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 0561 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interviews, clinical record review, and review of policy, the facility failed to ensure one sampled resident (#3) had the right to make a choice related to the placement of a video camera in her room. The deficient practice could result in residents not having the choice about aspects of their life in the facility that are significant to them. Findings include: Resident #3 was readmitted to the facility on (MONTH) 22, (YEAR), with [DIAGNOSES REDACTED]. A review of the quarterly Minimum Data Set assessments dated (MONTH) 20, 2019 and (MONTH) 17, 2019 revealed the Brief Interview for Mental Status score was 15, which indicated no cognitive impairment. Review of the current care plan revealed the resident was at risk for activities of daily living self-care performance deficit related to immobility and impaired balance. Interventions included for staff to assist with all activities of daily living as needed and to encourage the resident to use the bell to call for assistance. A review of the clinical record revealed a care plan review form dated (MONTH) 19, 2019. Signatures on the form included the resident, social services, a Registered Nurse, dietary and activities staff, and a Certified Nursing Assistant (CNA).The form included the medication list and the care plan summary was reviewed and discussed among the interdisciplinary members and the resident and included additional notes that a room change was discussed which the resident declined. A review of the clinical record from (MONTH) 19 through (MONTH) 16, 2019 revealed no evidence of communication between the resident and staff regarding concerns related to the placement of a video camera in her room. An interview was conducted with resident #3 on (MONTH) 27, 2019 at 11:50 a.m. She stated there is a video camera in her room and she does not like it. The resident stated a family member of her roommate requested a video camera and that a camera was placed in an area near the roommate's bed. The resident stated she could not remember how long the camera had been in the room. She stated that it was an invasion of her privacy. The resident also stated she is not sure if there is both video and audio on the camera. The resident further stated the staff never asked her about placing the camera in the room and that if they had, she would have said she does not like the camera and would have said no. She stated she has told the social worker, the Administrator, and an Assistant Director of Nursing (ADON) that she does not like or want the video camera in her room. She further stated she was told by all of the staff there was nothing they could do other than move her. She stated she repeatedly told the staff she does not want to move and thinks it would be wrong to make her move just because she does not like or want the video camera. During the resident interview the resident invited the ADON (staff #52) to join the interview. Staff #52 stated he was aware of the resident's concerns regarding the video camera. Staff #52 stated there are signs posted at the entry of the room to indicate a video camera is in use. He stated he told resident #3 the camera was only used for the roommate. The resident then asked staff #52 why she could be forced to move and not the roommate. Staff #52 stated the staff are working on moving her to a different room. The resident told him she wanted to stay in her room and have the roommate move. An interview was conducted with the Director of Social Services (DSS/staff #137) on (MONTH) 27, 2019 at 12:04 p.m. She stated that she thought the camera was installed in the room of resident #3 in (MONTH) 2019. She stated the camera is in the area of the roommate. The DSS stated resident #3 was offered a room change but that she does not want to move as she is very comfortable in her current room. Staff #137 stated there is a posting by the doorway of the room and also a posting by the front door of the facility. She stated everyone entering the facility or the resident's room, needs to know about the video camera due to HIPPA (Health Insurance Portability and Accountability Act), privacy, and dignity issues. The DSS stated the Director of Nursing and Administrator is aware of the resident's concerns regarding the camera and have talked with her about it. Staff #137 stated to her knowledge, there is no documentation in the clinical record regarding the ongoing communication camera concerns with resident #3 and the staff. Staff #137 stated she does not know for sure when the camera was actually placed in the resident's room as nothing is documented, including any concerns voiced from resident #3.An interview was conducted with the Director of Nursing (staff #151) and the Administrator (staff #152) on (MONTH) 27, 2019 at 12:15 p.m. Staff #151 stated several months ago she was told resident #3 stated there was no problem with the video camera in her room. Staff #151 stated even though it was not a problem, resident #3 was offered a new room and declined. Staff #151 stated the facility legal team was contacted and stated the camera placement could not be forbidden and that it would not affect HIPPA or privacy. Staff #151 stated she was aware resident #3 changed her mind about wanting and then not wanting to change rooms. Staff #151 stated residents have the right to make choices about their rights and room changes. Staff #152 stated that they do not have a policy regarding the use of video cameras because their legal team told him it was not necessary. Staff #152 stated it is very important to honor resident rights and their ability to make their own choices in their day to day life. The facility's policy regarding resident rights revealed a resident has the right to receive treatment that supports and respects the resident's individuality, choices, strengths, and abilities and to participate in the development or decisions concerning treatment.
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

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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NAME OF PROVIDER OF SUPPLIER **CASAS ADOBES POST ACUTE REHAB CENTER**		STREET ADDRESS, CITY, STATE, ZIP **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

(continued... from page 1)
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 clinical record.

F 0686

Level of harm - Actual harm

Residents Affected - Few

Provide appropriate pressure ulcer care and prevent new ulcers from developing.
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on clinical record review, observation, staff interviews, and review of policy and procedures, the facility failed to ensure one out of three sampled residents (#51) with a pressure ulcer received care consistent with professional standards of practice to prevent the development of an unstageable pressure ulcer and consistently received necessary treatment and services consistent with professional standards of practice. The deficient practice could result in the development and worsening of pressure ulcers.
Findings include:
Resident #51 was admitted to the facility on (MONTH) 8, 2014, with [DIAGNOSES REDACTED].
Review of a quarterly Minimum Data Set (MDS) assessment dated (MONTH) 10, 2019 revealed the Brief Interview for Mental Status (BIMS) assessment could not be completed, as the resident was rarely/never understood and the resident was severely impaired with cognitive skills for daily decision making. The assessment included the resident required extensive assistance with bed mobility and was totally dependent on staff for transfer, toilet use, and personal hygiene. The MDS assessment also included the resident was at risk for the development of pressure ulcers but did not have any pressure ulcers, had a pressure reducing device for the bed but not for the chair, and was not on a turning/repositioning program.
A physician's orders [REDACTED].
Additional review of the clinical record revealed the resident had previously received treatment for [REDACTED].
Review of the current care plan initiated (MONTH) 6, (YEAR), revealed the resident was actual for pressure ulcer development related to immobility. The goal was for the resident to have intact skin, free of redness, blisters or discoloration by/through review target date of (MONTH) 31, 2019. Interventions included to administer treatments as ordered and monitor for effectiveness, to encourage fluid intake and assist to keep skin hydrated, Low Air Loss (LAL) mattress, and a weekly head to toe skin at risk assessment.
Continued review of the current care plan revealed the resident was at risk for skin breakdown related to impaired mobility, 2/2 right-sided paralysis, and bowel and bladder incontinence. The goal was the resident will not have any skin breakdown through the next review target date of (MONTH) 31, 2019. Interventions included weekly skin assessments, reporting any red and/or open areas, pressure relieving mattress on the bed and pressure relieving device in wheelchair, and providing incontinence care following each incontinent episode.
The Braden Scale for Predicting Pressure Sore Risk forms dated (MONTH) 23 and 30, 2019 revealed a score of 9.0, indicating the resident was at very high risk. Some of the factors that contributed to the score included the resident's ability to respond meaningfully to pressure related discomfort was very limited; was only able to respond to painful stimuli and could not communicate discomfort, except by moaning or restlessness. Also included was that the resident was chairfast,

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F 0686

Level of harm - Actual harm

Residents Affected - Few

(continued... from page 2)
completely immobile, and that friction and shear were considered a problem as the resident required moderate to maximum assistance moving and complete lifting without sliding against the sheets was deemed impossible.
Review of the Treatment Administration Record (TAR) for (MONTH) 2019 revealed the weekly skin assessments were done.
Review of the physician's orders [REDACTED].
A Weekly Skin Evaluation dated (MONTH) 3, 2019 revealed no documentation of ulcers, wounds, or other skin problems. The evaluation included that there were no new skin issues noted at that time.
A nursing progress note dated (MONTH) 4, 2019 revealed a Certified Nursing Assistant (CNA) reported to the nurse resident #51's back was bleeding. The note included there was redness noted to the back, mostly the mid-back, with a wound noted to the site. The note also included the wound was cleaned and covered with a foam dressing and that an order for [REDACTED].
A physician's orders [REDACTED].
Review of the Weekly Skin Evaluation dated (MONTH) 4, 2019 revealed redness was noted to the back and a wound to the mid back and that wound care was to evaluate and treat.
Another physician's orders [REDACTED].
Review of the TAR for (MONTH) 2019 revealed monitoring for the LALM began on (MONTH) 7.
A physician's orders [REDACTED].
A Skin Pressure Ulcer Weekly form dated (MONTH) 8, 2019 revealed for an initial evaluation of the unstageable upper mid back wound. The wound measured 3.6 centimeters (cm) x 4.2 cm, had scant amount of serous drainage, and no odor. The wound bed was described as black/brown (eschar), edges of the wound were defined, and there was peripheral tissue [MEDICAL CONDITION]. The wound was cleansed with normal saline, pat dry, covered with therahoney, and covered with a foam dressing. Also documented was that the resident experienced non-verbal signs of pain that included grimacing, moaning/crying, guarding, irritability, anger, and being tense. Additional comments included orders would be changed to a LALM, staff would use wedges to rotate the resident every 2 hours, physical therapy and occupational therapy would be informed to take a look at the wheelchair, the registered dietician would be informed if any changes of nutrients were needed, and the resident's family would be informed.
A nursing progress note dated (MONTH) 8, 2019, revealed the resident's family was notified of the wound.
A Dietary Quarterly Evaluation dated (MONTH) 10, 2019, revealed the registered dietician had been informed of the pressure ulcer.
However, review of the clinical record revealed no documentation that care was provided for the pressure ulcer between (MONTH) 4 and 8, 2019 and no documentation that the resident was administered pain medication prior to the wound treatment on (MONTH) 8, 2019.
The quarterly MDS assessment dated (MONTH) 10, 2019 revealed the resident could not be assessed for the BIMS due to the resident rarely/never being understood. The assessment included the resident had one unstageable pressure ulcer, was receiving pressure ulcer care, had moisture associated skin damage, was not on a turning/repositioning program, had a pressure-reducing device for the bed, but no pressure reducing device for the chair. The assessment also included the resident required extensive assistance for activities of daily living.
A physician's orders [REDACTED].
A Skin Pressure Ulcer Weekly form dated (MONTH) 16, 2019 revealed the wound was unstageable and measured 3.6 cm x 4.2 cm x UTD (unable to determine depth), had scant amount of serous exudate, and no odor. The wound bed had black/brown eschar, defined wound edges, and peripheral tissue [MEDICAL CONDITION]. The treatment was provided and the resident showed signs of pain when turning and cleaning the wound of grimacing, moaning/crying, guarding, anger, and hitting.
A nursing progress note dated (MONTH) 27, 2019 revealed the unstageable pressure ulcer treatment had been provided by the wound nurse.
The Skin Pressure Ulcer Weekly form dated (MONTH) 31, 2019 revealed the unstageable pressure ulcer measured 3.6 cm x 4.2 cm, had scant amount of serous exudate, and no odor. The form included slough to the wound bed, defined wound edges, and normal surrounding tissue. The form included the treatment was provided and that the resident continued to show signs of pain when turning and cleaning the wound of grimacing, moaning/crying, and guarding.
Review of the clinical record did not reveal documentation the resident was administered pain medication prior to the wound treatments on (MONTH) 16 and 31, 2019.
Further review of the clinical record did not reveal a Skin Pressure Ulcer Weekly form or documentation that the wound was assessed for the week between (MONTH) 16 and (MONTH) 31, 2019.
A Skin Pressure Ulcer Weekly form dated (MONTH) 7, 2019 revealed the unstageable pressure ulcer measured 3.6 cm x 4.2 cm, had scant amount of serous exudate, and no odor. The documentation included the wound bed had black/brown eschar, defined wound edges, and normal surrounding tissue. Additional comments included the resident showed signs of pain when turning and cleaning the wound. Also included was that if there are no changes to the wound bed, the family will be asked if another product can be used.
A Skin Pressure Ulcer Weekly form dated (MONTH) 14, 2019 revealed the unstageable pressure ulcer measured 3.4 cm x 4.0 cm, had scant amount of serous exudate, and no odor. The wound bed had black/brown eschar, defined wound edges, and normal surrounding tissue. Additional comments included slough was beginning to separate and that the resident showed signs of pain when turning and cleaning the wound.
A Skin Pressure Ulcer Weekly form dated (MONTH) 21, 2019 revealed the unstageable pressure ulcer measured 3.6 cm x 4.2 cm, had scant amount of serous exudate, and no odor. The wound bed had slough, defined wound edges, and the surrounding tissue was normal. Comments included slough is continuing to separate, the periwound area has signs of [DIAGNOSES REDACTED], and there is no signs or symptoms of infection. The documentation also included the resident continued to show signs of pain when turning and cleaning the wound of grimacing, moaning/crying, and guarding.
Additional review of the clinical record revealed no documentation the resident was provided with pain medication prior to the wound treatments for (MONTH) 7, 14, and 21, 2019.
Further review of the clinical record revealed no evidence that the pressure ulcer treatment was consistently provided as ordered every Monday, Wednesday, and Friday on the day shifts for (MONTH) and (MONTH) 2019.
An observation was conducted of the pressure ulcer treatment on (MONTH) 26, 2019 at 7:37 AM with a Licensed Practical Nurse (LPN/staff #149) who stated she was a certified wound nurse. A CNA (staff #145) assisted the LPN by turning and holding the resident. As they rolled the resident onto her side, the resident began crying out and was slapping at staff #145. The wound nurse washed her hands, donned clean gloves, and began to remove the old dressing. As the wound nurse was removing the old dressing, she identified the black/brown substance, which was partially attached to the old dressing as eschar. As the old dressing was being removed, the eschar began tearing away from the wound bed, without fully detaching. During this time, the resident squirmed and cried out during the treatment, as staff #145 continued to hold her at the hip and hands. The nurse changed gloves and cleansed the area with normal saline. Resident #51 cried out again and squirmed against the hold of staff #145. The nurse measured the wound and stated it measured 2.6 cm x 1.6 cm. The nurse then changed gloves and applied therahoney and a foam dressing to the wound. The resident moaned and slapped at the CN[NAME]
During the observation, staff #149 stated that the pressure ulcer developed in the facility. She said the resident had been sleeping on a regular mattress, which contributed to the development of the pressure ulcer. The LPN also stated the wheelchair the resident was using contributed to the skin breakdown. She stated that the wound has decreased in size because it is healing. The wound nurse also stated that the resident was not administered pain medication prior to the treatment.
An interview was conducted on (MONTH) 26, 2019 at 7:42 AM with the CNA (staff #145). The CNA stated that she is very familiar with resident #51. She stated that part of the resident's daily care is to ensure the resident is clean and dry, and repositioned at least every 2 hours.
An interview was conducted on (MONTH) 26, 2019 at 12:36 PM with a LPN (staff #17). She stated that if she were providing treatment care to a resident who was experiencing pain, she would stop the treatment and administer pain medication. She said that it is never ok for the resident to be in pain during the treatment process.
During an interview conducted on (MONTH) 26, 2019 at 12:56 PM with the Director of Nursing (DON/staff #151), the DON agreed that if the resident was crying out in pain during treatment, it would be acceptable to stop the treatment, administer [MEDICATION NAME], and resume the treatment in a 1/2 hour.
On (MONTH) 27, 2019 at 10:15 AM, an interview was conducted with a CNA (staff #145). Staff #145 stated that she works with

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

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F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 3) resident #51 on a regular basis, and has become very familiar with the resident's responses. She stated that she definitely believed the resident was in pain during her treatment. She said that resident #51 reacted per her norm at first, but during the removal of the dressing, cleaning of the wound, and application of therahoney, the resident reacted as if she were in pain. Another interview was conducted on (MONTH) 27, 2019 at 12:14 PM with the certified wound nurse, staff #149. She stated the criteria for obtaining a physician's orders [REDACTED]. The wound nurse stated that resident #51 had a regular mattress when she started working at the facility approximately 3 months ago. She said she was informed of the redness on the resident's back on (MONTH) 4, 2019 and thought it might be from shearing. The LPN stated that she was not sure it was a pressure ulcer because the wound had not opened. She stated that on (MONTH) 4, 2019 she texted the provider, as that was a customary method of communication between them. She said she wanted to talk with the provider before putting a LALM on the resident's bed as the LALM could put the resident at risk for falling. She stated that the provider did not get back to her until (MONTH) 7, 2019. The wound nurse stated that at that time she obtained an order for [REDACTED].>On (MONTH) 27, 2019 at 1:18 PM, an interview was conducted with the Assistant Director of Nursing (ADON/ staff #52). He stated that if he was unable to contact the attending physician, his process for obtaining an order would include calling the Nurse Practitioner, Team Health (an on-call service), or the Medical Director. The ADON stated that if he needed a physician's orders [REDACTED]. On (MONTH) 27, 2019 at 1:46 PM, another interview was conducted with the DON (staff #151). The DON stated that if an unstageable pressure ulcer was found on a resident, she would expect nursing to contact the physician and notify the wound nurse to do an evaluation. She stated that a LALM is not always necessary, that it depends on the location of the injury and the mobility of the resident. In regard to resident #51, she stated that the wound nurse received a telephone call at home on a Saturday regarding the injury. She stated that after the floor nurse described the injury to the wound nurse, they thought it might be a friction injury. The DON stated that the wound nurse directed the floor nurse to apply a foam dressing to the site, and that it would be good for 5 days. The DON stated that when the wound nurse reported to work on (MONTH) 7th, she assessed the injury to be a pressure ulcer and put the appropriate treatment into place, including the LALM. The facility's policy titled Wound Management stated it is the policy of the facility that a resident who enters the facility without pressure ulcers does not develop pressure ulcers unless clinically unavoidable. The policy included care and services are provided to promote the prevention of pressure ulcer development, promote the healing of pressure ulcers that are present, and to prevent the development of additional, avoidable pressure ulcers. The policy also revealed the nurse is responsible for assessing and evaluating the resident's condition and is expected to take actions which include completing a weekly head to toe skin assessment with follow up as applicable. The policy included that once a wound has been identified, assessed, and documented, the nurses shall administer treatment to each affected area per the physician's orders [REDACTED]. The policy stated that in order to prevent the development of skin breakdown, the following approaches shall be implemented as appropriate: Reposition the resident. Use pressure relieving/reducing and redistributing devices (including but not limited to low air mattresses, wedges, pillows, etc.). Use transfer techniques which minimize friction and skin tears/shears as applicable (mechanical lift). If the resident is incontinent, make sure his/her skin remains clean and dry with regular pericare and toileting when appropriate. The facility's policy regarding Pain Management revealed residents will be assessed for pain and that residents who are cognitively impaired may exhibit pain through changed behaviors. The policy stated the facility assists each resident with pain to maintain or achieve the highest practicable level of well-being and functioning by identifying circumstances when pain can be anticipated.
F 0697 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide safe, appropriate pain management for a resident who requires such services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, staff interviews, and review of policy and procedures, the facility failed to ensure that 1 of 21 sampled residents (#51) received adequate pain management. The deficient practice could result in residents having pain that may diminish their quality of life. Findings include: Resident #51 was admitted to the facility on (MONTH) 8, 2014 with [DIAGNOSES REDACTED]. Review of a quarterly Minimum Data Set (MDS) assessment dated (MONTH) 10, 2019 revealed the Brief Interview for Mental Status (BIMS) assessment could not be completed, as the resident was rarely/never understood and the resident was severely impaired with cognitive skills for daily decision making. In Section J, the documentation included the resident was on a scheduled pain medication regimen, was not on PRN pain meds and non-medication interventions for pain were not in place. Under staff assessment for pain, the documentation included the resident exhibited nonverbal sounds (crying, whining, gasping, moaning or groaning) and indicators of pain were present on 3-4 days during the last 5 days of the look back period. A Braden Scale for Predicting Pressure Sore Risk dated (MONTH) 30, 2019 revealed a score of 9.0, indicating the resident was at very high risk. Some of the factors that contributed to the score included the resident's ability to respond meaningfully to pressure related discomfort was very limited; was only able to respond to painful stimuli and could not communicate discomfort, except by moaning or restlessness. Review of the physician orders [REDACTED]. The order had an original order date of (MONTH) 12, (YEAR). The orders also included to monitor the resident's pain level every shift using the following pain scale: 0=no pain; 1-3=mild pain; 4-6=moderate pain and 7-10=severe pain. Another physician's orders [REDACTED]. Review of the (MONTH) 2019 Medication Administration Record [REDACTED]. In addition, the documentation showed the resident's pain level was assessed every shift and was generally at 0-1. At times, the resident's pain level was assessed as follows: on (MONTH) 13, the resident's pain level was documented as a 6 on two separate shifts; on (MONTH) 14, the resident's pain level was documented as a 6 on two separate shifts; and on (MONTH) 29, the resident's pain level was a 6. Further review of the (MONTH) 2019 MAR indicated [REDACTED]. A pain care plan dated (MONTH) 2, 2019 included a goal for the resident to verbalize adequate pain relief or ability to cope with incompletely relieved pain through the review date. Interventions included to administer [MEDICATION NAME] medication as ordered, anticipate need for pain relief and respond immediately to any complaint of pain, follow pain scale to medicate as ordered and notify the physician if interventions were unsuccessful or if the current complaint was a significant change from the resident's past experience of pain. A physician's orders [REDACTED]. Cleanse with normal saline, pat dry, apply therahoney and cover with a foam dressing every Monday, Wednesday, and Friday and PRN for an unstageable pressure injury. A Skin Pressure Ulcer Weekly summary completed by the wound nurse dated (MONTH) 8, 2019 revealed the resident had an unstageable pressure injury to the vertebral, [MEDICATION NAME] area of the back which measured 3.6 cm x 4.2 cm x UTD (unable to determined depth), and the periwound area had signs of [DIAGNOSES REDACTED], but no symptoms of infection. The summary included that wound care was provided and that the resident showed signs of pain, when turning and cleansing the wound. The documentation also included the resident experienced pain related to the wound, as evidenced by grimacing, moaning/crying, guarding, irritability, anger and by being tense. Although there was documentation by the wound nurse that the resident was experiencing pain during the wound treatment, there was no clinical record documentation that the resident was administered PRN [MEDICATION NAME], prior to the wound treatment on (MONTH) 8. A quarterly MDS assessment dated (MONTH) 10, 2019 included the resident was rarely/never understood. Section J revealed the resident had pain indicated by non-verbal sounds such as; crying, whining, gasping, moaning or groaning. The MDS included that non-verbal indicators of pain were observed on 3-4 days out of 5 during the look back period. A Skin Pressure Ulcer Weekly summary dated (MONTH) 16, 2019 revealed that wound care was provided and that the resident showed signs of pain when turning and cleansing the wound; as evidenced by grimacing, moaning/crying, guarding, anger and hitting. A Skin Pressure Ulcer Weekly summary dated (MONTH) 31, 2019 revealed that wound care was provided and that the resident showed signs of pain when turning and cleansing the wound. The summary included the resident was unable to communicate pain

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NAME OF PROVIDER OF SUPPLIER **CASAS ADOBES POST ACUTE REHAB CENTER**	STREET ADDRESS, CITY, STATE, ZIP **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 0697

Level of harm - Actual harm

Residents Affected - Few

(continued... from page 4)
related to the wound, however, non-verbal demonstrations of pain were documented as; grimacing, moaning/crying and guarding.Despite documentation by the wound nurse that the resident was experiencing pain during the wound treatments, there was no
clinical record documentation that the resident was administered PRN [MEDICATION NAME], prior to the wound treatments on (MONTH) 16 and 31.
Further review of the (MONTH) 2019 MAR indicated [REDACTED]. The documentation also showed that the resident's pain was being assessed every shift and was generally rated at 0-1 on a 1-10 pain scale. However, on the following dates the resident's pain level was assessed as follows: on (MONTH) 13 for a pain level of 6; on (MONTH) 15 for a pain level of 7; and on (MONTH) 25 for a pain level of 5. However, further review revealed no documentation that PRN [MEDICATION NAME] was
administered at any time during the month.
A Skin Pressure Ulcer Weekly summary dated (MONTH) 7, 2019 revealed that wound care was provided and that the resident showed signs of pain when turning and cleansing the wound.
A Pressure Ulcer Weekly summary dated (MONTH) 14, 2019 revealed wound care was provided as ordered and that the resident showed signs of pain when turning and cleansing the wound.
A Pressure Ulcer Weekly summary dated (MONTH) 21, 2019 revealed that wound care was provided as ordered by the physician. The documentation included the resident was noted with an unstageable pressure injury to the [MEDICATION NAME] area of the back, which measured 3.6 cm x 4.2 cm x UTD and that slough was continuing to separate, the periwound area had signs of [DIAGNOSES REDACTED], and there were no signs or symptoms of infection. Per the summary, the resident showed signs of pain when turning and cleansing the wound, as evidenced by grimacing, moaning/crying and guarding.
Again, there was no clinical record documentation that the resident was administered PRN [MEDICATION NAME], prior to the wound treatments on (MONTH) 7, 14, and 21, despite documentation that the resident was in pain.
An observation of a pressure ulcer treatment for [REDACTED].#149), who stated that she was a certified wound nurse. The resident was observed in bed and as she was approached by a CNA (staff #145), she grimaced and held tightly to the blanket on her bed. When staff #145 touched the resident, she began guarding and hitting at staff #145. At this time, staff #145 assisted the wound nurse in rolling the resident onto her side. As this was being done, the resident began crying out and was slapping at staff #145. Staff #145 held the resident's hip with one hand, and restrained the resident's hands with the other. Staff #149 then donned clean gloves and began to remove the old dressing. Resident #51 cried out loudly as the old dressing was removed. As the wound nurse was removing the old dressing, she identified the black/brown substance, which was partially attached to the old dressing as eschar. As the old dressing was being removed, the eschar began tearing away from the wound bed, without fully detaching. During this time, the resident squirmed and cried out during the treatment, as staff #145 continued to hold her at the hip and hands. However, the nurse did not stop the treatment to assess the resident's pain. The nurse then changed her gloves and cleansed the area. Resident #51 cried out again and squirmed against the hold of staff #145. The wound nurse measured the wound and stated it measured 2.6 cm x 1.6 cm. The nurse then changed gloves and applied therahoney to the wound. The resident moaned and slapped at the CN[NAME]
During the above observation, staff #149 stated the resident was not provided with adjuvant pain medication prior to wound care today. She stated that she usually provides wound care to the resident during the early mornings at approximately 7:00 AM. She said she changes the dressing before the CNAs get the resident up for breakfast and before medications have been administered. Staff #149 stated the resident does not receive pain medication prior to wound care because the resident's family does not want her to have it, due to their concerns about the resident becoming over-sedated. Staff #149 stated the resident cries out whenever care is provided and that it was customary behavior for her.
Review of the clinical record including the (MONTH) 2019 MAR, revealed the resident did not receive any pain medication prior to the wound treatment which was done on (MONTH) 26, 2019 at 7:37 a.m. The (MONTH) MAR indicated [REDACTED]
Continued review of the (MONTH) 2019 MAR indicated [REDACTED]. However, on the following dates the resident was observed to
have pain as follows: on (MONTH) 7 a pain level of 7; on (MONTH) 9 a pain level of 2 and 4; on (MONTH) 10 a pain level of 4 on three separate shifts. There was no indication that the resident had been administered PRN [MEDICATION NAME] during the month.
On (MONTH) 26, 2019 at 12:27 PM, an interview was conducted with the Assistant Director of Nursing (ADON/staff #52). He stated that non-verbal residents are assessed for pain through demonstrations of behaviors such as grimacing, moaning or crying. He stated that there is a pain scale in the computer that helps the nurses evaluate by grimace (Pain Aid), and that if he noticed grimacing or signs that the resident was in pain, he would consider administering pain medication. He said he would anticipate giving an adjuvant pain medication prior to therapy, wound care, treatments, or appointments.
An interview was conducted on (MONTH) 26, 2019 at 12:36 PM with a LPN (staff #17). She stated that if she were providing treatment care to a resident who was experiencing pain, she would stop the treatment and administer pain medication, or call the provider for an order, or ask to have the order changed so that it could be administered as an adjuvant. She said that it would never be ok for the resident to be in pain during the treatment process.
An interview was conducted on (MONTH) 26, 2019 at 12:56 PM with the Director of Nursing (DON/staff #151). She stated that the administration of pain medication depends on how the medication is ordered, as some are ordered on a schedule. She said that if a resident was experiencing pain with a treatment or wound care, she would anticipate the nurse would look to see if the resident had an order for [REDACTED].#51, she stated that the resident's family has insisted the resident does not receive too much pain medication, due to the sedating effects. However, she agreed that if the resident were crying out in pain during treatment, it would be acceptable to stop the treatment and administer as needed [MEDICATION NAME], and come back to resume the treatment in a 1/2 hour.
A Pain Management Review dated (MONTH) 27, 2019 revealed the resident was not interviewable. The document stated that the resident displayed crying, grimacing, moaning, grunting, and yelling out at baseline. It stated that when the resident is experiencing pain or needed a break in care related to possible discomfort, she tapped her fist or open palm repeatedly on the nearest surface to indicate that there may be an issue or discomfort. The note stated that interventions included, but were not limited to, taking a break from care, repositioning, calming speech, distraction, tv, and offering as needed medication.
On (MONTH) 27, 2019 at 10:15 AM, an interview was conducted with a CNA (staff #145). She stated that while she provides care to residents, she definitely monitors for pain or changes in behaviors. She stated that she feels any type of pain is concerning. If a resident was non-verbal, she said she would watch for facial expressions and reactions to care. She said that if the resident always reacts to treatment as if they were in pain, she would pay attention to a more intense reaction. Staff #145 stated that she works with resident #51 on a regular basis, and has become very familiar with the resident's responses. She stated that she definitely believed the resident was in pain during her treatment. She said that resident #51 reacted per her norm at first, but during the removal of the dressing, cleaning of the wound, and application of therahoney, the resident reacted as if she were in pain.
The facility's policy titled Pain Management stated it is the policy of the facility to provide an environment and programs that assist each resident to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Residents are provided and receive the care and services needed according to established practice guidelines. Resident pain is assessed and managed by an interdisciplinary team who work together to achieve the highest practicable outcome. Additionally, the policy stated the facility assists each resident with pain to maintain or achieve the highest practicable level of well-being and functioning by screening to determine if the resident has been or is experiencing pain, comprehensively assessing the pain, and identifying circumstances when pain can be anticipated. The policy also stated that residents will be assessed for pain upon development of new symptoms of acute or chronic pain that have not previously been assessed, and staff should consult the physician for additional interventions if pain is not relieved by the currently ordered treatment modalities and comfort measures.

F 0732

Level of harm - Potential for minimal harm

Residents Affected - Some

Post nurse staffing information every day.

Based on observations and staff interviews, the facility failed to ensure the daily posted nurse staffing information was complete.
Findings include:
An observation was conducted on (MONTH) 24, 2019 at 10:14 a.m. of the posted nurse staffing information dated (MONTH) 24, 2019 located in a bookcase with glass doors at the entrance of the building to the right of the reception desk. On the

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NAME OF PROVIDER OF SUPPLIER **CASAS ADOBES POST ACUTE REHAB CENTER**	STREET ADDRESS, CITY, STATE, ZIP **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 0732 **Level of harm -** Potential for minimal harm **Residents Affected -** Some	(continued... from page 5) daily nurse staffing information form three nursing shifts were listed with the following times: 6:00 a.m. - 2:00 p.m., 2:00 p.m. - 10:00 p.m., and 10:00 p.m. - 6:00 a.m. for the Registered Nurses, Licensed Practical Nurses, and the Certified Nursing Assistants. However, no nursing hours were documented for the nursing staff on the 2:00 p.m. - 10:00 p.m. and 10:00 p.m. - 6:00 a.m. shifts. During an observation conducted on (MONTH) 25, 2019 at 11:03 a.m. of the daily posted nurse staffing information dated (MONTH) 25, 2019, again no hours were observed documented for the nursing staff on the 2:00 p.m. - 10:00 p.m. and the 10:00 p.m. - 6:00 a.m. shifts. An interview was conducted with the Staffing Coordinator (staff #118) with the Director of Nursing (staff #151) present on (MONTH) 26, 2019 at 10:02 a.m. Staff #118 stated that she is responsible for ensuring the daily nurse staffing information is accurate and posted. She stated that the hours missing for the two shifts on the nurse staffing information for (MONTH) 24 and 25, 2019 is required to be documented and that she would be including that information going forward. Review of the facility's policy regarding Posted Staffing Numbers revealed the daily posting is to include hours worked by the Registered Nurses, Licensed Practical Nurses, and Nursing Assistants for each shift.
F 0757 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and review of policy and procedures, the facility failed to ensure one of five sampled residents (#33) was free from unnecessary drugs, by failing to administer drugs according to the physician ordered parameters. The deficient practice could result in low blood pressures and residents receiving drugs which may not be necessary. Findings include: Resident #33 was admitted on (MONTH) 18, 2019 with [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. Review of the Medication Administration Record [REDACTED]. Review of the MAR for (MONTH) 2019 revealed [MEDICATION NAME] was administered on (MONTH) 21 for a blood pressure of 101/65 and (MONTH) 31 for a blood pressure of 80/89. Further review of the MAR for (MONTH) 2019 revealed [MEDICATION NAME] was administered on (MONTH) 6 for a pulse of 58, (MONTH) 10 for a pulse of 58, (MONTH) 13 for a pulse of 58, (MONTH) 14 for a pulse of 53, (MONTH) 15 for a pulse of 51, (MONTH) 17 for a pulse of 50, (MONTH) 18 for a pulse of 58, (MONTH) 19 for a pulse of 55, (MONTH) 20 for a pulse of 59, (MONTH) 25 for a pulse of 55, (MONTH) 26 for a pulse of 55, (MONTH) 28 for a pulse of 54, (MONTH) 29 for a pulse of 58, and (MONTH) 31 for a pulse of 56. Review of the MAR for (MONTH) 2019 revealed [MEDICATION NAME] was administered on (MONTH) 1 for a pulse of 58, (MONTH) 2 for a pulse of 52, and (MONTH) 3 for a pulse of 54. An interview was conducted on (MONTH) 25, 2019 at 2:02 PM with a Licensed Practical Nurse (LPN/staff # 5). The LPN stated that she checks a resident's blood pressure and pulse before administering antihypertensive medications. She also stated that she follows the physician's orders [REDACTED]. During an interview conducted with a LPN (staff #115) on (MONTH) 25, 2019 2:14 PM, the LPN stated that she would not administer an antihypertensive if the blood pressure and pulse were outside of the ordered parameters. She stated that administered the blood pressure medication outside of the ordered parameters could result in the resident having a low blood pressure and/or pulse. Review of the facility's policy for Administration of Drugs revealed medications must be administered in accordance with the written orders of the attending physician. The policy also included medications are checked against the order before they are given.
F 0761 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, and review of policy and procedures, the facility failed to ensure expired medications and biologicals in one of two medication rooms and one of four medication carts were not available for resident use. The deficient practice could result in expired medications being administered to residents. Findings include: On (MONTH) 25, 2019 at 11:20 a.m., an observation of the 200 hall medication room was conducted with a Licensed Practical Nurse (LPN/staff #51). The following medications and biologicals were observed stored on the shelves: -30 purple topped Vacutainer with an expiration date of (MONTH) 31, (YEAR) -7 bottles of Aspirin (nonsteroidal anti-[MEDICAL CONDITION] drug) with an expiration date of (MONTH) 2019 -2 bottles of[NAME]Vite (supplement) with an expiration date of (MONTH) 2019 -6 bottles of [MEDICATION NAME] (supplement) with an expiration date of (MONTH) 2019 -1 bottle of Folic acid (supplement) with an expiration date of (MONTH) 2019 -3 bottles of Magnesium chloride (supplement) with an expiration date of (MONTH) 2019 -4 18 Gauge shielded catheters with an expiration date of (MONTH) 30, 2019 During an observation of the medication cart on the 500 hall conducted on (MONTH) 26, 2019 at 2:10 p.m. with a Registered Nurse (RN/staff #70), the following were stored in the cart: -2 cards of [MEDICATION NAME] (antipsychotic) 1 mg tablets with an expiration date of (MONTH) 31, 2019 -1 Piston irrigation tray with an expiration date of (MONTH) 31, (YEAR) An interview was conducted with the Director of Nursing (DON/staff #151) on (MONTH) 26, 2019 at 12:56 p.m. The DON stated that her expectation is that the nurses dispose expired medications. During an interview conducted with the RN (staff #70) on (MONTH) 26, 2019 at 2:20 p.m., the RN stated that she had not noticed the expiration dates before the observation but that she would dispose the products. The facility's policy titled Medication Access and Storage revealed outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are removed from stock, disposed of according to procedures for medication destruction, and reordered from the pharmacy, if a current order still exists.