STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035101	A. BUILDING _____ B. WING _____	**04/19/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CHANDLER POST ACUTE AND REHABILITATION	**2121 WEST ELGIN STREET CHANDLER, AZ 85224**

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F 0578 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policy review, the facility failed to ensure 1 of 3 sampled residents (#20) code status was consistent in the clinical record. The census was 101. This deficient practice could result in residents receiving services, which are not in accordance with their wishes. Findings include: Resident #20 was initially admitted on (MONTH) 17, (YEAR) and readmitted on (MONTH) 13, 2019 with [DIAGNOSES REDACTED]. Review of the clinical record revealed the following: -Nurse progress notes dated (MONTH) 17, (YEAR) that the resident has a history of dementia and is oriented to self and that the resident's representative gave verbal consent for a Do Not Resuscitate (DNR) order. -A physician's orders [REDACTED]. -An Advance Directive/Medical Treatment Decisions form dated (MONTH) 18, (YEAR) that the resident's choice was not to be resuscitated. -An orange form titled Prehospital Medical Care Directive (DNR) signed by the resident's representative and a Licensed Health Care Provider on (MONTH) 18, (YEAR). The signature for the witness to the directive was blank. -A quarterly Minimum Data Set (MDS) assessment dated (MONTH) 24, 2019 that included a Brief Interview for Mental Status (BIMS) score of 6 which indicated the resident had severe cognitive impairment. Continued review of the clinical record revealed readmission physician's orders [REDACTED]. However, review of the Advance Directive/Medical Treatment Decisions form dated (MONTH) 13, 2019 revealed the resident's choice was not to be resuscitated. Review of the Initial Admission Record signed by the Licensed Practical Nurse (LPN/staff #146) on (MONTH) 16, 2019 revealed the resident's advanced directive was full code status. Review of the initial care plan signed by the LPN (staff #146) on (MONTH) 16, 2019 revealed the resident was a DNR. During an interview conducted with the admission LPN (staff #146) on (MONTH) 17, 2019 at 3:00 p.m., the LPN stated that when a resident is admitted she discusses advance directives with the resident and/or the resident's representative in detail. She stated that after the discussion, the Advanced Directive/Medical Treatment Decisions form is completed and signed by the resident or the resident's representative. She stated that once the form is signed, she will put the resident's advance directive wishes into the computer, notify the physician, and that the physician will write the order the next day. The LPN also stated that she will ask the resident or the resident's representative if they have any other advance directive and if so, will ask that they bring it to the facility. The admission nurse stated that when a resident is discharged to the hospital and readmitted back to the facility, she will repeat this process. She stated that resident #20 is a full code and has always been a full code. She stated that when the resident was readmitted , she spoke with the resident's representative and that the resident is a full code. An interview was conducted with the Director of Nursing (DON/staff #159) on (MONTH) 17, 2019 at 3:32 p.m. The DON stated that regardless of the paperwork, until the orange Prehospital Medical Care Directive (DNR) form is signed with the required signatures, a resident will be treated as a full code status. The DON stated that whenever a resident is readmitted and their wish is to be a DNR, another orange form has to be signed. She stated that resident #20's representative has been informed that he needs to sign the orange form but that he has not come into the facility to sign the form. She stated that if resident #20 was to stop breathing, they would call 911 and initiate CPR (cardiopulmonary resuscitation). The DON stated that this is the facility's policy. The facility's policy titled Advance Directives (revised ,[DATE]) revealed a resident's choice about advance directives will be recognized and respected. The policy included that once the advance directive or information regarding resident preferences regarding treatment options is received by the facility, it will be confirmed in the resident medical record and communicated to members of the care plan team. The facility will also notify the attending physician of advance directives so that, if necessary, appropriate orders can be documented in the resident's medical record and plan of care.
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 the Resident Assessment Instrument (RAI) Manual, the facility failed to ensure that the Minimum Data Set (MDS) assessments for 2 of 21 sampled residents (#75 and #57) accurately reflected their status. The deficient practice has the potential to affect continuity of care. Findings include: -Resident #75 was admitted to the facility on (MONTH) 1, 2012, with [DIAGNOSES REDACTED]. A quarterly MDS assessment with an Assessment Reference Date (ARD) of (MONTH) 17, (YEAR), revealed a score of 13 on the Brief Interview for Mental Status which indicated the resident had intact cognition. Review of the current care plan revealed the resident was at risk for falls related to impaired mobility, impaired cognition, and narcotic [MEDICATION NAME] use. The goal was for the resident to be free from falls. Interventions included ensuring the call light is within reach, floor mats at bedside, and following the fall protocol. The care plan also included the resident had a fall on (MONTH) 31, (YEAR). Review of a nursing note dated (MONTH) 31, (YEAR) revealed the resident was found on the floor facing down. The note also revealed the resident was assessed and had a skin tear to his wrist measuring 3 centimeters (cm) by 3.5 cm that was cleaned and covered with a Band-Aid. However, review of the quarterly MDS assessment with an ARD of (MONTH) 19, 2019, revealed the resident had no falls since the prior MDS assessment. An interview was conducted on (MONTH) 19, 2019 at 12:13 p.m. with the MDS coordinator (staff #46). The MDS coordinator stated the look-back period for falls on a quarterly MDS assessment is 3 months. Staff #46 stated that the fall risk management reports includes all resident falls and the injuries sustained and is used to find out how many falls a resident has had when coding the MDS assessment. After reviewing the report, staff #46 stated that resident #75 did have a fall on (MONTH) 31, (YEAR) and the fall should have been coded on the quarterly MDS assessment dated (MONTH) 19, 2019. An interview was conducted on (MONTH) 19, 2019 at 12:40 p.m. with the Director of Nursing (DON/staff#159). The DON stated

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

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F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) the expectation is that the MDS assessments are coded according to the Resident Assessment Instrument (RAI) manual. The RAI manual revealed the review period for falls is from the day after the ARD of the last MDS assessment to the ARD of the current assessment. The manual instructs to review all available sources including incident reports, fall logs, and the clinical record, for any fall since the last assessment, no matter whether the fall occurred while out in the community, in the hospital, or in the nursing home. The manual also instructs to code yes if the resident has fallen since the last assessment. -Resident #57 was admitted to the facility on (MONTH) 5, (YEAR), with [DIAGNOSES REDACTED]. Review of the annual MDS assessment dated (MONTH) 12, 2019, revealed a BIMS score of 15 which indicated the resident was cognitively intact. The MDS assessment also included the resident received an anticoagulant medication for 7 days during the 7 look-back period. Review of the physician's orders [REDACTED]. Review of the Medication Administration Record [REDACTED]. An interview was conducted on (MONTH) 19, 2019 at 12:31 p.m. with the MDS Coordinator (staff #46). She stated that she follows the RAI manual when coding MDS assessments. She stated that she reviews the resident's MAR indicated [REDACTED]. Staff #46 stated that she had been coding [MEDICATION NAME] as an anticoagulant, but after reviewing the RAI manual, she realized it should not have been coded as an anticoagulant on the assessment. An interview was conducted on (MONTH) 19, 2019 at 12:43 p.m., with the DON. She stated the facility's policy is to follow the RAI manual when coding the MDS assessment. The DON stated that her expectation is that the RAI manual be followed when coding MDS assessments. The RAI manual instructs to review the resident's clinical record for documentation that anticoagulant medications were received by the resident during the 7 day look-back period and record the number of days the resident was administered an anticoagulant medication. The RAI manual also instructs to not include antiplatelet medications such as [MEDICATION NAME].
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, facility documentation, and policy and procedures, the facility failed to ensure 1 of 8 sampled residents (#200) received an adequate number of showers. The deficient practice could result hygiene needs not being met. The census was 101. Findings include: Resident #200 was admitted to the facility on (MONTH) 3, 2019, with [DIAGNOSES REDACTED]. Review of a care plan imitated (MONTH) 3, 2019 revealed the resident had an Activities of Daily Living (ADL) self-care performance deficit related to right sided [MEDICAL CONDITION]. The goal was that the resident would maintain the current level of function in grooming and personal hygiene with one person physical care. Interventions included encouraging the resident to participate to the fullest extent possible with each interaction. Review of the paper Skin Monitoring: Comprehensive CNA (Certified Nursing Assistant) Shower Review forms revealed refused on (MONTH) 6 and 11, 2019. Review of the electronic CNA documentation for what types of bathing activity was completed revealed the resident did not receive a shower until (MONTH) 15, 2019. During an observation conducted of resident #200 on (MONTH) 15, 2019 at 2:34 PM, the resident appeared unclean and his hair appeared greasy. An interview was conducted with the resident's spouse on (MONTH) 16, 2019 at 8:33 AM. The spouse stated she had a concern regarding showers being provided to the resident. The spouse stated that she had requested the resident be showered on Mondays, Wednesdays, and Fridays. An interview was conducted with a CNA (staff #127) on (MONTH) 18, 2019 at 12:21 PM. The CNA stated that the residents receive showers twice a week. The CNA said if a resident wants a specific schedule or an extra shower, they will provide it. Staff #127 stated that if a resident refuses a shower, they will have the resident sign the shower sheet and write refused on it. The CNA stated that resident #200 is scheduled for showers on Monday and Thursday evenings and that the resident should receive a shower tonight. Staff #127 further stated that it is documented electronically if the resident receives a shower, bed bath, or refuses. An interview was conducted with resident #200 on (MONTH) 19, 2019 at 10:38 AM. The resident stated that the scheduled shower was not provided last night. The resident stated that only one shower has been provided since admission. The resident stated that he is supposed to be provided showers three times a week. Resident #200 stated that his hair is dirty and he feels yucky and he wants a shower. During an interview conducted with a staff member during the survey, the staff member stated that if they are short staffed, showers are the first thing that will not get done. During an interview conducted with another staff member during the survey, the staff member stated that if staff calls out or they are short staffed, showers are not provided. The staff member also stated that the bed linens are changed when the resident receives a shower and that the linens are not changed if the resident does not get a shower. An interview was conducted with the Director of Nursing (DON/staff #159) on (MONTH) 19, 2019 at 11:03 AM. She stated that her expectation is that the residents receive showers twice a week. She stated they will try to accommodate the resident if they request showers more often. The DON said if the resident refuses, they can offer a bed bath but that the resident has the right to refuse. The facility's policy and procedure for Activities of Daily Living revealed that if a resident is unable to carry out activities of daily living, the necessary services to maintain good nutrition, grooming and personal oral hygiene will be provided by qualified staff. Bathing will be offered at least twice weekly and PRN per resident request. The policy included ADL care will be documented in the medical record accordingly.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policy review, the facility failed to ensure medications were administered in accordance with professional standards of practice for 1 of 4 sampled residents (#26). The deficient practice could result in a resident missing doses of physician ordered medications. Findings include: Resident #26 was admitted to the facility on (MONTH) 21, (YEAR), with [DIAGNOSES REDACTED]. Review of the clinical record revealed physician's orders [REDACTED]. A quarterly Minimum Data Set (MDS) assessment dated (MONTH) 1, (YEAR) revealed a score of 12 on the Brief Interview for Mental Status which indicated the resident had moderate impaired cognition. Review of a physician's note dated (MONTH) 17, (YEAR), revealed the resident has had an overall expected decline with her dementia both physically and mentally and that the resident continues to have approximately 2 [MEDICAL CONDITION] a month which is her baseline. The note revealed there has been several days where the resident has pocketed her medications including her [MEDICAL CONDITION] medications, and has thrown them under her bed or in the trash can. Staff has found the medications several times. The note also included that the physician had spoken with the nursing staff in depth about making sure the resident is taking her medications without pocketing them. An interview was conducted with a Certified Nursing Assistant (CNA/staff #81) on (MONTH) 17, 2019 at 1:53 PM. The CNA stated that resident #26 does have a habit of spitting out her medications and that she usually finds the pills in the resident's bed. The CNA stated that it happens every now and then and that each time it happens she notifies the nurse. An interview was conducted with a Licensed Practical Nurse (LPN/staff #92) on (MONTH) 17, 2019 at 2:10 PM. The LPN stated

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F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) that she has never seen resident #26 spit out or pocket her pills. The LPN also stated that resident #26 refuses to take her medications in front of the nurse, so she leaves them at the bedside and returns later to make sure the resident has taken the medications. During an interview conducted with resident #26 on (MONTH) 18, 2019 at 11:10 AM., the resident stated that she always takes her pills and the nurse watches her take her medications. An interview was conducted with the Director of Nursing (DON/staff #159) on (MONTH) 18, 2019 at 2:37 PM. The DON stated that there were no long term care residents who were able to self-administer medications. She stated that the nurse is expected to stand there and make sure the resident takes their medications. The DON also stated that if the resident refuses to take the medications in front of one nurse, another nurse can try to get the resident to take the medications. The DON stated that the medications cannot be left at the bedside for the resident to take whenever they want. The facility's policy for Administration of Drugs states that medication 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. The policy also included right documentation included documenting the refusal of the medication or the attempt and noting any concerns.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on personnel record reviews, staff interviews, and policy review, the facility failed to ensure 3 of 10 sampled staff members (#19, #38, and #85) had current evidence of freedom from [MEDICAL CONDITION] (TB). The deficient practice could result in the potential exposure of infectious TB. Findings include: -Review of the personnel record for staff #19 (housekeeping staff) revealed a hire date of (MONTH) 5, (YEAR), for full time employment. A form titled [MEDICATION NAME] Skin Test for Employees revealed the staff member received a TB skin test on (MONTH) 3, (YEAR), and the results were read on (MONTH) 5, (YEAR). The form did not indicate whether the skin test results were positive or negative. -Review of the personnel record for staff #38 (dietary aide) revealed a hire date of (MONTH) 20, (YEAR), for full time employment. A form titled [MEDICATION NAME] Skin Test for Employees revealed the staff member received a TB skin test on (MONTH) 20, (YEAR), and the results were read to be negative on (MONTH) 22, (YEAR). The form indicated that the [MEDICATION NAME] purified protein derivative (PPD) used to administer the skin test had expired in (MONTH) (YEAR). -Review of the personnel record for staff #85 (Registered Nurse) revealed a hire date of (MONTH) 16, (YEAR), for full time employment. A form titled [MEDICATION NAME] Skin Test for Employees revealed the staff member received a TB skin test on (MONTH) 30, 2019, and the results were read on (MONTH) 1, 2019. The form did not indicate whether the skin test results were positive or negative. An interview was conducted on (MONTH) 16, 2019 at 3:37 p.m., with the Human Resources Manager (staff #111), the Administrator (Staff #158), and the Director of Nursing (DON/staff#159). Staff #111 stated she was responsible for maintaining employee files. She stated the facility's policy was for staff to provide evidence of freedom from TB upon hire and annually thereafter. She also stated that she kept a spreadsheet to track the due dates for staff members to submit renewals of their TB testing documentation. All 3 staff members (#111, #158, and #159) stated that because expired PPD was used to administer a TB skin test for staff #38, they would not be able to tell if the results of the test were valid. All 3 staff members (#111, #158, and #159) stated they are pretty sure that staff #19 and #85 TB skin tests were negative, because if the results had been positive there would have been immediate follow-up actions taken. They stated that since there were no additional actions taken, the test results were most likely negative. Review of the facility's policy for TB Screening-Staff revealed that each employee hired by the facility shall be screened for TB, and receive screening at least annually. The policy states acceptable documentation would include documentation of a negative skin test.