed and the resident protected. |
| F 0641<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Ensure each resident receives an accurate assessment.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on clinical record review, staff interviews, and the Resident Assessment Instrument (RAI), the facility failed to ensure Minimum Data Set (MDS) assessments were accurate for 2 of 15 sampled residents (#58 and #30). The deficient practice could affect continuity of care, result in inaccurate discharge tracking information and result in data that it not accurate for quality monitoring.<br>Findings include:<br>-Resident #58 was admitted to the facility on (MONTH) 4, 2019 with [DIAGNOSES REDACTED].<br>Review of a discharge summary dated (MONTH) 18, 2019 revealed the resident had been discharged to an independent living facility.<br>However, the discharge MDS assessment dated (MONTH) 18, 2019, revealed the resident was discharged to an acute hospital.<br>An interview was conducted with the MDS nurse (staff #41) on (MONTH) 10, 2019 at 1:35 p.m. She stated that there is a system in place for her to track discharge location when a resident is being discharged . Staff #41 stated that she made an error when she completed the discharge MDS assessment for resident #58.<br>An interview was conducted with the Administrator (staff #106) on (MONTH) 10, 2019 at 3:54 p.m., who stated that they use the RAI manual as a MDS policy and guide.<br>The RAI manual instructs to review the clinical record including the discharge plan and discharge orders for documentation of a resident's discharge location and code that location.<br>-Resident #30 was admitted to the facility on (MONTH) 3, (YEAR) with a [DIAGNOSES REDACTED].<br>Review of a weekly skin assessment dated (MONTH) 5, 2019, revealed the resident had a fluid filled blister on the right heel, which measured 2 centimeter (cm) in diameter.<br>However, a physician's orders [REDACTED].<br>A wound assessment dated (MONTH) 8, 2019 revealed the resident had a wound measuring 2.6 x 3.5 cm on her right heel.<br>The weekly skin assessment dated (MONTH) 12, 2019 revealed the resident had a blister on her right heel.<br>Review of the Treatment Administration Record for (MONTH) 2019 revealed the treatment was provided to the left heel (not the right heel) on (MONTH) 5-16, 2019.<br>However, review of the quarterly MDS assessment dated (MONTH) 16, 2019 revealed the resident had no unhealed pressure ulcers.An interview was conducted on (MONTH) 10, 2019 at 1:35 p.m. with the MDS coordinator (staff #41). Staff #41 stated that she<br>reviews the nursing notes and assessments in the electronic clinical record to see if a resident has a pressure ulcer. She stated that there was no evidence of a pressure ulcer in resident #30's electronic chart. Staff #41 stated that the wound assessment was completed on paper, so she did not include the pressure ulcer in the quarterly MDS assessment. Staff #41 stated It is supposed to be in the computer or I cannot include it in my review or on the MDS.<br>Another interview was conducted with staff #41 on (MONTH) 10, 2019 at 2:54 p.m. She stated that a fluid filled blister should be coded as a stage 2 pressure ulcer according to the RAI manual.<br>During an interview conducted with the administrator (staff #102) on (MONTH) 10, 2019 at 4:36 p.m., the administrator stated she was aware the wound care notes were done on paper and not entered into the electronic record. The administrator stated that the wound nurse should be documenting in the electronic record so that the MDS nurse is able to locate wounds when completing MDS assessments. Staff #102 also stated that she was aware the physician's orders [REDACTED]. She said the resident had a pressure ulcer on her right heel and that the location of the pressure ulcer was incorrect on the physician order.<br>Review of the RAI manual revealed unhealed pressure ulcers should be coded if the resident had any pressure ulcers during the 7-day look-back period of the assessment. The RAI manual included a stage 2 pressure ulcer may also present as an intact or open/ruptured blister. The RAI manual steps for assessment of pressure ulcers includes performing a head-to-toe full body assessment of the resident focusing on bony prominences and pressure-bearing areas and that when a pressure ulcer presents as an intact blister, examine the adjacent and surrounding areas.<br>The manual also included .the importance of accurately completing and submitting the MDS cannot be over-emphasized . and that Federal regulations require the assessment accurately reflects the resident's status. |
| F 0644<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on clinical record review and staff interviews, the facility failed to ensure one resident (#50) with a [DIAGNOSES REDACTED]. The deficient practice could result in necessary specialized services not being provided for residents who need it.<br>Findings include:<br>Resident #50 was admitted to the facility on (MONTH) 4, (YEAR) with diagnoses of dementia with behavioral disturbance, [DIAGNOSES REDACTED], anxiety, and major [MEDICAL CONDITION].<br>Review of the PASARR Level I Screening dated (MONTH) 3, (YEAR) completed prior to admission, revealed the resident had a primary [DIAGNOSES REDACTED].<br>Further review of the Level I Screening revealed serious mental illnesses include [MEDICAL CONDITION] and psychotic/delusional disorder and that mental disorders include anxiety disorder and depression (mild or situational).<br>A physician order [REDACTED].<br>The face sheet now included a [DIAGNOSES REDACTED].<br>The quarterly MDS assessment dated (MONTH) 9, (YEAR) included an active [DIAGNOSES REDACTED].<br>Review of the care plan for [MEDICAL CONDITION] drug use initiated (MONTH) 6, (YEAR) now included the resident was receiving [MEDICATION NAME] for [MEDICAL CONDITION] and hallucinations.<br>Review of the Behavior/Intervention Monthly Flow Record for (MONTH) (YEAR) revealed a [DIAGNOSES REDACTED].<br>Despite documentation that the resident now has a [DIAGNOSES REDACTED].<br>During an interview conducted with social services (SS/staff #85) on (MONTH) 10, 2019 at 10:56 a.m., she stated they ensure a PASARR screening is completed for a resident prior to admission. She stated a new PASARR is not completed unless there is a change in the resident's status such as a resident who was initially admitted for rehab who will now be at the facility for more than 30 days or if a resident is discharging to another skilled nursing facility. She stated residents admitted for convalescence care, rehab or respite care only have the PASARR completed prior to admission and do not need a new one after admission. Staff #85 stated the purpose of the PASARR is to identify and determine proper placement of residents with diagnoses of mental illness.<br>After reviewing the clinical record, staff #85 stated that resident #50 had a PASARR completed prior to admission and that the resident do not need a new one because the resident was admitted for placement in the long term care unit.<br>Attempts were made to conduct an interview with the DON (staff #79) on (MONTH) 10, 2019 but were unsuccessful because staff #79 was unavailable. |

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| F 0644<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | (continued... from page 6)<br>During an interview conducted on (MONTH) 10, 2019 at 3:37 p.m. with the administrator/Registered Nurse (staff #102), she stated residents admitted for convalescence care, rehab or respite care have a PASARR completed prior to admission and do not need a new one after admission. She also stated that if the resident continues to stay at the facility longer than 30 days after admission, a new PASARR is completed. She further stated that a new PASARR is required for any change in the resident's status including a new [DIAGNOSES REDACTED]. |
| F 0686<br><br>**Level of harm -** Actual harm<br><br>**Residents Affected -** Few | **Provide appropriate pressure ulcer care and prevent new ulcers from developing.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observations, clinical record reviews and staff interviews, the facility failed to ensure that pressure ulcers were assessed timely and thoroughly, and/or failed to notify the physician timely regarding pressure ulcer development for 2 of 3 sampled residents (#5 and #52). Continued non compliance could place other residents at risk for pressure ulcer development and complications.<br>Findings include:<br>-Resident #5 was admitted on (MONTH) 1, 2010, with [DIAGNOSES REDACTED].<br>According to a Braden Scale for Predicting Pressure Sore Risk dated (MONTH) 3, 2019, the resident was assessed to be at risk.Review of a wound/pressure ulcer care plan with a start date of (MONTH) 15, (YEAR) revealed the resident was at risk for development of pressure ulcers due to mobility impairment and incontinence. A goal was to manage risk factors to effectively reduce the risk of ulcer development. Approaches included pressure redistributing devices in place at all times, watch for skin condition as care is provided daily as well as during weekly skin assessments, and to notify wound team and provider as needed.<br>The annual MDS (Minimum Data Set) assessment dated (MONTH) 29, 2019 included the resident was severely impaired with cognitive skills for daily decision making. The MDS included the resident was at risk of developing pressure ulcers, but did not have any unhealed pressure ulcers.<br>Regarding the left heel/foot:<br>Review of the clinical record revealed there was no documentation of any pressure redistributing devices/treatments which were in place, such as an air mattress or floating of the heels in (MONTH) 2019. There was also no documentation that the resident had any pressure ulcers or skin breakdown to the left heel/foot from (MONTH) 1, 2019 through (MONTH) 14, 2019.<br>A skin assessment dated (MONTH) 15, 2019 included the resident had three pressure spots located along the left lateral foot. Per the documentation, the spot closest to the heel was dark purple and the other two spots further towards the toes were red. The documentation included that all three areas measured 2-3 cm (centimeters), and the feet were offloaded with pillows and that the wound nurse was informed.<br>A nursing note dated (MONTH) 15, 2019 included the resident had three pressure spots along the side of the left foot: the spot closest to the heel was dark purple and the other two spots further towards the toes were red and all spots measured approximately 2-3 cm.<br>A nursing note dated (MONTH) 16, 2019 included that skin prep was applied to the pressure spots on the left heel and that both heels were offloaded from the mattress.<br>Despite documentation of three pressure spots to the left foot, there was no documentation that the physician was notified on (MONTH) 15 or 16, nor were there any orders for wound treatment.<br>A nursing note dated (MONTH) 17, 2019 revealed that a pressure injury was noted to the outer part of the left foot close to the heel, which was black in color and measured 1.5 cm, and the margins were red and slightly swollen. This note only identified one pressure injury, not three as in the above notes.<br>Another nursing note dated (MONTH) 17, 2019 included the physician assessed the resident's pressure areas on the feet and ordered treatment.<br>A physician's progress note dated (MONTH) 17, 2019 (which was two days after the left foot wounds were first identified) included the resident had a [MEDICAL CONDITION] pressure area on the lateral aspect of the left foot. There was no description of this wound, nor did the note address any other wounds to the left foot.<br>A physician's orders [REDACTED]. The orders included for [MEDICATION NAME] swab to left lateral foot and foam boots bilaterally every shift.<br>Review of the Resident at Risk Review dated (MONTH) 19, 2019, revealed the resident had three new pressure ulcers to the left foot, one was to the left heel, one near toes and a 2nd area near toes, with each wound measuring 2-3 cm. The documentation included that the left heel was dark purple. The resident's overall oral intake was very poor and not sufficient to heal pressure injuries. The goal was for the resident to not have signs and symptoms of infection with the pressure injuries. The documentation included that the wound nurse had not assessed the wounds yet.<br>A skin evaluation was completed by the wound nurse (staff #40) on (MONTH) 20, 2019, which was five days after the wounds had been identified. The documentation included a pressure injury to the lateral aspect of the left heel which measured 1.3 cm x 1.6 cm and was circular shaped. The wound was described as black and dark brown spot with skin intact and surrounding skin was red. The wound documentation also included the tissue type was necrotic/eschar and there was no undermining or drainage present. The evaluation did not address the status of the two pressure spots located on the left lateral foot, as previously identified.<br>A skin assessment dated (MONTH) 28, 2019 which was eight days after the last assessment included a wound to the left heel. However, a description of the wound bed, surrounding skin, and measurements were not documented. No other wounds to the left lateral foot were mentioned.<br>Review of the (MONTH) 2019 TAR (Treatment Administration Record) revealed the orders for [MEDICATION NAME] swab to left lateral foot and foam boots bilaterally every shift. The treatments were provided as ordered.<br>A nursing note dated (MONTH) 1, 2019 revealed the pressure injury to the left outer foot had black eschar, with no redness. Per the note, the area was painted with [MEDICATION NAME] and left open to air. Foam heel protectors in place on both feet.Further review of the clinical record revealed there was no documentation that the physician was notified of the left heel pressure injury, which now had black eschar from (MONTH) 20, 2019 through (MONTH) 3, 2019. There was also no evidence of any thorough assessments of the left heel pressure injury from (MONTH) 21 through (MONTH) 3, 2019.<br>A skin evaluation dated (MONTH) 4, 2019 included a pressure injury to the left heel, which previously was a closed unstageable wound which had opened. The wound measured 1.4 cm x 1.6 cm with necrotic/eschar tissue including slough and that the wound bed was not visible. The drainage was described as brown exudate, and there was bright redness to the periwound. There was no documentation regarding the other two pressure ulcers on the left foot.<br>A physician's orders [REDACTED]. The order also included to float heel on foam boots at bedtime until healed.<br>Review of the (MONTH) 2019 TAR revealed the above order. The documentation included that the treatments were provided as ordered.<br>A skin observation was conducted with a RN (staff #15) and a CNA (staff #130) on (MONTH) 10, 2019 at 11:08 a.m. Staff #15 stated he could not remove the dressing on the left heel, because it may disrupt the [MEDICATION NAME] healing process of the wound.<br>Regarding the pressure ulcer on the right foot bunion area:<br>The skin assessment dated (MONTH) 15, 2019 included the resident had a red pressure spot located on the bunion of the right foot, which was approximately 2-3 cm. The documentation included the feet were offloaded with pillows and the wound nurse was informed.<br>A physician's progress note dated (MONTH) 17, 2019 revealed the resident had a [MEDICAL CONDITION] pressure area on the right feet ball of big toe showing [MEDICAL CONDITION] changes, however, there was no documentation regarding a pressure ulcer on the right foot bunion area.<br>Review of the physician orders [REDACTED]. A physician's orders [REDACTED].<br>The skin evaluation dated (MONTH) 20, 2019 did not address the pressure spot on the bunion area of the right foot.<br>A nursing note dated (MONTH) 30, 2019 included that [MEDICATION NAME] was the treatment for [REDACTED].<br>Review of the (MONTH) 2019 TAR revealed for [MEDICATION NAME] swab to the right foot bunion and foam boots bilaterally every shift for wound care. The documentation showed that the treatments were provided as ordered.<br>Continued review of the clinical record revealed there were no further thorough wound assessments of the right toe bunion pressure spot, which included a description of the wound bed and surrounding skin and any measurements from (MONTH) 18 |

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| F 0686<br><br>**Level of harm -** Actual harm<br><br>**Residents Affected -** Few | (continued... from page 7)<br>through (MONTH) 9, 2019. There was also no documentation if the area had healed.<br>A skin observation was conducted with a RN (staff #15) and a CNA (staff #130) on (MONTH) 10, 2019 at 11:08 a.m. There was no wound observed to the bunion area of the right foot.<br>Regarding the right buttocks:<br>Review of the clinical record revealed no evidence that the resident had any skin issues to the right buttocks area from (MONTH) 1, through (MONTH) 4, 2019.<br>On (MONTH) 5, 2019, a nursing note stated the resident had a new pressure ulcer on the right butt cheek. There was no further description of the pressure area.<br>Nursing notes dated (MONTH) 6 and 7, 2019 included the resident had a blister with some redness on the right buttock and had a dry dressing in place.<br>A nursing note dated (MONTH) 8, 2019 included that treatment was ongoing for the pressure ulcer on the right buttocks.<br>Despite documentation that the resident had a pressure ulcer to the right buttocks, there was no documentation of a thorough assessment of the right buttocks pressure ulcer from (MONTH) 5-9, 2019, which included any measurements, if the blister had opened up and if so a description of the wound bed, if any drainage or odor was present, and the condition of the surrounding skin.<br>In addition, a nursing note referred to ongoing treatments to the right buttocks pressure ulcer, however, there was no physicians order for any treatment, nor was there documentation that wound care was consistently provided.<br>In an interview with a registered nurse (RN/staff #15) conducted on (MONTH) 9, 2019 at 11:24 a.m., he stated when a resident develops a pressure ulcer, he will assess the wound and notify the wound nurse, who works at the facility on a daily basis. He said that every Friday the wound nurse is scheduled to do wound rounds which includes assessing and measuring the wound, and documenting the assessment in the clinical record. He said the wound nurse and the floor nurses can provide wound treatments and that treatments should be documented on the MAR/TAR.<br>Multiple attempts were made on (MONTH) 8, 9 and 10 to conduct a wound observation with the wound nurse (LPN/staff #40), however, staff #40 was unavailable.<br>A skin observation was conducted with a RN (staff #15) and a CNA (staff #130) on (MONTH) 10, 2019 at 11:08 a.m. There were no open areas on the coccyx/buttocks area, however, there was redness to the coccyx/buttocks area. Staff #15 stated the resident's buttocks had redness from moisture, but there were no open areas.<br>Attempts were made to conduct an interview with the DON (staff #79) on (MONTH) 10, 2019, but were unsuccessful because staff #79 was unavailable.<br>During an interview conducted on (MONTH) 10, 2019 at 3:37 p.m. with the Administrator (RN/staff #102), she stated when a CNA identifies a skin issue such as pressure ulcer, it should be reported to the nurse who will assess the area, contact the physician for orders and notify the wound nurse. She stated the floor nurses can assess, measure and stage pressure ulcers. She said it should include the stage, measurements and description of the wound and should be documented on the skin assessment or IDT note in the clinical record. She stated it is expected that when a wound is identified, the nurses will assess and measure the wound. She said the wound nurse (staff #40) conducts wound rounds every Friday and works a normal shift three other days of the week, so the wound nurse does not have to wait until Friday to do an assessment. She stated for a while the wound nurse (staff #40) was documenting in the electronic record and the paper record, because the facility's software had some issues. However, she said the DON is working with the wound nurse to have all wound assessments documented in the electronic record. She further stated that the DON and staff #40 work together and are involved with the facility's wound program.<br>Regarding the pressure injuries for resident #5, the Administrator stated that she does not have the answers as to why the wounds were not assessed and monitored or why there was a lack of documentation of these wounds. She stated the DON may have answers, but was unavailable at this time.<br>-Resident #52 was admitted to the facility on (MONTH) 28, 2019, with [DIAGNOSES REDACTED].<br>An admission note dated (MONTH) 28, 2019 included the resident was non weight bearing due to a pressure ulcer on the left heel. The note included skin issues to the left heel and left great toe and that treatment and dressing changes were done by the hospice nurse twice a week and as needed. The note did not include the resident had any skin breakdown to the coccyx/buttocks area.<br>Despite having a pressure ulcer to the left heel, the Braden Scale for predicting pressure sore risk dated (MONTH) 29, 2019 identified that the resident was at mild risk of developing pressure sores.<br>Review of the physician's orders [REDACTED].<br>-skin assessment weekly<br>-encourage and assist to turn and reposition frequently every shift<br>-encourage and assist to float heels in bed every shift<br>-barrier cream to buttocks and peri area every shift and after episodes of incontinence for skin integrity<br>A physician's note dated (MONTH) 30, 2019 included the resident had multiple sores on the lower extremity and on the left heel, with wound care being done. However, there was no documentation that the resident had any pressure ulcers or skin concerns to the coccyx/buttocks area.<br>A skin integrity care plan dated (MONTH) 30, 2019 included the resident was at risk for further alteration in skin integrity related to generalized weakness, immobility and incontinence. The care plan included the resident had a left heel stage 3 pressure ulcer with [MEDICAL CONDITION] and had an unstageable pressure ulcer to the left great toe. The goal was for the resident's skin to remain free of further skin breakdown through the next review. Interventions included the resident will receive a skin assessment on admission and weekly, provide treatments as ordered, a pressure relieving mattress and a cushion to wheelchair as ordered.<br>A nursing note dated (MONTH) 31, 2019 included that an air mattress was on the resident's bed to protect red buttock and was ordered by hospice. This is the first documentation of a skin issue to the resident's buttocks area. Per the note, the resident spends most of the day in bed watching TV, is encouraged to turn and elevate feet, and barrier cream to buttock. The documentation did not include any further description of the red buttock area or any measurements.<br>Review of the Treatment Administration Record (TAR) for (MONTH) 2019 revealed the order for barrier cream every shift and that it was administered as ordered from (MONTH) 29-31.<br>Nursing notes dated (MONTH) 1 and 2, 2019 included wound on bottom and that the resident was on an air mattress. There were no further descriptors of the wound or any measurements.<br>Review of a weekly skin assessment dated (MONTH) 3, 2019 revealed the resident had skin excoriation to the coccyx area, which was described as shallow excoriated skin with redness. There were no further description of the coccyx area and no measurements to indicate how large of an area which was excoriated.<br>Nursing notes dated (MONTH) 3, 2019 included wound on bottom. The coccyx skin was excoriated with redness, and was cleaned and moisture barrier cream was applied. The resident experienced incontinence and has been using briefs. The resident was encouraged to stay off her back but refused.<br>An admission Minimum Data Set (MDS) assessment dated (MONTH) 4, 2019 included the resident had a brief interview for mental status (BIMS) score of 8, which indicated the resident had moderate cognitive impairment. The MDS included the resident was at risk for developing pressure ulcers and currently had a stage 3 and an unstageable that were both present upon admission. Further, the assessment included for pressure reducing devices for bed and chair, pressure ulcer care, and applications of ointments or medications.<br>A nursing note dated (MONTH) 5, 2019 included the resident was on an air mattress and it was too difficult for her to turn from side to side, and was up in a recliner chair for meals via mechanical lift.<br>A weekly skin assessment dated (MONTH) 9, 2019 included the resident had a red area to the coccyx/buttocks and that barrier cream was applied with each incontinent episode.<br>A nursing note dated (MONTH) 10, 2019 included the resident's bottom was red and barrier cream was applied. There were no further description of the redden area and no measurements.<br>A nursing note dated (MONTH) 15 and 16, 2019 included the coccyx and bilateral buttocks areas were red, barrier cream was applied, and that the resident was on an air mattress. There was no further description of the coccyx and bilateral buttock areas and there were no measurements.<br>A nursing note dated (MONTH) 17, 2019 included the coccyx and bilateral buttocks areas were red and barrier cream applied. |

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| F 0686<br><br>**Level of harm -** Actual harm<br><br>**Residents Affected -** Few | (continued... from page 8)<br>However, a weekly skin assessment dated (MONTH) 17, 2019 revealed there was no mention of any concerns to the coccyx or sacral area.<br>Review of a nursing note dated (MONTH) 26, 2019 revealed the sacral area was slightly red and moisture barrier applied. There was no further description of the sacral area and there were no measurements.<br>Review of the clinical record revealed that from (MONTH) 31, when the resident was first identified to have redness to the coccyx area through (MONTH) 30, 2019, there was no documentation that a thorough assessment of the coccyx and buttocks areas had been completed, which included a description of the wound bed and surrounding skin, and any measurements.<br>Review of the TAR for (MONTH) 2019 revealed barrier cream was administered as ordered from (MONTH) 1- 30, 2019.<br>A weekly skin assessment dated (MONTH) 1, 2019 included the sacral area was slightly red and the top layer of skin was excoriated. There were no measurements of the area.<br>Further review of the skin integrity care plan revealed it was not revised to reflect skin breakdown to the coccyx/buttock area and there were no additional interventions which were implemented to prevent further breakdown.<br>A nursing note dated (MONTH) 1, 2019 included the sacral area remained excoriated due to patient refusing to stay off her back and that moisture barrier cream was applied with incontinent care. There was no further descriptors of the sacral area and no measurements.<br>A nursing note dated (MONTH) 5, 2019 included the resident had a small open area on the coccyx, which was covered with a foam dressing, barrier cream was applied with every incontinent episode and that the wound nurse was informed. There was no description of the wound bed or surrounding skin, or if any drainage or odor was present and there were no measurements of the open area on the coccyx.<br>In addition, there was no clinical record documentation that the wound nurse had assessed the open area to the coccyx on (MONTH) 5 or 6, 2019. There was also no documentation that the physician was notified of the open area.<br>A nursing note dated (MONTH) 6, 2019 included a small open area on the coccyx with a foam dressing in place. This is the second reference to a foam dressing in place, however there were no orders for this.<br>A weekly skin assessment dated (MONTH) 7, 2019 included a pressure ulcer to the coccyx with treatment ongoing. There was no description of the pressure ulcer to the coccyx and no measurements.<br>A nursing note dated (MONTH) 7, 2019 included the resident was very incontinent and prefers sleeping on her back, and did not turn side to side this shift, after it was stressed to her the importance to reduce pressure to buttocks even with the air mattress in place.<br>Another nursing note dated (MONTH) 7, 2019 included the resident was turned every two hours today. Per the note, there was an open area on the coccyx, with a foam dressing in place. Further, the note included a hospice RN came to assess the resident and looked at the new open area on the buttocks and wasn't concerned. There was no documentation of an assessment of the open area to include a description of the wound bed and surrounding skin and any measurements.<br>A nursing note dated (MONTH) 8, 2019 included the resident's open area on the coccyx had a foam dressing in place and treatment was ongoing, toileting and repositioning were done frequently to ease the pressure on the back especially the coccyx area, and that barrier cream was used with incontinent episodes.<br>An observation was conducted on (MONTH) 9, 2019 at 11:08 a.m. of the resident in her room, lying in bed with the head of the bed elevated at approximately 45 degrees. The resident was on a pressure relieving mattress.<br>A nursing note dated (MONTH) 10, 2019 included the sacral area was red and the area was cleaned and moisture barrier was applied. There was no further description of the wound, nor any measurements.<br>Review of the TAR for (MONTH) 2019 revealed barrier cream was administered as ordered from (MONTH) 1-10, 2019.<br>Continued review of the clinical record revealed that from (MONTH) 1-9, 2019, there was no documentation that a thorough assessment of the coccyx and buttock areas were done, nor were there any measurements. There was also no documentation that the physician was notified of the open area on the coccyx.<br>A skin observation of the resident was conducted on (MONTH) 10, 2019 at 10:30 a.m., with a Registered Nurse (staff #15). The resident was observed to be lying in bed and the head of the bed was elevated approximately at a 45 degree angle. He stated that he observes the skin for any areas of concern and then describes them for the weekly skin assessment. Staff #15 stated that he would not be measuring the wound because it is strictly the wound nurse who does the measurements, when she does her weekly skin assessments. At this time, the resident's brief was removed and an open area approximately the size of a quarter was observed on the right upper buttocks. The wound bed was pink with intact wound edges, no drainage and no odor. Staff #15 stated there is an open area to the resident's right gluteal cleft and described the open area as a beefy red wound with no drainage. He said that he will call the provider to get an order and will also let the wound nurse know. He stated it was a pressure wound and the wound nurse does the staging of pressure ulcers. Immediately following this observation, staff #15 checked the electronic record to see if the open area on the resident's bottom had been identified previously. He stated it had been identified and the treatment was barrier cream. He stated the wound nurse would have any assessments or measurements, but she was unavailable today. He stated he would notify the wound nurse just in case she was not aware of this area.<br>A wound treatment observation was conducted on (MONTH) 10, 2019 at 1:15 p.m. with staff #15. He stated that he would be measuring and staging the wound. Staff #15 measured the wound which was 3 x 1.9 x 0.3 cm and staff #15 identified it as a stage 2 pressure ulcer with red granulation tissue and intact edges, no odor, no drainage, no undermining and no tunneling. In an interview with the Administrator (RN/staff #102) on (MONTH) 10, 2019 at 3:54 p.m., she stated the expectation regarding skin assessments is, if a new skin concern is identified, the nurse will be notified and assess the area and contact the physician to get orders. She stated the floor nurse should also make the wound nurse aware of the area of concern. She said the floor nurses can stage and measure the area and determine if it is a pressure ulcer, and they should document their assessment, including size, stage and wound description in a skin assessment or in a nursing note. Staff #102 stated all wound assessments are in the electronic record for continuity, so all nurses can see previous assessments and measurements. Regarding this resident's wound on the coccyx, she stated that she was unable to find any measurements. She stated the expectation is that the floor nurse or whoever identifies the new area should do an assessment and take measurements, then notify the appropriate parties. She stated it doesn't matter if the resident is on hospice, there still should be measurements done at the time the wound is identified. She stated the Director of Nursing oversees the wound nurse.<br>The DON and wound nurse were unavailable for interviews on (MONTH) 10, 2019. |
| F 0756<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on clinical record review, staff interviews, facility documentation and policies and procedures, the facility failed to ensure there was documentation by the physician as to why a gradual dose reduction (GDR) was contraindicated for one resident (#54) receiving a psychoactive medication and the pharmacist failed to consistently identify the lack of behaviors related to its use. The deficient practice could result in residents receiving psychoactive medications which may be unnecessary.<br>Findings include:<br>Resident #54 was admitted to the facility on (MONTH) 30, 2019, with [DIAGNOSES REDACTED].<br>A physician's orders [REDACTED].<br>A care plan dated (MONTH) 31, 2019 identified the use of a [MEDICAL CONDITION] drug ([MEDICATION NAME]) for depression, and that the resident was at risk for adverse effects. The goal was that the resident would not show any increase in depressive episodes. Interventions included to document adverse changes in mood such as; an increase in crying, decreased appetite, increase in difficulty in sleeping, talk of suicide, feelings of worthlessness, etc.<br>The admission Minimum Data Set (MDS) assessment dated (MONTH) 6, 2019 revealed the resident had no cognitive impairment. In the mood section, it was documented that the resident was feeling down, depressed, hopeless, had little energy, and had trouble concentrating. The MDS also included the resident had been administered an antidepressant medication, within the past 7 days. |

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| F 0756<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | (continued... from page 9)<br>Review of the behavior/intervention monthly flow record for (MONTH) 2019 revealed the resident was being monitored for negative statements, related to the use of [MEDICATION NAME]. For the month, the documentation included all zeros, which indicated the resident did not have any negative statements.<br>Review of the clinical record including the interdisciplinary progress notes for (MONTH) 2019 revealed no evidence that the resident had voiced negative statements related to depression. The interdisciplinary team included the physician, nursing staff, and social services staff.<br>According to the (MONTH) 2019 Medication Administration Record [REDACTED].<br>Review of the monthly medication pharmacy review dated (MONTH) 2019 revealed no recommendations regarding the [MEDICATION NAME].<br>The behavior/intervention monthly flow records for (MONTH) and (MONTH) 2019 included the resident was being monitored for negative statements, related to the use of [MEDICATION NAME]. The documentation included all zeros, which indicated the resident did not have any negative statements related to depression.<br>Review of the clinical record and the interdisciplinary progress notes for (MONTH) and (MONTH) 2019 revealed no evidence the resident had voiced negative statements related to a [DIAGNOSES REDACTED].<br>Review of the (MONTH) and (MONTH) 2019 MARs revealed the [MEDICATION NAME] had been administered daily as ordered.<br>Review of the monthly medication pharmacy reviews for (MONTH) and (MONTH) 2019 revealed no evidence of any recommendations regarding the [MEDICATION NAME].<br>A quarterly MDS assessment dated (MONTH) 6, 2019 included in the mood section that the resident was feeling tired or having too little energy. There was no indication that the resident was feeling down, depressed, hopeless, had a poor appetite or had trouble concentrating. The MDS also documented the resident had been administered an antidepressant within the past 7 days.<br>Review of the behavior/intervention monthly flow record from (MONTH) 1 through 7, 2019 revealed all zeros, which indicated the resident did not have any negative statements related to depression.<br>According to the MAR from (MONTH) 1 through 7, 2019, the resident received the [MEDICATION NAME] daily as ordered.<br>A pharmacy review note to the attending prescriber dated (MONTH) 7, 2019 included the resident was currently on [MEDICATION NAME] 7.5 mg at bedtime and that the resident had no documented behaviors in the last 60 days. There were two recommendations listed: 1) Attempt to discontinue the [MEDICATION NAME] or 2) Continue [MEDICATION NAME] as ordered, resident is clinically stable and at lowest effective dose, and a reduction attempt would likely result in resident condition decompensating. Per the documentation, the physician agreed with the second recommendation and signed the note on (MONTH) 7.<br>However, there was no documentation by the physician of the clinical rationale as to why a GDR or discontinuing the medication was contraindicated.<br>Review of the behavior/intervention monthly flow record from (MONTH) 8 though 21, 2019 revealed no episodes of negative statements by the resident related to depression.<br>Review of the clinical record including the interdisciplinary progress notes through (MONTH) 21, 2019, revealed no evidence that the resident had voiced any negative statements related to depression. In addition, there was no evidence the resident had displayed or expressed any statements related to feeling depressed, hopeless, changes in mood or crying.<br>Review of the MAR from (MONTH) 8 through 21, 2019 revealed the resident received [MEDICATION NAME] daily as ordered.<br>Review of a pharmacy note to the attending physician dated (MONTH) 21, 2019 revealed the following: The Federal guidelines state that psychopharmacological drugs should have a GDR twice per year for the first year in 2 quarters with one month between attempts when used to manage behavior, stabilize mood or treat a psych disorder. Current orders included for [MEDICATION NAME] 7.5 mg at bedtime. The pharmacy recommendation included the following: The behavioral team met and discussed that this resident is exhibiting signs and symptoms of depression and may be harmed from attempted dose decrease. If a GDR is not possible at this time due to resident being at lowest effective dose for all psychoactive medications with risk of decompensation if dose is reduced, please indicate this below and future dose reduction attempts will be clinically contraindicated. The physician agreed and the note was signed by the physician dated (MONTH) 24, 2019.<br>However, there was no clinical record documentation or any interdisciplinary progress notes by the behavioral team that the resident was experiencing signs and symptoms of depression.<br>Review of the behavior/intervention monthly flow record for (MONTH) 2019 revealed no episodes of negative statements related to depression.<br>The (MONTH) 2019 interdisciplinary progress notes revealed no evidence that the resident had voiced negative statements related to depression.<br>According to the (MONTH) 2019 MAR, the [MEDICATION NAME] was administered daily as ordered.<br>Review of the behavior/intervention monthly flow record from (MONTH) 1 though 22, 2019 revealed no evidence of any negative statements related to depression.<br>Review of the interdisciplinary progress notes from (MONTH) 1 though 22, 2019 revealed no evidence that the resident had voiced negative statements related depression.<br>According to the MAR from (MONTH) 1 through 22, 2019, the [MEDICATION NAME] was administered daily as ordered.<br>A pharmacy note to the attending prescriber dated (MONTH) 22, 2019 included the resident's medications were reviewed due to a recent and recurrent fall. The documentation included the resident was receiving [MEDICATION NAME], which could contribute to falls. The pharmacist's recommendation was to consider the risk versus the benefit, with a dose reduction or discontinuation as clinically appropriate. Per the note, the physician disagreed with the pharmacy recommendation. The form was dated (MONTH) 2, 2019 and was signed by the physician.<br>However, there was no documentation by the physician of the clinical rationale as to why a GDR or discontinuing the medication was contraindicated.<br>Review of the behavior/intervention monthly flow records for (MONTH) and (MONTH) 2019 revealed the resident was being monitored for negative statements related to depression. The documentation showed all zeros, which indicated the resident did not verbalize any negative statements.<br>Review of the (MONTH) and (MONTH) 2019 interdisciplinary progress notes revealed no evidence the resident had voiced negative statements related to depression.<br>Review of the (MONTH) and (MONTH) 2019 MARs revealed that [MEDICATION NAME] had been administered daily.<br>Review of the (MONTH) and (MONTH) 2019 pharmacy medication review forms revealed no evidence of any recommendations by the pharmacist to the physician related to the continued use of [MEDICATION NAME], despite a lack of documentation that the resident was exhibiting negative statements and symptoms of depression.<br>An interview was conducted with a Registered Nurse (RN/staff #58) on (MONTH) 9, 2019 at 11:30 a.m. Staff #58 stated she has not observed the resident displaying any signs or symptoms of depression, sadness and has not expressed any negative statements. She said if the resident did, it would be noted in the progress notes or on the behavior monitoring flowsheet. She said any resident who is on a psychoactive medication has to be monitored for behaviors and side effects and this has to be documented.<br>Attempts were made to conduct an interview with the DON (staff #79) on (MONTH) 10, 2019, but were unsuccessful as staff #79 was unavailable.<br>Attempts were made to conduct an interview with the pharmacist on (MONTH) 10, 2019, but were unsuccessful as the pharmacist was not available.<br>During an interview conducted on (MONTH) 10, 2019 at 3:37 p.m. with the Administrator (registered nurse/staff #102), she stated that the pharmacist should be able to catch if a psychoactive medication like an antidepressant needs further review if it is being used and there are no symptoms or evidence of behaviors on the flowsheets. She said the facility monitors target behaviors associated with the use of the psychoactive medication. She said the goal is to minimize the medication residents take so they can have the medications that they really need. She stated the pharmacist comes on a regular basis and should review the clinical record, including the monitoring sheets and make recommendations to the physician/prescriber. She said that continued follow up by the pharmacist may be necessary if a medication recommendation is made, particularly with a GDR.<br>The policy regarding Monthly Drug Review/Pharmacy Committee revealed the duties and responsibilities of the Pharmacy Services Committee include, but are not limited to the following: |

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| | 035176 | A. BUILDING _____ B. WING _____ | 10/10/2019 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| BEATITUDES CAMPUS | 1712 WEST GLENDALE AVENUE PHOENIX, AZ 85021 |

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| F 0756<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | (continued... from page 10)<br>establish policies and procedures for preventing the use of unnecessary medications and the inappropriate use of [MEDICAL CONDITION] drugs and for gradual dose reductions of [MEDICAL CONDITION] drugs; review monthly drug regimen reviews including irregularities and updates on previously noted irregularities; and determine the status of monthly drug regimen reviews.<br>A policy regarding [MEDICAL CONDITION] Medications included that the goal is to monitor the resident's use of [MEDICAL CONDITION] medications and use only when needed to treat a specific condition that is diagnosed and documented. A GDR is the stepwise tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or the medication be discontinued. The pharmacist performing the monthly medication regimen will also review the resident's medical record to appropriately monitor the medication regimen and ensure that medications are clinically indicated. |
| F 0758<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | **Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on clinical record reviews, staff interviews, facility documentation and policy and procedures, the facility failed to ensure there were adequate indications for the use of [MEDICAL CONDITION] medications for three residents (#'s 32, 50 and 54) and that there was documentation by the physician of the clinical rationale as to why gradual dose reductions (GDR's) were contraindicated. The deficient practice could result in residents receiving psychoactive medications that are unnecessary and possibly experiencing adverse side effects.<br>Findings include:<br>-Resident #32 was admitted to the facility on (MONTH) 17, 2014, with [DIAGNOSES REDACTED].<br>Regarding [MEDICATION NAME] (an antipsychotic medication):<br>Review of the clinical record revealed that on (MONTH) 27, (YEAR), the [MEDICATION NAME] dose was reduced to 25 mg at bedtime.<br>The [MEDICAL CONDITION] drug use care plan with a start date of (MONTH) 6, (YEAR) included the resident was receiving the antipsychotic [MEDICATION NAME] for [MEDICAL CONDITION], as evidenced by paranoia and delusions. The care plan also identified the resident was verbally resistant and refused cares most of the time, and pushes and hits peers on occasion.<br>An interdisciplinary note dated (MONTH) 28, (YEAR) included that [MEDICATION NAME] will be decreased to 12.5 mg as part of a dose reduction.<br>A physician's orders [REDACTED].<br>A nursing note dated (MONTH) 28, (YEAR) included that [MEDICATION NAME] was decreased to 12.5 mg at bedtime.<br>Review of the Behavior/Intervention Monthly Flow Record for (MONTH) (YEAR) revealed the resident was receiving [MEDICATION NAME] and was being monitored for hitting, punching and pushing peers. The record showed that the resident had two episodes on (MONTH) 21.<br>The Behavior/Intervention Monthly Flow Records for (MONTH) and (MONTH) (YEAR) revealed 0 for the number of behavioral episodes related to hitting, punching and pushing peers exhibited by the resident.<br>Review of the clinical record documentation from (MONTH) 28, (YEAR) through (MONTH) 31, (YEAR), revealed the resident was not monitored for or exhibited any paranoia or delusional behaviors.<br>A quarterly MDS (Minimum Data Set) assessment dated (MONTH) 20, (YEAR) revealed the resident did not have any physical or verbal behavioral symptoms that occurred 1 to 3 days of the last 7 days of the assessment, and had no potential indicators of [MEDICAL CONDITION] such as, hallucinations or delusions. The MDS also included the resident received an antipsychotic on a routine basis.<br>Review of the pharmacy [MEDICAL CONDITION] and Sedative/Hypnotic Utilization form dated (MONTH) 27, (YEAR), revealed the resident was on [MEDICATION NAME] 12.5 mg by mouth daily for [DIAGNOSES REDACTED].<br>A physician's progress note dated (MONTH) 4, (YEAR) included the resident had dementia with depression and anxiety, and was on [MEDICATION NAME] 12.5 mg every night.<br>A pharmacy [MEDICAL CONDITION] and Sedative/Hypnotic Utilization form dated (MONTH) 19, (YEAR), revealed the resident was on [MEDICATION NAME] 12.5 mg daily for [DIAGNOSES REDACTED].<br>The Behavior/Intervention Monthly Flow Records for (MONTH) (YEAR) revealed the resident was on [MEDICATION NAME] and was being monitored for hitting, punching and pushing peers. The record showed that the resident had multiple episodes during the month.<br>However, there was no clinical record documentation that the resident was being monitored for or exhibited any paranoia or delusional behaviors.<br>According to the Medication Administration Records (MARs) from (MONTH) through (MONTH) (YEAR), the resident continued to receive [MEDICATION NAME] 12.5 mg daily as ordered.<br>The Pharmacy Note to the Attending Physician/Prescriber dated (MONTH) 22, 2019 included the resident has [MEDICATION NAME] ordered and may benefit from an attempted dose decrease. The recommendation included reducing [MEDICATION NAME] to 12.5 mg by mouth every other day for 2 weeks, then discontinue. If you agree that the resident is at the lowest effective dose due to the potential that resident condition will decompensate if dose is decreased, please indicate and further GDR attempts will be clinically contraindicated. If you do not agree please write orders for a dose reduction attempt. The physician agreed with the pharmacy recommendation to discontinue the [MEDICATION NAME]. The pharmacy note was signed by the physician/prescriber on (MONTH) 25, 2019.<br>The physician recapitulation of orders for (MONTH) 2019 included an order dated (MONTH) 22, to discontinue the [MEDICATION NAME].<br>A nursing progress note dated (MONTH) 29, 2019 included the resident was seen pushing and kicking other residents after dinner and was seen regularly getting into other resident's rooms and picking up their clothes and pictures. Per the note, attempts to redirect agitated the resident more.<br>Review of the Behavior/Intervention Monthly Flow Record for (MONTH) 2019 revealed the resident was being monitored for hitting, punching and pushing peers. The documentation showed that the resident did not exhibit any of these behaviors.<br>There was no clinical record documentation that the resident was being monitored for paranoia and delusions related to [MEDICATION NAME].<br>On (MONTH) 29, 2019, a physician's orders [REDACTED].<br>However, review of the clinical record revealed no evidence that the resident had a [DIAGNOSES REDACTED].<br>Another physician's orders [REDACTED]. However, the [DIAGNOSES REDACTED].<br>An annual MDS assessment dated (MONTH) 19, 2019 included the resident had short and long term memory problems and had moderate cognitive impairment, with skills for daily decision making. The MDS also included the resident had no potential indicators of [MEDICAL CONDITION] such as; hallucinations or delusions; and the resident had physical behavioral symptoms that occurred 1 to 3 days of the last 7 days of the assessment.<br>The Behavior/Intervention Monthly Flow Record for (MONTH) 2019 revealed the resident was being monitored for hitting and pushing peers. The documentation showed that the resident did not exhibit any behaviors except on (MONTH) 11, there were three episodes.<br>The pharmacy [MEDICAL CONDITION] & Sedative/Hypnotic Utilization form dated (MONTH) 26, 2019 included the resident had [MEDICATION NAME] 12.5 mg by mouth daily for [DIAGNOSES REDACTED].<br>However, there was no clinical record documentation that the resident exhibited any paranoia or delusional behaviors in (MONTH) 2019.<br>According to the (MONTH) 2019 MAR, the [MEDICATION NAME] was administered daily to the resident.<br>A physician's progress note dated (MONTH) 29, 2019 included the resident had a [DIAGNOSES REDACTED].<br>The Behavior/Intervention Monthly Flow Records for March, (MONTH) and (MONTH) 2019 revealed the resident was being monitored |

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F 0758

**Level of harm -** Minimal harm or potential for actual harm

**Residents Affected -** Some

(continued... from page 11)
for hitting and pushing peers. The documentation showed the resident did not have any episodes.
Review of the pharmacy [MEDICAL CONDITION] & Sedative/Hypnotic Utilization forms for March, (MONTH) and (MONTH) 2019
revealed documentation that the resident was on the lowest effective dose of [MEDICATION NAME] for [DIAGNOSES REDACTED].
In addition, there was no documentation that the resident was being monitored for or exhibited any paranoia or delusional behaviors in March, (MONTH) and (MONTH) 2019.
The quarterly MDS assessment dated (MONTH) 17, 2019 revealed the resident did not have any physical or verbal behavioral symptoms that occurred 1 to 3 days of the last 7 days of the assessment, and had no potential indicators of [MEDICAL CONDITION] such as hallucinations or delusions. The MDS also included the resident received an antipsychotic medication on a routine basis, that a GDR has not been attempted and that a GDR has not been documented by a physician as clinically contraindicated.
Review of the Pharmacy [MEDICAL CONDITION] and Sedative/Hypnotic Utilization forms for (MONTH) 2019 revealed the resident
was on [MEDICATION NAME] for [DIAGNOSES REDACTED].
Review of the Behavior/Intervention Monthly Flow Record for (MONTH) 2019 revealed the resident did not have any episodes of hitting and pushing peers. There was no documentation that the resident was being monitored for paranoia or delusions.
According to the (MONTH) 2019 MAR, the resident received [MEDICATION NAME] daily as ordered.
A physician progress notes [REDACTED]. There were no specific behaviors or symptoms described that explained how the resident did not do well.
The quarterly MDS assessment dated (MONTH) 16, 2019 revealed the resident had short and long term memory problems and had moderate cognitive impairment, with skills for daily decision making. The MDS also included the resident had no potential indicators of [MEDICAL CONDITION] such as hallucinations or delusions, and did not have any physical or verbal behavioral symptoms. Per the MDS, the resident received antipsychotic medications during the last 7 days of the assessment.
Review of the Behavior/Intervention Monthly Flow Records for (MONTH) through (MONTH) 2019 revealed the resident was being monitored for hitting and pushing. The documentation showed that the resident did not have any episodes. There was also no documentation that the resident was being monitored for paranoia and delusions.
The Pharmacy [MEDICAL CONDITION] and Sedative/Hypnotic Utilization forms for July, (MONTH) and (MONTH) 2019, continued to
include that the resident was on [MEDICATION NAME] for [DIAGNOSES REDACTED].
However, there was no clinical record documentation that the resident exhibited any paranoia or delusional behaviors in July, (MONTH) and (MONTH) 2019.
According to the MARs for July, (MONTH) and from (MONTH) 1-26, 2019, the resident continued to receive [MEDICATION NAME]
daily as ordered.
On (MONTH) 27, 2019, a physician's orders [REDACTED].
A nursing note dated (MONTH) 2, 2019 included there were no adverse effects from the [MEDICATION NAME] being discontinued.
Despite documention that the resident had paranoia and delusional behaviors, there was no clinical record documentation to support that the resident exhibited these type of behaviors. The behaviors documented by the resident were related to hitting and pushing peers and the resident continued to receive [MEDICATION NAME], without adequate indications for its use.
Regarding [MEDICATION NAME] (antidepressant medication):
The (MONTH) (YEAR) physician orders [REDACTED].
The [MEDICAL CONDITION] drug use care plan included the resident was receiving an antidepressant medication [MEDICATION NAME], and that a GDR was done and the [MEDICATION NAME] was reduced to 10 mg daily.
A quarterly MDS assessment dated (MONTH) 20, (YEAR) included the resident had minimal depression.
The Pharmacy [MEDICAL CONDITION] and Sedative/Hypnotic Utilization forms dated (MONTH) 27, (YEAR) and (MONTH) 19, (YEAR),
revealed the resident was on [MEDICATION NAME] 10 mg by mouth daily for a [DIAGNOSES REDACTED].
Review of the Behavior/Intervention Monthly Flow Records from (MONTH) (YEAR) through (MONTH) 30, (YEAR) revealed the resident was being monitored for tearfulness and crying related to depression. The documentation showed that the resident did not exhibit any of these behaviors during this time frame.
Review of the MARs from (MONTH) (YEAR) through (MONTH) (YEAR) revealed the resident was administered [MEDICATION NAME] 10 mg daily.
A quarterly MDS assessment dated (MONTH) 17, 2019 revealed the resident had no depressive symptoms.
Review of the Behavior/Intervention Monthly Flow Records from (MONTH) 1, 2019 through (MONTH) 30, 2019, revealed the resident was monitored for tearfulness and crying, however, did not exhibit any episodes.
A pharmacist's note to the attending physician/prescriber dated (MONTH) 22, 2019 included the resident was on [MEDICATION NAME] 10 mg daily for depression. The recommendations included the resident has not had an attempt at dose reduction of [MEDICATION NAME] since (MONTH) (YEAR) and for the physician/prescriber to consider decreasing [MEDICATION NAME] to 10 mg
daily every other day for 14 days and then discontinue. The documentation also included for the physician/prescriber to indicate if a GDR is not possible due to being at the lowest effective dose with risk of decompensation if dose is reduced; and that future dose reduction attempts will be clinically contraindicated. The physician response was disagree however,
the section to document the clinical rationale was left blank.
A physician progress notes [REDACTED]. Per the note, the resident was on a decreased dose of [MEDICATION NAME] and the plan
was to continue the use of [MEDICATION NAME].
There was no clinical record documentation by the physician of the clinical rationale as to why the GDR was contraindicated.
A quarterly MDS assessment dated (MONTH) 16, 2019 revealed the resident had no depressive symptoms.
Review of the Behavior/Intervention Monthly Flow Records from (MONTH) 2019 through (MONTH) 2019 revealed the resident did not exhibit any episodes of tearfulness and crying.
The MARs for (MONTH) through (MONTH) 2019 included that the resident continued to receive [MEDICATION NAME].
Observations were conducted on (MONTH) 9, 2019 from 8:15 a.m. through 10:30 a.m. of resident #32. The resident was observed in the dining room and she was interacting with staff who were assisting her with eating. At 9:27 a.m., the resident was assisted to the lounge chair located at the nurse's station and she was listening to music. The resident was heard talking to herself, was calm and was interacting with staff in a pleasant manner.
Another observation of resident #32 was conducted on (MONTH) 10, 2019 from 1:43 p.m. through 2:43 p.m. She was observed sitting in a chair at the nurse's station. Resident #32 was alert and responded to staff in a calm manner. During this time, multiple staff approached the resident and she did not appear anxious, upset, combative or angry with staff or other residents.
An interview with a certified nursing assistant (CNA/unit clerk/staff #5) was conducted on (MONTH) 10, 2019 at 1:45 p.m. Staff #5 stated resident is alert but not oriented and likes to touch things and/or persons. She stated the resident's behavior included taking things from the rooms of other residents, but is easily redirectable. She stated she has not seen the resident hit, kick or punch other residents.
In an interview with another CNA (staff #130) conducted on (MONTH) 10, 2019 at 2:09 p.m., she stated that she had been at the facility for two years and has always worked in the unit where resident #32 resides. Staff #130 stated the resident's behavior included wandering in the rooms of other residents and takes things from the room. She said the resident can be redirected easily sometimes. She said that she has not seen the resident be aggressive or hitting, punching or kicking other residents and has not seen or heard reports of the resident having hallucinations, delusions or paranoia.
During an interview with a registered nurse (RN/staff #15) conducted on (MONTH) 10, 2019 at 2:53 p.m., he stated the only behavior that the resident has is shopping meaning that the resident wanders to other resident rooms and take things. He said that he has not seen the resident being aggressive or hit, kick or punch other residents. He also stated that the resident does not say much, but has not reported any hallucinations, delusions or paranoia.
-Resident #50 was admitted to the facility on (MONTH) 4, (YEAR), with [DIAGNOSES REDACTED].
The [MEDICAL CONDITION] Medication Use and Consent form dated (MONTH) 4, (YEAR) for [MEDICATION NAME] (antipsychotic/[MEDICATION NAME]) included the reason for its use was for the following Diagnoses: [REDACTED].
A care plan for cognitive loss and dementia dated (MONTH) 6, (YEAR) included the resident had cognitive deficits, because of the progression of [DIAGNOSES REDACTED] with behavioral disturbance and was on [MEDICATION NAME] 5 mg twice daily.
The [MEDICAL CONDITION] drug use care plan included the resident was receiving an antipsychotic ([MEDICATION NAME] 5 mg
twice daily) for [MEDICAL CONDITION], wandering and hallucinations.

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F 0758

**Level of harm** - Minimal harm or potential for actual harm

**Residents Affected** - Some

(continued... from page 12)
A physician's orders [REDACTED].
The Behavior/Intervention Monthly Flow Record for (MONTH) (YEAR) included the resident was monitored for hitting, kicking and yelling, and had multiple episodes of these behaviors on (MONTH) 5, 6, 10 and 12.
However, there was no documentation that the resident was monitored for hallucinations or had any hallucinations.
The NP (nurse practitioner) initial comprehensive evaluation note dated (MONTH) 4, (YEAR) revealed the resident had [DIAGNOSES REDACTED], memory loss, cognitive impairment and was alert, awake and confused. The plan was to continue [MEDICATION NAME] 5 mg twice daily and to monitor for wandering.
The Behavior/Intervention Monthly Flow Record for (MONTH) (YEAR) included the resident did not have any episodes of hitting, kicking, yelling or exit seeking.
There was no evidence that the resident was monitored for or had any hallucinations in (MONTH) (YEAR).
The Behavior/Intervention Monthly Flow Record for (MONTH) (YEAR) included the resident did not have any episodes of hitting, kicking, yelling and exit-seeking behaviors except on the night shift on (MONTH) 21, where the resident had one episode.
There was no evidence that the resident was monitored for or had any hallucinations in (MONTH) (YEAR).
The Consultant's Pharmacist's Medication Regimen Review form dated (MONTH) 23, (YEAR) included a recommendation to add hallucinations to the [MEDICATION NAME] behavior monitoring sheet.
The Pharmacy Note to the Attending Physician/Prescriber dated (MONTH) 23, (YEAR) included the resident may benefit from a trial dose reduction of [MEDICATION NAME] to 2.5 mg by mouth in the morning and 5 mg by mouth at bedtime. Per the documentation, the physician/prescriber agreed with this recommendation.
A physician's orders [REDACTED].
On (MONTH) 30, (YEAR), a physician's orders [REDACTED]. However, the [DIAGNOSES REDACTED].
However, further review of the clinical record revealed there was no evidence that the resident exhibited any psychotic behaviors, including hallucinations.
The quarterly MDS assessment dated (MONTH) 9, (YEAR) included resident had no potential indicators of [MEDICAL CONDITION]
such as hallucinations or delusions; and did not have any physical or verbal behavioral symptoms that occurred 1 to 3 days of the last 7 days of the assessment.
The physician progress notes [REDACTED]. The plan was to slowly wean the resident off [MEDICATION NAME] ([MEDICATION NAME])
and that the resident still had occasional wandering impulses, but was redirectable.
On (MONTH) 13, (YEAR), a physician's orders [REDACTED].
The Behavior/Intervention Monthly Flow Records for (MONTH) 1, (YEAR) through (MONTH) 31, (YEAR) included the resident was
monitored for hallucinations, but did not have any.
Review of the (MONTH) (YEAR) MAR revealed the resident was administered [MEDICATION NAME] in the evening as ordered.
A significant change MDS assessment dated (MONTH) 14, 2019 included an active [DIAGNOSES REDACTED]. However, the MDS also
included the resident had no potential indicators of [MEDICAL CONDITION] such as hallucinations or delusions; and did not have any physical or verbal behavioral symptoms that occurred 1 to 3 days of the last 7 days of the assessment.
A Pharmacy Note to the Attending Physician/Prescriber dated (MONTH) 22, 2019 included the resident continued to have behavioral issues and may be physiologically harmed by a decrease in the dose of [MEDICATION NAME] at this time. The note also included for the physician/prescriber to indicate on the form if the resident was at the lowest effective dose due to the potential that the residents condition will decompensate if dose is decreased and further attempts to decrease the dose will be clinically contraindicated. The physician/prescriber agreed and signed the form on (MONTH) 25, 2019.
However, there was no documentation by the physician of the clinical rationale as to why a dose reduction was contraindicated.
Review of the clinical record including the Behavior/Intervention Monthly Flow Records from (MONTH) 1, 2019 through (MONTH) 31, 2019, revealed the resident did not exhibit any hallucinations or psychotic behaviors.
According to the MARs from (MONTH) 2019 through (MONTH) 2019, the resident was administered [MEDICATION NAME] in the evening as ordered.
The quarterly MDS assessment dated (MONTH) 12, 2019 included the resident had no potential indicators of [MEDICAL CONDITION] such as hallucinations or delusions; did not have any physical or verbal behavioral symptoms that occurred 1 to 3 days of
the last 7 days of the assessment; and received an antipsychotic in the last 7 days of the assessment.
The physician progress notes [REDACTED].
Review of the clinical record including the Behavior/Intervention Monthly Flow Records from (MONTH) 2019 through (MONTH) 2019 revealed the resident did not exhibit any hallucinations.
Review of the MARs for (MONTH) through (MONTH) 2019 revealed the resident received [MEDICATION NAME] as ordered.
The quarterly MDS assessment dated (MONTH) 2, 2019 included resident was moderately impaired with cognitive skills, had disorganized thoughts, had no potential indicators of [MEDICAL CONDITION] such as hallucinations or delusions; and did not have any physical or verbal behavioral symptoms that occurred 1 to 3 days of the last 7 days of the assessment.
Review of the clinical record including the Behavior/Intervention Monthly Flow Records from (MONTH) 2019 through (MONTH) 2019 revealed the resident did not exhibit any hallucinations.
Continued review of the clinical record revealed no evidence that the resident exhibited psychotic behaviors from (MONTH) 2019 through (MONTH) 2019.
Per the MARs, the resident continued to be administered [MEDICATION NAME] in the evenings from (MONTH) 2019 through (MONTH)
2019.
Although there was no clinical record documentation to support that the resident was having psychotic behaviors including hallucinations, the resident continued to be administered an antipsychotic medication.
An observation of resident #50 was conducted on (MONTH) 8, 2019 at 2:20 p.m. The resident was awake, alert, calm and would smile when staff talked to him. At 2:40 p.m., he was directed by staff to go to the main dining room. The resident stood up, giggled and proceeded to the sunroom where an activity was going on. No behaviors were observed.
During an interview with a registered nurse (RN/staff #15) on (MONTH) 9, 2019 at 11:24 a.m., he stated the Director of Nursing (DON), the pharmacist and the staff nurses meet every quarter to discuss all residents on psychoactive medications. He said that during these meetings, psychoactive medications will be reviewed for appropriate [DIAGNOSES REDACTED]. He said once a GDR is ordered, it will be transcribed onto the MAR and this will alert the staff nurses that there was a change in the resident's medication. He stated the staff nurses are to document for 7 days in the progress notes regarding the specific behavior a resident exhibits, after the medication is changed. He said the physician or prescriber will review the progress notes in the clinical record after 7 days and will decide whether to continue the GDR or not.
Another observation of resident #50 was conducted on (MONTH) 10, 2019 from 8:15 a.m. through 9:21 a.m. The resident was observed in the dining room eating breakfast with two other residents sitting with him at a table. The resident was awake, alert, pleasant and conversational when the two other residents. Multiple staff approached the resident during this time and he was not observed to exhibit any behaviors.
Another interview was conducted with RN (staff #15) on (MONTH) 10, 2019 at 1:53 p.m. He stated resident #50 is alert and aware of his surroundings. He stated the resident does not talk much and does not have hallucinations.
Attempts were made to conduct an interview with the DON (staff #79) on (MONTH) 10, 2019, but were unsuccessful, as staff #79 was unavailable.
Attempts were made to conduct an interview with the pharmacist on (MONTH) 10, 2019, but were unsuccessful, as the pharmacist was unavailable.
During an interview conducted on (MONTH) 10, 2019 at 3:37 p.m. with the Administrator (registered nurse/staff #102), she stated when psychoactive medications are ordered, staff should verify the order, obtain a consent from the resident or responsible party and ensure every medication ordered has a diagnosis. She stated the nurse and the physician are to ensure there are adequate indications for the use of psychoactive medication. She said the pharmacist should be able to catch if a psychoactive medication does not have an adequate [DIAGNOSES REDACTED]. She said the facility uses behavior monitoring forms for target behaviors associated with the use of psychoactive medication. She said the goal is to minimize the medication residents take so they can have the medications that they really need.
-Resident #54 was admitted to the facility on (MONTH) 30, 2019, with [DIAGNOSES REDACTED].
A physician's orders [REDACTED].
A care plan dated (MONTH) 31, 2019 identified the use of a [MEDICAL CONDITION] drug ([MEDICATION NAME]) for depression and

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) |
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| F 0758<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | (continued... from page 13)<br>that the resident was at risk for adverse effects. The goal was that the resident would not show any increase in depressive episodes. Interventions included to document adverse changes in mood such as; an increase in crying, decreased appetite, increase in difficulty in sleeping, talk of suicide, feelings of worthlessness, etc.<br>The admission MDS assessment dated (MONTH) 6, 2019 revealed the resident had no cognitive impairment. In the mood section, it was documented that the resident was feeling down, depressed, hopeless, had little energy and had trouble concentrating. The MDS also included the resident had been administered an antidepressant medication within the past 7 days.<br>According to the behavior/intervention monthly flow record for (MONTH) 2019, the resident was receiving [MEDICATION NAME] and was being monitored for negative statements related to depression. The documentation included all zeros, which indicated the resident did not verbalize any negative statements.<br>Review of the (MONTH) 2019 Medication Administration Record (MAR) revealed that licensed staff had initialed that the [MEDICATION NAME] had been administered per physician orders.<br>Review of the clinical record including the interdisciplinary progress notes for (MONTH) 2019, revealed no evidence that the resident had voiced any negative statements related to depression. The interdisciplinary team included the physician, nursing staff, and social services staff.<br>Review of the behavior/intervention monthly flow records for (MONTH) and (MONTH) 2019 revealed the resident was being monitored for negative statements related to depression. The MAR showed that zeros were documented on each shift, which indicated the resident had not expressed any negative statements.<br>Review of the clinical record, including the interdisciplinary progress notes for (MONTH) and (MONTH) 2019 revealed no evidence that the resident had voiced any negative statements related to depression.<br>Review of the (MONTH) and (MONTH) 2019 MARs revealed that [MEDICATION NAME] had been administered daily.<br>A quarterly MDS assessment dated (MONTH) 6, 2019 included the resident was assessed to have intact cognition. The MDS also included that the only depressive symptom the resident experienced was feeling tired or having too little energy. There was no evidence of the resident feeling down, depressed, hopeless or had trouble concentrating. The MDS further documented the resident had been administered an antidepressant within the past 7 days and that a GDR had not been attempted.<br>Review of the behavior/intervention monthly flow record from (MONTH) 1 through 7, 2019 revealed to monitor the resident for negative statements. The documentation included all zeros, which indicated no negative statements were verbalized.<br>Review of the MAR dated (MONTH) 1 through 7, 2019 revealed [MEDICATION NAME] had been administered per physician orders.<br>A pharmacy review note to the attending prescriber dated (MONTH) 7, 2019 revealed documentation that the resident was currently on [MEDICATION NAME] 7.5 mg at bedtime and that there were no documented behaviors in the last 60 days. There were two recommendations listed: 1) Attempt to discontinue the [MEDICATION NAME] or 2) Continue [MEDICATION NAME] as<br>ordered, resident is clinically stable and at lowest effective dose and that a reduction attempt would likely result in resident condition decompensating. Per the note, the physician agreed with the second recommendation and the note was signed by the physician on (MONTH) 7, 2019.<br>However, there was no documentation by the physician of the clinical rationale as to why a GDR or discontinuing the medication was contraindicated.<br>Review of the behavior/intervention monthly flow records from (MONTH) 7 though 21, 2019 revealed the resident was on [MEDICATION NAME] and was being monitored for negative statements related to depression. The documentation included all zeros, which indicated no negative statements were verbalized.<br>Review of the clinical record and the interdisciplinary progress notes through (MONTH) 21, 2019 revealed no evidence that the resident had voiced any negative statements related to depression. In addition, there was no evidence the resident had displayed or expressed any statements related to feeling depressed, hopeless, changes in mood, crying or changes in appetite or sleeping.<br>Review of the MAR from (MONTH) |
| F 0812<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.**<br><br>Based on facility documentation, observations, staff interviews, and policy review, the facility failed to ensure that refrigerator temperatures were consistently monitored, sanitizing solution strength was consistently monitored, and that all dietary employees wore hair restraints while in the kitchen. The deficient practice could result in unsafe food temperatures and food contamination placing residents at risk for foodborne illnesses.<br>Findings include:<br>Regarding refrigerator temperatures and sanitizer monitoring:<br>The equipment temperature logs for walk-in refrigerator #3 were reviewed for (MONTH) through (MONTH) 7, 2019. The temperature was not recorded on (MONTH) 28, 29, and 30. The equipment temperature log included that the temperature is to be recorded twice a day.<br>Review of the equipment temperature logs for two walk-in refrigerators (titled #1 and #2) and three freezers (titled #1, #2, and #3) from (MONTH) through (MONTH) 7, 2019 revealed the temperature is to be recorded twice per day. There were no temperatures recorded for (MONTH) 28, 29, and 30, 2019 and (MONTH) 6 and 7, 2019.<br>The sanitizing solution strength logs were reviewed for (MONTH) through (MONTH) 7, 2019. The sections for initials and ppm (parts per million) both contained initials and not the ppm for the AM and PM on (MONTH) 1- 5, 2019. No initials or ppm were documented on (MONTH) 6 or 7, 2019.<br>An observation was conducted of the kitchen on (MONTH) 7, 2019 at 8:30 a.m. No thermometer was observed in the dairy walk-in refrigerator (refrigerator #3).<br>An interview was conducted with the Dietary Director (staff #136) on (MONTH) 7, 2019 at 8:40 a.m. He stated that the normal process in the kitchen is to check the temperatures of all refrigerators and freezers twice a day, in the morning and in the evening. Staff #136 stated the logs were not completed over the weekend. He stated that he did not know why the staff completing the sanitizer solution log were documenting their initials instead of documenting the ppm of the solution.<br>An interview was conducted with the Registered Dietitian (RD/ staff #70) on (MONTH) 10, 2019 at 10:55 a.m. Staff #70 stated that she only knows of one freezer, and is not sure why there are logs for 3 freezers. She also stated there are three walk in refrigerators, and refrigerator #3 is the dairy refrigerator. Staff #70 stated she did not know why there were gaps in the (MONTH) and October's temperature logs.<br>The facility's policy regarding cold storage temperatures revised (MONTH) 2019, revealed temperatures of food storage areas and cold food vendors are monitored and action is taken to maintain temperatures within ranges recommended by licensing and surveying agencies. Each refrigerated storage unit shall have an independent thermometer in addition to the built-in thermometer. Each morning at opening and evening at closing, record temperatures of each storage unit, initial each entry, and circle any deviant readings.<br>Review of the facility's policy regarding sanitizing food contact surfaces revised (MONTH) 2019 revealed each work area shall be equipped with sanitizing solution. Moist cloths used for wiping food spills shall be clean and rinsed frequently in a sanitizing solution used for no other purpose. Moist cloths and sanitizing solution used for wiping food spills at stations handling raw animal products shall not be used for any other purpose. Sanitizer solution must be at 200 ppm to 400 ppm. Complete Sanitizer Solution Concentration Log once a day.<br>Regarding hair restraints:<br>An observation was conducted in the kitchen at 10:45 a.m. on 10/10/19. Three cooks were observed to have facial hair, one of which had a full beard with hair that was longer than one inch. The other two had shorter goatee style beards. Two of the cooks, including the one with the full beard, were in the preparation area and were involved in preparing food for the lunch meal. The other one was in the food preparation area, but was not actively preparing food at the time of the observation. None of the cooks had a beard restraint on.<br>During an interview conducted with the RD (staff #70) at 10:55 a.m. on 10/10/19, she said that the facility does have beard restraints for the staff who have beards and that they normally would have them on when working in the kitchen.<br>Review of the facility's uniform dress code policy revealed facial hair must be kept neatly trimmed. The policy included that associates working with food must wear the approved hair restraint when on duty and that facial hair must be |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **035176** | A. BUILDING _____ B. WING _____ | **10/10/2019** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **BEATITUDES CAMPUS** | **1712 WEST GLENDALE AVENUE PHOENIX, AZ 85021** |

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 0812<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | (continued... from page 14)<br>effectively restrained as per local and state regulations. |
| F 0880<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **Provide and implement an infection prevention and control program.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, staff interviews, and policy review, the facility failed to ensure infection control practices were followed during medication administration. The deficient practice could result in the cross contamination, spreading infections to others.<br>Findings include:<br>During a medication administration observation conducted on (MONTH) 9, 2019 at 8:09 a.m., a Licensed Practical Nurse (LPN/staff #40) was observed to remove a [MEDICATION NAME] (antihypertensive) 25 milligrams (mg) tablet from a bottle and place it in a medication cup. Staff #40 stated the physician's orders [REDACTED]. The LPN was observed to pick up the medication with her bare hands, remove it from the medication cup, and place it on the top of the medication cart. Staff #40 then went to get a knife to cut the medication in half. When the LPN returned to the medication cart, she donned gloves before touching the medication. At 8:14 a.m., the LPN administered the medication to the resident.<br>An interview was conducted with LPN on (MONTH) 9, 2019 at 2:15 p.m. Staff #40 stated that she knows she should wear gloves and not touch any medication with her bare hands. The LPN stated that placing a medication on top of the medication cart is an infection control issue because the top of the medication cart is dirty.<br>The facility's policy regarding infection control revealed standard and transmission based precautions are to be followed to prevent the spread of infections which includes preparation, administration, and care of medications.<br>Review of the facility's policy regarding medication administration revised (MONTH) (YEAR), revealed that medications are administered in a manner consistent with good infection control and standards of practice. The policy included that if breaking tablets is necessary to administer the proper dose, hands are washed with soap and water or alcohol gel prior to the handling of the tablets. |