STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **035190**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **01/04/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CATALINA POST ACUTE AND REHABILITATION	**2611 NORTH WARREN AVENUE TUCSON, AZ 85719**

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 0641 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, staff interviews, and policy, the facility failed to ensure MDS (Minimum Data Set) assessments for two residents (#80 and #280) were accurate. Findings include: -Resident #280 was admitted to the facility on (MONTH) 28, (YEAR), with [DIAGNOSES REDACTED]. The resident was discharged (MONTH) 29, (YEAR). Review of the clinical record revealed a discharge MDS assessment dated (MONTH) 29, (YEAR) that the resident received a diuretic for one day and an opioid for one day. However, review of the Medication Administration Record [REDACTED]. An interview was conducted with the Director of Nursing (DON/staff #155) on (MONTH) 4, 2019 at 8:52 a.m. She stated that the information to code the MDS assessment for medications would be obtained from the MAR. The DON stated that according to the MAR, neither a diuretic nor an opioid was administered to the resident. She stated that the MDS assessment had been coded incorrectly. -Resident #80 was admitted on (MONTH) 5, (YEAR), with [DIAGNOSES REDACTED]. Review of a nurse's note dated (MONTH) 21, (YEAR), revealed the resident was discharged on (MONTH) 21, (YEAR). The Social Services progress note dated (MONTH) 23, (YEAR), revealed the resident was discharged to her home on (MONTH) 21, (YEAR). However, review of the discharge MDS assessment dated (MONTH) 21, (YEAR) revealed the resident was discharged to an acute care hospital. During an interview conducted with the DON on (MONTH) 4, 2019 at 3:33 p.m., she stated that the MDS assessment was coded incorrectly and should have been coded as discharge to the community. Review of the facility's policy Accuracy of Assessment (MDS 3.0) revealed that it is the facility policy to ensure that the assessment accurately reflects the resident's status.
F 0757 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policy, the facility failed to ensure one resident (#180) was administered pain medications as ordered by the physician. Findings include: Resident #180 was admitted on (MONTH) 31, (YEAR), with [DIAGNOSES REDACTED]. A review of the physician's orders [REDACTED]. The care plan regarding the resident's acute and chronic pain included a goal that she would voice a level of comfort. Interventions included to complete pain assessments every shift and to reposition her for comfort. A review of the Medication Administration Record [REDACTED]. An interview was conducted on (MONTH) 4, 2019 at 9:00 a.m. with a Licensed Practical Nurse (LPN/staff #124). The LPN stated that when a resident complains of pain she assess their pain, offer them a snack or maybe reposition them to relieve the pain. She stated if that did not relieve the pain, she would offer the resident pain medicine. The LPN also stated that if the resident requested pain medication other than what was ordered or in an amount other than what was ordered, she would call the provider for instructions. An interview was conducted on (MONTH) 4, 2019 at 9:15 a.m. with the Director of Nursing (DON/staff #155), who stated that for residents having pain she would expect the nurses to assess the pain and use non-pharmacologic interventions to treat the pain. She stated that if the non-pharmacologic interventions did not relieve the pain, the nurse would be expected to obtain orders for pain medication. The DON stated that the nurse is expected to follow the physician's orders [REDACTED]. The facility's policy regarding pain management revealed the physician is to be consulted for additional interventions if pain is not relieved by currently ordered treatment modalities and comfort measures.
F 0761 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, resident and staff interviews, and policy, the facility failed to ensure a controlled medication was not left at one resident's (#21) bedside. Findings include: Resident #21 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the admission Minimum Data Set assessment dated [DATE], revealed a Brief Interview for Mental Status score of 15 that indicated the resident was cognitively intact. During an initial interview conducted with the resident on 01/02/19 at 11:53 AM, a prescription bottle containing [MEDICATION NAME] 50 milligram tablets (opioid pain medication) prescribed for the resident was observed to be on the bedside table in the resident's room. The resident stated that his family member brought the medication from home on 01/01/19 in case it was needed and that he had not taken any. An interview was conducted with a Registered Nurse (RN/staff #156) on 01/02/19 at 11:56 AM. The RN was informed about the opioid on the resident's bedside table. He stated that he had not been in that room, but that the medication should never be left at the bedside. The RN removed the medication and counted the tablets. During an interview conducted with the Director of Nursing (DON/staff #155) on 01/02/19 at 12:05 AM, the DON stated that she had been in the resident's room earlier that the morning but did not notice the medication on the bedside table. She stated that the medication should not have been brought in. The DON stated that the medication will be counted and secured until the medication can be returned to the resident's family member. Review of the facility's policy titled Medication Access and Storage, [NAME] kit access revealed that the facility will store all drugs and biologicals in locked compartments under lock and key and that medications are only accessible to persons lawfully authorized to administer medications. The policy included that Schedule III and IV controlled medications

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 0761 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) are stored separately from other medications in a locked drawer or compartment designated for that purpose. The policy also included Schedule II controlled medications are stored in a separate area under double lock.