DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **035070**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **06/27/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CASAS ADOBES POST ACUTE REHAB CENTER	**1919 WEST MEDICAL STREET TUCSON, AZ 85704**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 0658

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

Ensure services provided by the nursing facility meet professional standards of quality.
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY >
Based on clinical record review, observations, staff interviews, and review of policy, the facility failed to ensure prescribed medications were not outdated for one of four sampled residents (#35) and failed to ensure medications ordered for infection were administered as ordered for one of two sampled residents (#2). The deficient practice could result in residents receiving expired medications and delays in treatment for [REDACTED].
Findings include:
-Resident #35 was readmitted to the facility on (MONTH) 30, 2019 with a [DIAGNOSES REDACTED].
A review of the physician orders [REDACTED].
During a medication administration observation conducted on (MONTH) 25, 2019 at 8:25 a.m., a Licensed Practical Nurse (LPN/staff #99) was observed to remove two [MEDICATION NAME] 10 mg from a box that was stored in the medication cart and placed the two capsules in a medication cup to be administered to resident #35.
However, upon further inspection of the box of [MEDICATION NAME], it was observed to have an expiration date of (MONTH) 2019.
As staff #99 was entering the room of resident #35, the LPN stated that he was going to administer the [MEDICATION NAME] to the resident. When asked to look at the expiration date, he stated the expiration date was (MONTH) 2019 and that since the medication was expired, he could not administer it to the resident. The LPN stated that it is the responsibility of the nurses to check the medication carts to ensure there are no expired medications.
An interview was conducted with the Director of Nursing (DON/staff #151) on (MONTH) 27, 2019 at 10:42 a.m. The DON stated that all nurses are to check the medication carts and remove any medications that have expired. Staff #151 also stated that it was standard nursing practice to not administer expired medications.
The facility's policy regarding Medication Storage revealed outdated medications are removed from stock, disposed of, and reordered from the pharmacy if a current order exists.
-Resident #2 was admitted on (MONTH) 25, (YEAR) with [DIAGNOSES REDACTED].
A nurse note dated (MONTH) 10, 2019 at 3:30 p.m. included that resident #2 had an inflamed follicle on the buttock and the health provider had been notified. The note included medication as ordered.
A physician's orders [REDACTED].
A written care plan initiated (MONTH) 10, 2019 for follicle included administering antibiotic(s) as per physician orders [REDACTED]. The care plan also included to monitor for effectiveness and adverse reaction to antibiotic therapy.
A skin ulcer non-pressure weekly assessment dated (MONTH) 11, 2019 included that resident #2 had an inflamed hair follicle to the left buttock that measured 2.0 cm (centimeters) by 2.0 cm and was indurate (raised) greater than 2.0 cm. The assessment included that the nurse had spoken with the healthcare provider and IV antibiotics had been ordered.
Review of the MAR (Medication Administration Record) for resident #2 revealed spaces to document the administration of [MEDICATION NAME] 750 mg IV.
However, further review of the MAR indicated [REDACTED]. Review of the clinical record did not reveal any additional information regarding whether or not resident #2 had received [MEDICATION NAME] IV while at [MEDICAL TREATMENT] on (MONTH)
12 and (MONTH) 14, 2019.
A nurse note dated (MONTH) 14, 2019 at 3:30 p.m. included that resident #2 had an open area on the left buttock that measured approximately 1/4 inches in size and was found to have purulent drainage.
An annual MDS (Minimum Data Set) assessment dated (MONTH) 16, 2019 included that resident #2 had a BIMS (Brief Interview for Mental Status) score of 15, which indicated that the resident was cognitively intact. The assessment included that resident #2 was provided with application of non-surgical dressings and applications of ointments.
Review of the MAR indicated [REDACTED].
An E-MAR Medication Administration Note dated (MONTH) 17, 2019 included that the resident had refused to go to [MEDICAL TREATMENT] and the physician had been notified.
A nurse note dated (MONTH) 17, 2019 included that the infected follicle on the left buttock had opened and measured 0.5 cm. by 0.5 cm. The note included that the nurse had spoken to a staff at the [MEDICAL TREATMENT] center regarding whether or not resident #2 had been started on IV antibiotics and had been provided a phone number to speak with the physician at the center. However, there was no additional information included in the nurses note, or anywhere in the clinical record that the nurse had contacted the physician at the [MEDICAL TREATMENT] center, or if the antibiotic medications had been provided at the [MEDICAL TREATMENT] center.
Review of the MAR indicated [REDACTED].
Review of E-MAR Medication Administration Notes dated (MONTH) 19, 2019 at 6:37 a.m. included that resident #2 had refused to go to [MEDICAL TREATMENT], and an E-MAR note at 2:43 p.m. included that the [MEDICAL TREATMENT] center had contacted the
facility and that the resident had not received the antibiotic medication because the medication needed to be verified by the resident's nephrologist.
Continued review of the clinical record did not reveal any additional documented information the resident's attending physician had been notified that the resident had missed multiple doses of [MEDICATION NAME].
A nurse note dated (MONTH) 21, 2019 at 11:25 included that the nurse had phoned the [MEDICAL TREATMENT] center and confirmed that resident #2 had been provided with the first dose of [MEDICATION NAME].
During an interview conducted on (MONTH) 26, 2109 at 10:45 a.m. with the ADON (Assistant Director of Nursing/staff #21), the ADON stated that when a physician's orders [REDACTED]. Staff #21 stated the medication can only be given during the [MEDICAL TREATMENT] treatment because of the potential for toxicity. The ADON stated that upon return of the resident to the facility, the [MEDICAL TREATMENT] center is supposed to provide a note that would include whether or not the resident had been provided with [MEDICATION NAME] during the [MEDICAL TREATMENT] treatment. The ADON stated that if the center
failed to provide a note, the nurse should call the center to verify of the resident had received [MEDICATION NAME].
During an interview conducted on (MONTH) 26, 2019 at 11:10 a.m. with the Director of Nursing (DON/staff #151), the DON stated that the [MEDICAL TREATMENT] center is supposed to send a paper with the resident that would include if the resident had received [MEDICATION NAME] IV. The DON stated that on (MONTH) 12 and 14, 2019, the nurse should have verified whether or not the resident had received [MEDICATION NAME] and noted it on the MAR. Staff #151 stated that if the resident did not receive the [MEDICATION NAME], the nurse should have notified the physician and documented the notification when the resident missed the first dose.
The facility's policy and procedure titled Administration of Drugs included a statement that it is the policy of the facility that medications shall be administered as prescribed by the attending physician. The policy included that if a medication is withheld, refused, or given other than at the scheduled time, the documentation will be reflected in the

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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