STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035242	A. BUILDING _____ B. WING _____	**03/15/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CHINLE NURSING HOME	**PO BOX 910 CHINLE, AZ 86503**

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

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F 0574 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**The resident has the right to receive notices in a format and a language he or she understands.** Based on observation, and interviews the facility failed to ensure contact information for the State and Local Advocacy programs was accessible for 13 of 13 residents who attended a group meeting. This had the potential to affect all 57 residents in the facility. Findings include: On 03/12/19 at 2:00 PM the surveyors met with 13 members of the resident council. The resident council revealed they did not know how to contact the Ombudsman or who to contact to file a formal complaint regarding their care. Observation on 03/14/19 at 11:15 AM failed to reflect the contact information for the State and Local Advocacy programs was posted. On 3/14/19 at 11:20 AM, Social Services Coordinator Staff 4, stated, I am not aware of where the postings that contain the Ombudsman and advocacy contact information for the residents is located. On 03/14/19 at 11:25 AM, Social Services Coordinator Staff 13, stated she was not sure if the board with the posting was removed from the building since they had just moved to a new building. On 03/14/19 at 11:30 AM, the Maintenance Supervisor stated he was not sure if the board (that had contact information posted) was brought from the old building to the new building when they moved. On 03/14/19 at 1:30 PM a policy was requested from the Assistant Director of Nursing (ADON) who stated, There was not a policy available.
F 0577 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**Allow residents to easily view the nursing home's survey results and communicate with advocate agencies.** Based on observation and interview the facility failed to ensure the Survey results for the past three years including recertifications and complaints along with the plan of correction were readily accessible for residents and family members to review. This has the potential to affect all 57 residents in the facility. Findings Include: On 03/12/19 at 2:00 PM during the resident council meeting it was revealed that the survey results were not available for the residents to review. Observation on 03/14/19 at11:30 AM during a tour of the facility failed to locate the survey results. Interview on 03/14/19 at 11:40 AM, Social Services Coordinator 4, who was on Household 1 unit, revealed that she was unaware of where the survey results would be kept. Observation of Social Services Coordinator 13's office which was on Household 2 unit, identified a sign posted on the window of the office that identified Survey Results with an arrow pointing down. Observation failed to identify anything was below the arrow. On 03/14/19 at 12:40 PM the Assistant Director of Nursing (ADON) indicated the survey results should be outside the Social Services office. On 03/14/19 at 3:45 PM Social Services Coordinator 13 identified she had the survey result book in her office and if residents wanted to see it they would need to ask. On 03/14/19 at 1:30 PM a policy related to posting of survey results was requested and on 03/15/19 at 8:21 AM the ADON stated there was not a policy available.
F 0580 **Level of harm** - Actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to notify and consult with a physician after a resident developed low oxygen levels in the blood approximately 4 hours after the resident complained of pain and immobility of his leg. In addition the facility did not notify the physician when there was an approximate 5 hour delay in Emergency Medical System (EMS) response for one resident (Resident 59). This deficient practice resulted in a delay in treatment and unnecessary suffering with pain and breathlessness for Resident 59. This finding is as a result of the investigation into a facility reported incident with intake number AZ 493 of reported fall with fracture that occurred on 1/5/2019. Findings include: 03/15/19 at 06:16 AM, the following was found in the medical record review: Resident 59 was a [AGE] year old male who was a long-time resident of the facility with [DIAGNOSES REDACTED]. The minimum data set (MDS-an assessment tool) dated 11/28/2018 indicated the resident needed limited assistance with most activities of daily living (ADLs), he had limited range of motion on one side of his body, needed human assistance to transfer from surface to surface. The resident used a wheel chair (w/c) for locomotion. He was able to propel himself. He had a history of [REDACTED]. The 12/31/2018 Morse Fall Scale (a fall risk assessment tool) had a fall risk score of 55. Scores over 45 are considered a high risk of falling. The 1/5/2019 (post fall) Morse Fall Scale score was 80. Continued record review on 3/15/2019 read as follows: Incident progress notes dated 1/5/2019 @ 3:45 PM, unwitnessed fall. Staff heard resident yelling from his room and found him lying on his back next to his w/c. Resident stated he was transferring from w/c to bed the w/c slipped out from under him. Stated he landed on his buttocks and laid back. He denied hitting his head. Two staff assisted him to his feet for a full body skin assessment. Skin intact over buttocks, back and posterior legs. Placed in wheel chair (w/c), resident taken to dining hall for evening meal. Vital signs were stable. Oxygen saturations

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

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F 0580 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) (O2 sats) level on room air (RA) was 94%. (Oxygen saturation is a measurement of oxygen in the tissues of the body. This is measured with an instrument called a pulse oximeter. The device is clipped on a finger and quickly gives a percent of oxygen in the tissues. Normal O2 saturation levels are above 95% according to the National Institute of Health (NIH)). There was communication note to the physician (Staff 34) written on 1/5/2019 at 4:07 PM informing him of the resident's fall. The physician ordered the staff to continue to monitor resident often for skin assessment, mentation changes, and to call back with change in condition (e.g. bleeding, change in skin condition, change in mentation). Incident progress note dated 1/6/2019 @03:09 AM, Resident reported right leg pain with movement. He was unable to independently move around and required assist. There was no documentation that a physician was notified. Review the Medication Administration Record [REDACTED]. 1/6/2019 @ 06:55 AM, Resident remained in bed, O2 was given at 3 liters by nasal cannula (O2 @ 3L/nc) provided due to room air (RA) O2 sat at 63 -74%. (Resident)Denies SOB (shortness of breath) but continued to complain of pain right leg and low back with attempts to move. Tylenol given. Emergency Medical Services (EMS) notified of needed services. Currently on another call, but will be here to pick rsd (resident) as soon as possible (sic). Called emergency room (ER) with report that resident being sent over for evaluation. 1/6/2019 @07:01 AM, Report to ER nurse Anthony received report. No documentation was found or provided to indicate that the ER physician was consulted. 1/6/2019 @ 08:23 AM, resident was yelling in bed and taking off his oxygen (nasal cannula) .He reported difficulty breathing but wouldn't wear O2 cannula. (He is not) cooperative and moving arms a lot when taking vital signs. Called EMS three times but they are not answering the call. Awaiting EMS to pick him up. Resident still NPO (nothing by mouth). He is complaining pain to right leg with little movement. Oxygen saturation range on room air 75-89% fluctuating and resident is refusing to apply oxygen. Vital Signs (VS) @ 8 AM O2 sat 83% on room air, temperature 100.4 degrees Fahrenheit; Blood Pressure 78/50; respiratory rate 28 and Heart Rate 83. (Normal temperature range 97.6 - 99.6; normal blood pressure range 90/60 - 140/90; normal respiratory range 16-28) There was no documentation provided that a physician was notified of the resident's change of condition. After several attempts to get EMS to respond to the resident's need the staff called the police at 11 AM (four hours after his O2 sats were found to be 63-74%.) EMS arrived and the resident was sent to Chinle hospital ER at 11:47 AM. There was no documentation that a physician was notified of the delay in the EMS response. Review of the Medical records from the Chinle Comprehesive (sic) Health Care Facility (CCHCF) ER did not include in the chief complaint the resident's hypoxic and hypotensive episodes during the morning. The vital signs on 1/6/2019 at 01:53 PM; were Temp 100.1 degrees Fahrenheit; BP; 84/51; and O2 Sat 91%. Follow up with the ER doctor reported to the facility at 2:45 PM on 1/6/2019 the resident had a [MEDICAL CONDITION] and a fever. 03/15/19 at 07:47 AM, when asked about the incident, Staff 20 reported the following; It took a long to transfer him to the ER, the EMS is at the hospital. She called the hospital for EMS services. When asked if this delay in EMS response was a common problem Staff 20 said it depends. When asked if she had notified the physician of the low O2 Sat, she said she called the ER Nurse and reported to day shift at the facility to notify the attending physician. She stated, the attending (doctor) does not answer calls at night. She did not call the Medical Director at that time, because she stated she was told that staff were not to call him at night. Review of the No. NV-CA-18-0011 Collaborative Agreement Between Chinle Comprehesive (sic) Health Care Facility (CCHCF) Navajo Area Indian Health Service and Chinle Nursing Home (CNH): the following read in pertinent part: .1. CCHCF AGREES: B. These services shall fulfill the requirements of the Federal Regulations for Primary Medical Provider for IHS beneficiaries residing the in the home. These services include but are not limited to: .5. On-call after hours physician services are available to I.H.S. beneficiaries residing in the home for purposes of medical consultation, clarification of orders, and urgent queries . 03/15/19 at 08:40 AM, when asked to speak with the attending physician. Staff 2 stated she received notice that Resident 59's attending physician would not be available to talk with surveyors, until after the survey was completed. 03/15/19 at 12:20 PM, on a phone interview: When asked if he was aware of the delay in EMS response for Resident 59; The Medical Director stated he was not aware of the extent of the delay of services for this resident; however he was aware that the Chinle EMS system sometimes responded late. He stated that the facility did not know what else they could do about it. In regards to Resident 59's situation; he stated the night shift nurse should have notified the physician when the resident had pain and couldn't move his leg on 1/6/2019 at 03:09 AM. They should have called the CCHCF emergency room and spoke with the doctor at the hospital for direction. When informed that Staff 20 informed the surveyor that she was told they were told not to call the attending physician or the medical director at night; he stated that the Chinle hospital (CCHCF) ER doctors cover for night shift and weekends and they do speak directly to the facility nurses. When informed of the resident's 02 sat levels at 6:55 AM of 63-74% he stated they should have taken the resident directly to the ER when EMS was not available. He said that they should have put the resident in a wheelchair and taken him across the parking lot to the ER. When asked if the facility had discussed the EMS slow response time in QAPI he stated he did not think so. 03/15/19 at 02:15 PM during an interview when asked how often the EMS is late responding to their calls, Staff 5 stated it happens pretty often; however it usually was not this bad. When asked if they had included this issue in their QAPI, she said everyone is aware of the problem; however we did not discuss it because we didn't think we could do anything about it. She said that she will make sure it is addressed ASAP. Requested a list of calls made to the EMS and their response time. Staff 5 stated the facility did not keep track of that information. However she said she would call the EMS to obtain the information. According to an article about complications of [MEDICAL CONDITION] in the elderly the following Webster https://www.ncbi.nlm.nih.gov/pmc/articles/PMC 33/ read in part as follows: .Mortality incidence due to fat embolism syndrome (FES) varies among varied studies, probably because of its underdiagnosis.(27) Acute fulminant FES may lead to death due to right heart failure, while majority of deaths are usually due to [MEDICAL CONDITION]. Though prognosis for neurological defects is good, deaths have also been reported. Incidents of acute coronary syndrome, probably due to circulating fat globules have also been reported.(57) Overall, the mortality is estimated to be 5-15%.
F 0625 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on document review and staff interview, the facility failed to provide notification to the resident and/or responsible party regarding the facility's bed-hold and reserve bed payment policy upon transfer to a hospital for one sampled resident (R16) who was transferred to the hospital on 3 separate occasions. Finding include: Review of the facility's Bed hold policy revised 01/2019 directs Upon admission and at the time a resident is allowed to transfer for hospitalization for therapeutic leave Social Services Coordinator shall provide the resident and a family member or legal representative with information concerning the bed hold policy .When emergency transfers are necessary, the facility will provide the resident or representative with information concerning the facilities (sic) bed hold policy within 24 hours of said transfer. Review of the facility's bed hold documents for R16 revealed transfer to the hospital on [DATE], /1/9/19 and 02/23/19. The Bed Hold Request revealed a document that discusses the type of bed hold requested and the Date of Return. The facility

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F 0625 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) failed to ensure the resident was informed of the facility bed hold policy when transfer occurred. Interview with Social Services 4 on 3/13/2019 at 12:36 PM confirmed the Bed Hold notification for 1/9/19, 2/23/19, and 12/15/18 were given to the resident and/or responsible party upon the resident's return to the facility. Social Services 4 confirmed Notice of Bed Hold Request is a document provided to payor source and resident/family upon the resident's return from hospital. Social Services 4 confirmed bed hold information is not provided to the resident upon transfer to the hospital is completed after the resident returns.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure a comprehensive nursing care plan was generated for 2 of 36 sampled residents (residents 16 and 50). Failure to generate comprehensive care plans to address the resident's medical, nursing, mental and/or psychosocial needs could potentially result in a negative outcome due to a failure to meet an identified resident problem. Findings include: 1. Resident 50 is an [AGE] year old male who was originally admitted into the facility on [DATE]. Some of his [DIAGNOSES REDACTED]. Resident 50 was observed several times during the survey sitting up and self propelling himself in his wheel chair. He did not have a hand roll or other device/item in his left hand which appeared to be contracted. During a concurrent record review and interview with licensed nurse (LN) 2 on 03/21/2019 near 1:00PM she validated Resident 50 was taking [MEDICATION NAME] 300mg at bedtime to reduce or eliminate [MEDICAL CONDITION]. She also validated Resident 50 had limitations in range of motion to his left arm with what appeared to be a contracture to his left hand. During further investigation LN 2 also acknowledged Resident 50 did not have comprehensive nursing care plans related to the resident's history of [MEDICAL CONDITION] nor did he have a care plan with interventions to prevent any worsening of his left hand contracture. 2. Review the Face Sheet in the electronic medical record identified R16 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The Admission Minimum Data Set (MDS) Assessment with an Assessment Reference Date (end of look back period) of 01/04/19, identified a Brief Interview for Mental Status (BIMS) score of 14 of 15, indicating intact cognition and can make decisions, and Physical Function identified independence for ambulation. Review of the electronic medical record identified R16 was transferred to the hospital or urgent care on the following dates:12/15/18- for acute confusion and hospitalized ; 12/20/18- for increased agitation and hospitalized ; 12/23/18- for increased confusion and suggested the patient drank hairspray for emergency room visit; 01/01/19- the resident unarousable, empty container of hairspray in resident's room for an emergency room visit; 01/09/19- for increased confusion and hospitalized with hepatic [MEDICAL CONDITION] (an altered level of consciousness because of liver failure); and 02/23/19- unresponsive, unable to arouse with painful stimuli and hospitalized with hepatic [MEDICAL CONDITION]. Review of the Care Plan written on 01/15/19 and reviewed 01/25/19 revealed R16 is dependent on staff for meeting emotional, intellectual, physical, and social needs with a goal for the resident to attend and participate in activities of choice 4-6 times a week. The care plan failed to address R16's [DIAGNOSES REDACTED]. Interview with Social Services 4 on 03/13/19 at 10:30 AM revealed the facility did not update or revise R16's plan of care to address the resident's behaviors that required transfer to urgent care for treatment and hospitalization .
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to revise resident care plans to include individualized interventions regarding nursing responses to hypoglycemic (low blood sugar) episodes for two of three residents (Resident (R) 159 and R27) reviewed with diabetes mellitus (DM). Additionally, based on observation, interview and record review the facility failed to ensure it revised a resident care plan to include individualized interventions for Resident (R) 34's Foley catheter care. Failure to have a care plan which addresses the care needs of a resident who has [DIAGNOSES REDACTED]'s could possibly contribute to urinary tract infections. ([DIAGNOSES REDACTED] is a condition in which the opening of the urethra is on the underside of the penis instead of at the tip. The urethra is the tube through which urine drains from your bladder and exits your body). Findings include: 1. Review of the admission Minimum Data Set (MDS), located under the MDS tab in the Electronic Health Record (EHR), with an Assessment Reference Date (ARD) of 04/08/19, revealed R159 was admitted to the facility on [DATE]. This MDS identified the resident received daily injections and had a Brief Interview for Mental Status (BIMS) score of 10, indicative of moderately impaired cognition. The Medical [DIAGNOSES REDACTED]. Review of R159's care plan, located under the Care Plan tab of the EHR, revealed a focus area of DM, initiated on 04/10/19. This care plan included goals that the resident would be free from complications of diabetes and not experience either hyper- or hypoglycemic episodes. The care plan did not identify what blood glucose (BG) levels would be considered either hyper- or [DIAGNOSES REDACTED] for this resident; what interventions should be implemented should the resident experience either one of those conditions; how frequently the resident should be monitored should hyper-or hypoglycemic episodes be present; when the physician should be notified; what to do if the interventions were unsuccessful; or when or how it could be determined that the episode had resolved. On 07/23/19 at 4:08 PM, during an interview with the Director of Nursing (DON), Assistant Director of Nursing (ADON), and Quality Assurance (QA) nurse, the DON stated the facility did not have a policy on responding to hyper- or hypoglycemic episodes and did not typically include specific information about responding to those symptoms in a resident's care plan. The DON stated the facility's Medical Director (MD) had provided standing orders for nurses to follow when responding to symptoms of hyper- or [DIAGNOSES REDACTED], and that was considered individualized and specific enough to provide R159 the care she needed. The DON stated, She (R159) tolerates BG's in the 40's. We all know this, because we take care of her every day. We don't need the care plan to tell us that.During this interview, the QA nurse stated the care plan needed to be more clearly defined regarding how nurses should respond to episodes of hyper- or [DIAGNOSES REDACTED]. 2. Review of the quarterly MDS, located under the MDS tab in the EHR, with an ARD of 03/24/19, revealed R27 was admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. According to this MDS, R27 rejected care one to three days during the seven-day lookback period. Review of R27's Care Plan, located under the Care Plan tab of his EHR, revealed a focus area of DM, initiated on 06/07/17 and in use at the time of his discharge from the facility on 05/18/19. This care plan identified the goals for R27 to be free from complications of diabetes, and not experience either hyper- or hypoglycemic episodes. The care plan did not document what blood glucose levels would be considered either hyper- or [DIAGNOSES REDACTED] for this resident; what interventions should be implemented should the resident experience either one of those conditions; how frequently the resident should be monitored should hyper-or hypoglycemic episodes occur; when the physician should be notified; what to do if the interventions were unsuccessful; or when or how it could be determined that the episode had resolved. The care plan did not identify that R27 was noncompliant or offer any goals or approaches related to his non-compliance. On 07/22/19 at 3:29 PM the DON and ADON were interviewed regarding R27. The DON stated that R27 was often non-compliant with efforts to manage his diabetes and some of his other chronic health conditions. The DON stated most of the facility nurses have worked here for years, so they know these residents. They know what to do, and they know when something has changed. The DON stated if R27's noncompliance rose to an unusual level, a referral would be made to Social Services, but that had

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F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) not occurred and therefore did not need to be included in the care plan. The DON stated that if the resident displayed symptoms of hyper- or [DIAGNOSES REDACTED], nursing staff should refer to and follow the MD's standing orders, not the care plan. 3. Record review shows R34 is a [AGE] year-old male who was originally admitted on [DATE] and had a readmission date of [DATE]. Some of his current [DIAGNOSES REDACTED]. Both his annual comprehensive assessment (dated (MONTH) 8, 2019) and his quarterly assessment (dated (MONTH) 7, 2019) show he has an indwelling Foley catheter. The physician progress notes [REDACTED]. Review of the recapitulated physician orders [REDACTED]. The indication for the catheter is bladder outlet obstruction/[MEDICAL CONDITION]. There are no orders or an indication of the frequency of Foley catheter care. Review of the nursing care plans related to chronic Foley catheter use and bladder outlet obstruction show under the interventions that Foley catheter care is to be provided EVERY shift but there is no specific guidance on how to provide that care when the resident has [DIAGNOSES REDACTED]. On (MONTH) 23, (YEAR) a Foley catheter care observation was completed near 1:30PM for R34 by staff 7 and staff 8 in the presence of Assistant Director of Nurses (ADON). Prior to the catheter care peri care was provided. Staff 7 and staff 8 proceeded to clean the left groin first then cleaned the right groin and then turned R34 to his left side and cleaned his buttocks several times to remove the fecal material that had collected in the adult diaper. Hand washing or the removal of the gloves that were being used while providing the peri care did not occur. The new adult diaper was placed then the staff removed their gloves and used hand sanitizer and put fresh gloves. Staff 7 and staff 8 did not use soap and water to provide the catheter care. A sterile catheter tray was opened and the 3 non-sterile BZK ([MEDICATION NAME] Chloride) swab sticks were removed to provide the catheter care. The ADON questioned staff 7 and staff 8 in regards to use of the swab sticks and they indicated they had been recently instructed to use the swab sticks by one of the licensed nurses. Staff 8 cleaned what normally would be the meatus then cleaned the head of the penis and moved to the catheter exit site. During the catheter care R34 was observed to have [DIAGNOSES REDACTED]. Staff 8 cleaned the glans penis then moved toward what would be the urinary meatus. Again, R34, was observed to have [DIAGNOSES REDACTED]; his urinary meatus (opening) was underneath the glans penis rather than at the tip of the penis. Staff 8 provided catheter care using the same technique each time; cleaning the glans penis then cleanings the urinary meatus in that order with each of the three swab sticks. On that same date the nursing care plan was re-reviewed. None of the nursing care plans indicated how catheter care was to be implemented (with soap and water or with some special swabs). Nor did the care plans have interventions/guidance/directions specifically tailored to the needs of a resident with [DIAGNOSES REDACTED]. After the entire procedure staff 7 and staff 8 were questioned in the presence of that ADON. They acknowledged they probably could have removed their gloves and sanitized their hands after cleaning up the fecal material and prior to putting on the new adult diaper. Additionally they acknowledged, to help prevent infection, the meatus (catheter entrance or exit site) needed to be cleaned first rather than cleaning the head of the penis and moving toward the meatus.
F 0684 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**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 interview and record review the facility failed ensure that a resident received timely treatment and care for a resident who fell and approximately eleven (11) hours later complained of pain and immobility of his leg. No pain medication was given. Four hours after the pain the resident then developed low oxygen levels in the blood, and low blood pressure although the EMS was called, the facility did not notify the physician when there was an approximate 5 hour delay in Emergency Medical System (EMS) response for one resident (Resident 59). This deficient practice resulted in a delay in treatment and unnecessary suffering with pain and breathlessness for Resident 59. 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Continued record review on 3/15/2019 read as follows: Incident progress notes dated 1/5/2019 @ 3:45 PM, unwitnessed fall. Staff heard resident yelling from his room and found him lying on his back next to his w/c. Resident stated he was transferring from w/c to bed the w/c slipped out from under him. Stated he landed on his buttocks and laid back. He denied hitting his head. Two staff assisted him to his feet for a full body skin assessment. Skin intact over buttocks, back and posterior legs. Placed in wheel chair (w/c), resident taken to dining hall for evening meal. Vital signs were stable. Oxygen saturations (O2 sats) level on room air (RA) was 94%. (Oxygen saturation is a measurement of oxygen in the tissues of the body. This is measured with an instrument called a pulse oximeter. The device is clipped on a finger and quickly gives a percent of oxygen in the tissues. Normal O2 saturation levels are above 95% according to the National Institute of Health (NIH)). There was communication note to the physician (Staff 34) written on 1/5/2019 at 4:07 PM informing him of the resident's fall. The physician ordered the staff to continue to monitor resident often for skin assessment, mentation changes, and to call back with change in condition (e.g. bleeding, change in skin condition, change in mentation). Incident progress note dated 1/6/2019 @03:09 AM, Resident reported right leg pain with movement. He was unable to independently move around and required assist. There was no documentation that a physician was notified. Review the Medication Administration Record [REDACTED]. Record review continued: on 1/6/2019 @ 06:55 AM, Resident remained in bed, O2 was given at 3 liters by nasal cannula (O2 @ 3L/nc) provided due to room air (RA) O2 sat at 63 -74%. (Resident)Denies SOB (shortness of breath) but continued to complain of pain right leg and low back with attempts to move. Tylenol given. Emergency Medical Services (EMS) notified of needed services. Currently on another call, but will be here to pick rsd (resident) as soon as possible (sic). Called emergency room (ER) with report that resident being sent over for evaluation. 1/6/2019 @07:01 AM, Report to ER nurse Anthony received report. No documentation was found or provided to indicate that the ER physician was consulted for treatment or what to do when the EMS had not arrived. 1/6/2019 @ 08:23 AM, resident was yelling in bed and taking off his oxygen (nasal cannula) .He reported difficulty breathing but wouldn't wear O2 cannula. (He is not) cooperative and moving arms a lot when taking vital signs. Called EMS three times but they are not answering the call. Awaiting EMS to pick him up. Resident still NPO (nothing by mouth). He is complaining pain to right leg with little movement. Oxygen saturation range on room air 75-89% fluctuating and resident is refusing to apply oxygen. Vital Signs (VS) @ 8 AM O2 sat 83% on room air, temperature 100.4 degrees Fahrenheit; Blood Pressure 78/50; respiratory rate 28 and Heart Rate 83. (Normal temperature range 97.6 - 99.6; normal blood pressure range 90/60 - 140/90; normal respiratory range 16-28) There was no documentation provided that a physician was notified of the resident's change of condition or request for consultation on what to do for the resident. After several attempts to get EMS to respond to the resident's needs the staff called the police at 11 AM (four hours after his O2 sats were found to be 63-74%.) EMS arrived and the resident was sent to Chinle hospital ER at 11:47 AM.

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F 0684 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 4) There was no documentation that a physician was notified of the delay in the EMS response. Review of the Medical records from the Chinle Comprehesive (sic) Health Care Facility (CCHCF) ER did not include in the chief complaint the resident's hypoxic and hypotensive episodes during the morning. The vital signs on 1/6/2019 at 01:53 PM; were Temp 100.1 degrees Fahrenheit; BP; 84/51; and O2 Sat 91%. Follow up with the ER doctor reported to the facility at 2:45 PM on 1/6/2019 the resident had a [MEDICAL CONDITION] and a fever. 03/15/19 at 07:47 AM, when asked about the incident, Staff 20 reported the following; It took a long to transfer him to the ER, the EMS is at the hospital. She called the hospital for EMS services. When asked if this delay in EMS response was a common problem Staff 20 said it depends. When asked if she had notified the physician of the low O2 Sat, she said she called the ER Nurse and reported to day shift at the facility to notify the attending physician. She stated, the attending (doctor) does not answer calls at night. She did not call the Medical Director at that time, because she stated she was told that staff were not to call him at night. Review of the No. NV-CA-18-0011 Collaborative Agreement Between Chinle Comprehesive (sic) Health Care Facility (CCHCF) Navajo Area Indian Health Service and Chinle Nursing Home (CNH): the following read in pertinent part: .1. CCHCF AGREES: B. These services shall fulfill the requirements of the Federal Regulations for Primary Medical Provider for IHS beneficiaries residing the in the home. These services include but are not limited to: .5. On-call after hours physician services are available to I.H.S. beneficiaries residing in the home for purposes of medical consultation, clarification of orders, and urgent queries . 03/15/19 at 08:40 AM, when asked to speak with the attending physician. Staff 2 stated she received notice that Resident 59's attending physician would not be available to talk with surveyors, until after the survey was completed. 03/15/19 at 12:20 PM, on a phone interview: When asked if he was aware of the delay in EMS response for Resident 59; The Medical Director stated he was not aware of the extent of the delay of services for this resident; however he was aware that the Chinle EMS system sometimes responded late. He stated that the facility did not know what else they could do about it. In regards to Resident 59's situation; he stated the night shift nurse should have notified the physician when the resident had pain and couldn't move his leg on 1/6/2019 at 03:09 AM. They should have called the CCHCF emergency room and spoke with the doctor at the hospital for direction. When informed that Staff 20 informed the surveyor that she was told they were told not to call the attending physician or the medical director at night; he stated that the Chinle hospital (CCHCF) ER doctors cover for night shift and weekends and they do speak directly to the facility nurses. When informed of the resident's 02 sat levels at 6:55 AM of 63-74% he stated they should have taken the resident directly to the ER when EMS was not available. He said that they should have put the resident in a wheelchair and taken him across the parking lot to the ER. According to an article about complications of [MEDICAL CONDITION] in the elderly the following Webster https://www.ncbi.nlm.nih.gov/pmc/articles/PMC 33/ read in part as follows: .Mortality incidence due to fat embolism syndrome (FES) varies among varied studies, probably because of its underdiagnosis.(27) Acute fulminant FES may lead to death due to right heart failure, while majority of deaths are usually due to [MEDICAL CONDITION]. Though prognosis for neurological defects is good, deaths have also been reported. Incidents of acute coronary syndrome, probably due to circulating fat globules have also been reported.(57) Overall, the mortality is estimated to be 5-15%.
F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, policy review, and interview the facility failed to ensure hazardous chemicals and materials were secured and not accessible. Specifically, for one sampled resident (R16), with behaviors of ingesting hazardous chemicals and materials, the facility's failure to properly store and secure hazardous materials constituted a finding of Immediate Jeopardy. The facility's deficient practice has the likelihood to place R16 and all 57 residents in the facility at risk for injury. Findings Include: Observation on 03/12/19 between 5:00 PM and 5:25 PM of the Women's unit identified an unlocked/unattended housekeeping room that revealed the following chemicals left unattended and accessible to unauthorized or cognitively impaired residents: OASIS 499 HBV disinfectant- full gallon jug; OASIS 100- full gallon jug; Advance Antibacterial Clean and Smooth- approximately gallon; OASIS 499 HBV disinfectant- 400cc (cubic centimeters) in spray bottle Spray bottle without a label of contents containing clear fluid- written on the bottle For furniture, beds, wheelchairs; Foaming Hand Sanitizer 19 full containers- 1200cc; Peroxide disinfectant and glass cleaner- two full bottles; Clorox toilet wand refills- five packages of six scrubbers; Windex- approximately 1/8 gallon; Sysco spray bottle with yellow fluid- approximately half full; Liquid bleach- full bottle; Bottle with purple fluid- approximately half full; One-Step detergent/disinfectant- approximately half full; Sysco spray bottle with blue fluid- approximately half full; Spray bottle with purple fluid- approximately half full; Sysco air freshener- one can. Interview with Housekeeper 26 on 03/12/19 at 5:00 PM stated the door should be locked, I left it open while I took out the trash. Housekeeper 26 described the trash is taken way out there and confirmed the housekeeping room that contained chemicals was left unattended and unlocked. Observation on 03/12/19 at 5:25 PM identified the Clean Supply Room on the Women's unit identified the door was propped open with a small trash can with the following hazardous items present: Two Spray bottles with clear liquid-approximately half full; Six 0.5 gram tubes of McKesson Skin protectant ointment with Vitamin A; Two 4 gram containers of Theracalazinc Body Shield (a skin protectant). Observation on 03/12/19 at 5:30 PM identified the following items were unattended in an unlocked Examination Room on the Women's unit: Top Care nail polish remover six ounces (oz); Sunmark [MEDICATION NAME] iodine 10% 8oz. (skin disinfectant); Two four oz. [MEDICATION NAME] (skin protectant); 40 tubes of [MEDICATION NAME] cream 1% 0.9gm; Sesame Street Baby Wash 10 oz; Sesame Street Baby Shampoo; Zinc Oxide ointment 16 oz (skin protectant); Caviwipes disinfectant wipes 1 lb., 3oz tub; EcoLab Digiscan (a foaming hand sanitizer) container; Observation o 03/12/19 at 5:40 PM identified the storage room door on the Women's unit was able to be opened without a key. A purple paper was placed in the door latch plate to prevent the latch from engaging. The following items were observed in

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 5) the unlocked/unattended room: SunMark hand sanitizer 8 oz; McKesson Hand Sanitizer 8oz; Clorox Wipes 1lb10oz; 3M High Strength Contact Adhesive 17.6oz; Krylon Metallic spray paint (Brilliant Gold) 15oz. Review the Face Sheet in the electronic medical record identified R16 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The Admission Minimum Data Set (MDS) Assessment with an Assessment Reference Date (end of look back period) of 01/04/19, identified Brief Interview for Mental Status (BIMS) score 14 of 15, indicating intact cognition and able to make decisions, and Functional Status identified independence for ambulation. Review of the Care Plan last reviewed on 01/15/19 revealed R16 is dependent on staff for meeting emotional, intellectual, physical, and social needs with a goal for the resident to attend and participate in activities of choice 4-6 times a week. The care plan failed to address R16's alcohol seeking and dependence and failed to identify R16 as alcohol seeking and a danger to herself. The Progress Note dated 12/10/18 revealed Resident would like to make all decisions for herself and there is no Power of Attorney in place. The Progress Note dated 12/15/18 revealed the resident was sent to the hospital for acute confusion, increased sleepiness, wandered without knowing where she was, incontinent, decreased coordination, shaking. The Progress Note dated 12/20/18 revealed the resident was sent to the hospital for increased confusion and agitation, wandering and being uncooperative. A nurse Incident Note dated 12/23/18 at 8:03 AM revealed R16 was intermittently confused during the night exhibiting disorientation, confusion and combative behaviors. The nurse's assessment revealed a musty breath odor with shaky/flapping arms and co (complaints of) RUQ (right upper quadrant of abdomen) discomfort. At 5:41AM, Emergency Medical Services was called. R16's room was searched for possible exacerbation of confusion, 3 bottles of hairspray and a bottle of APAP ([MEDICATION NAME]- an over the counter pain medication) was found in drawer. Confiscated items and noted 1 hairspray empty.The Progress Note dated 12/23/19 at 5:41 AM revealed Emergency Medical Services was called for possible exacerbation of confusion, 3 bottles of hairspray and a bottle of [MEDICATION NAME] found in drawer. Confiscated items and noted 1 hairspray empty. Returned from ED. Nurse documented ED notes states suggested the patient drank hairspray. The Progress Note dated 01/01/19 revealed the physician was called to report resident was unarousable. Physician recommends to send Resident{sig} her condition does not improve. Nursing found a can of aerosol hairspray in the resident's room. Resident was sent to the emergency room . The Behavior Note dated 02/16/19 at 7:17 AM revealed, two Certified Nursing Assistants (CNA) searched R16's room because the resident observed hiding a green bottle the previous day. The CNA's found empty bottles of hand sanitizer and perfume/body spray. The CNA's also found a paper towel wrapped in a white powder substance. The CNA's reported that when the resident goes out on pass to home, this is the behavior she displays upon return. The Communication Note dated 02/18/19, written by Social Worker 4 revealed R16's case manager was coming to see her. The care manager notified the social worker that R16 required transfer to the behavior health facility for her safety no 02/18/19 at 11:24 AM. The facility was to send a transfer packet to Winslow Campus of Care. R16's sister was notified of the need to transfer the resident. The Communication Note dated 2/19/19 written by Social Worker 4 revealed R16 came in to the social worker office requesting to leave this place. R16 stated that the devil is talking to me and that she was hearing voices, saying take off and kill yourself, these guys are naughty. God is here, he cast out the devil. The communication note indicated the Director of Nursing (DON) is aware of the suicidal ideation and 1:1 was recommended to the DON and a possible transfer out to a behavioral unit where (R16) can get the help she needs. The Communication Note written by Social Worker 4 on 02/21/19 at 3:23 PM revealed the social worker conducted a follow-up counseling session related to R16's suicidal thought The Nursing Admission Screening/History dated 02/28/19 untimed, revealed R16 returned from the acute care hospital after a stay that began on 02/23/19. R16's behavior was documented as has a flat affect and sad with anxiety. The Behavior Note dated 02/28/19 at 3:22 PM revealed the resident used her craft scissors to remove the band of her exit door alarm ankle bracelet after setting off the door alarms she was near. R16 stated I'm no child at a playground area. You guys don't need to keep track of me. Leave me alone. The Behavior Note written 02/28/19 at 7:34 PM revealed INCREASED VERBAL STATEMENTS OF NON-COMPLIANCE . I don't need any help I want to sit right here. and You people are just jealous of me and think you can tell me what to do, I can do whatever I want to do. The Wandering Risk Scale dated 02/28/19 revealed R16 is independent with ambulation, has a history of wandering and is at high risk of wandering. The Behavior Note dated 03/05/19 at 7:21 AM revealed Inappropriate behavior this shift. She was holding candy in her hand and was talking to them, each one had a name. The Behavior Note dated 03/06/19 revealed resident was not oriented to time, appeared confused, eyes glazed and not focusing. The nurse discussed the findings with physician and will likely send resident to return to ER (emergency room) due to increased irritability, increased confusion/altered Mental status. Review of R16's Discharge Planning Review dated 03/11/19 revealed resident has an anticipated length of stay of Long Term/Short Term, is expected to be discharged to another facility, determination has not been made regarding discharge to the community, if the resident were to return home she would be alone and does not have a support network, requires assist with medication administration and some activities of daily living, The Overall Summary for Potential Discharge indicates R16 has had a behavior issue within the last month. Elopement, SI ([MEDICAL CONDITION]) and consuming alcohol when she goes home OOP (out on pass) and states she does not like to stay here in the facility and wants to leave. Interview with Social Services 4 on 03/13/19 at 10:30 AM revealed the facility did not place the resident on one-to-one observation as recommended to the Director of Nursing. Interview with Social Services Coordinator/Certified Nursing Assistant (SSC/CNA) 4 on 03/14/19 at 8:30 AM revealed R16 has medical [DIAGNOSES REDACTED]. The SSC/CNA confirmed the tribal police were in the facility on 3/11/19 and removed a container of apple juice that contained an unknown substance. The SSC also confirmed R16 is has been ingesting hairspray and foaming hand sanitizer and has stated she would look everywhere to find her hairspray. The SSC acknowledged that if the resident were looking for substances to ingest and chemicals were unsecured, R16 could access the chemicals and cause harm to herself. Interview with the Assistant Director of Nursing on 03/14/19 at 11:40 AM confirmed the facility lacked a policy to direct staff to ensure chemicals are secured and unable to be accessed by residents. On 03/12/19 at 7:03 PM, the Director of Nursing, Assistant Director of Nursing, Quality Assurance and the Dietary Manager were notified that the facility's failure to properly store and secure hazardous chemicals, from R16 and residents at risk for wandering, independently mobile and with a cognitive impairment constituted findings of Immediate Jeopardy. The Immediate Jeopardy was determined to first exist on 03/12/19 at 7:03 PM when the facility failed to ensure chemicals and hazardous materials were secured. The facility presented an acceptable plan for removal of the Immediate Jeopardy on 03/15/19 at 6:40 PM, which time the survey team validated that the Immediate Jeopardy was removed with the facility' implementation of staff education on proper storage of chemicals.
F 0732 **Level of harm -** Potential for minimal harm **Residents Affected -** Many	**Post nurse staffing information every day.** Based on observation, interview and record review the facility failed to post the nursing staff information in a prominent place that is readily accessible to residents and visitors. This failure limits residents, family and visitors awareness of current staffing levels. Findings include:

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F 0732 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	(continued... from page 6) Observation on 3/11/19 at 03:45PM of the reception area revealed the nursing hours to be posted on a white board affixed to a side wall behind the reception desk, not readily visible to the public. The nurse staffing hours at Households 1 and 2 are posted inside the nursing station on a white board set 4-5 feet off the floor along a wall not easily visible. Interview on 03/11/2019 03:30 with the receptionist X 2 years she stated that since moving to the new building 2 months ago, nurse staffing information is kept behind the desk and that people would have to ask for that information. She further noted that since it is over there on one asks anymore. Interview 03/11/2019 at 03:18 with a Licensed Nurse when asked if the nurse staffing was posted in a manner that was readily visible and accessible to residents she stated No. Requested Policy and procedure on posting - not received .
F 0740 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	**Ensure each resident must receive and the facility must provide necessary behavioral health care and services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation and interview, the facility failed to ensure the necessary behavioral health services were provided to meet the needs for one of 34 Residents (R16) who exhibited unsafe practices of ingesting hazardous chemicals. Finding Include: Review of the Face Sheet in the electronic medical record identified R16 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The Admission Minimum Data Set (MDS) Assessment with an Assessment Reference Date (end of look back period) of 01/04/19, identified a Brief Interview for Mental Status (BIMS) score of 14 of 15, indicating intact cognition and Functional Status identified independence for ambulation. Review of the Care Plan last reviewed on 01/15/19 revealed R16 is dependent on staff for meeting emotional, intellectual, physical, and social needs with a goal for the resident to attend and participate in activities of choice 4-6 times a week. The care plan failed to address R16's alcohol seeking and dependence and failed to identify R16 as alcohol seeking and a danger to herself. The Progress Note dated 12/10/18 revealed Resident would like to make all decisions for herself and there is no Power of Attorney in place. The Progress Note dated 12/15/18 revealed the resident was sent to the hospital for acute confusion, increased sleepiness, wandered without knowing where she was, incontinent, decreased coordination, shaking. The Progress Note dated 12/20/18 revealed the resident was sent to the hospital for increased confusion and agitation, wandering and being uncooperative. The electronic medical record identified R16 was transferred to the hospital or urgent care on the following dates: 12/15/18- for acute confusion and hospitalized ; 12/20/18 for increased agitation and hospitalized ; 12/23/18 for increased confusion and suggested the patient drank hairspray for emergency room visit; 01/01/19-resident unarousable, empty container of hairspray in resident's room for an emergency room visit; 01/09/19 for increased confusion and hospitalized with hepatic [MEDICAL CONDITION] (an altered level of consciousness because of liver failure); and 02/23/19 for unresponsive, unable to arouse with painful stimuli and hospitalized with hepatic [MEDICAL CONDITION]. A nurse Incident Note dated 12/23/18 at 8:03 AM revealed R16 was intermittently confused during the night exhibiting disorientation, confusion and combative behaviors. The nurse's assessment revealed a musty breath odor with shaky/flapping arms and co (complaints of) RUQ (right upper quadrant of abdomen) discomfort. At 5:41AM, Emergency Medical Services was called. R16's room was searched for possible exacerbation of confusion, 3 bottles of hairspray and a bottle of APAP ([MEDICATION NAME]- an over the counter pain medication) was found in drawer. Confiscated items and noted 1 hairspray empty.The Progress Note dated 12/23/19 at 5:41 AM revealed Emergency Medical Services was called for possible exacerbation of confusion, 3 bottles of hairspray and a bottle of [MEDICATION NAME] found in drawer. Confiscated items and noted 1 hairspray empty. Returned from ED. Nurse documented ED notes states suggested the patient drank hairspray. The progress note dated 01/01/19 revealed the physician was called to report resident was unarousable. Physician recommends to send Resident{sig} her condition does not improve. Nursing found a can of aerosol hairspray in the resident's room. Resident was sent to the emergency room . The Behavior Note dated 02/16/19 at 7:17 AM revealed, two Certified Nursing Assistants (CNA) searched R16's room because the resident observed hiding a green bottle the previous day. The CNA's found empty bottles of hand sanitizer and perfume/body spray. The CNA's also found a paper towel wrapped in a white powder substance. The CNA's reported that when the resident goes out on pass to home, this is the behavior she displays upon return. The Communication Note dated 02/18/19, written by Social Worker 4 revealed R16's case manager was coming to see her. The care manager notified the social worker that R16 required transfer to the behavior health facility for her safety no 02/18/19 at 11:24 AM. The facility was to send a transfer packet to Winslow Campus of Care. R16's sister was notified of the need to transfer the resident. The Communication Note dated 2/19/19 written by the Social Worker 4 revealed R16 came in to the social worker office requesting to leave this place. R16 stated that the devil is talking to me and that she was hearing voices, saying take off and kill yourself, these guys are naughty. God is here, he cast out the devil. The communication note indicated the Director of Nursing (DON) is aware of the suicidal ideation and 1:1 was recommended to the DON and a possible transfer out to a behavioral unit where (R16) can get the help she needs. The Communication Note written by Social Worker 4 on 02/21/19 at 3:23 PM revealed the social worker conducted a follow-up counseling session related to R16's suicidal thought The Communication Note dated 2/19/19 written by the Social Worker 4 revealed R16 came in to the social worker office requesting to leave this place. R16 stated that the devil is talking to me and that she was hearing voices, saying take off and kill yourself, these guys are naughty. 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Review of R16's Discharge Planning Review dated 03/11/19 revealed resident has an anticipated length of stay of Long Term/Short Term, is expected to be discharged to another facility, determination has not been made regarding discharge to the community, if the resident were to return home she would be alone and does not have a support network, requires assist

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F 0740 **Level of harm -** Potential for minimal harm **Residents Affected -** Some	(continued... from page 7) with medication administration and some activities of daily living, The Overall Summary for Potential Discharge indicates R16 has had a behavior issue within the last month. Elopement, SI ([MEDICAL CONDITION]) and consuming alcohol when she goes home OOP (out on pass) and states she does not like to stay here in the facility and wants to leave. Interview with Social Services 4 on 03/13/19 at 10:30 AM revealed the facility did not place the resident on one-to-one observation as recommended to the Director of Nursing on 02/19/19. A subsequent interview with Social Worker 4 on 03/13/19 at 2:30 PM confirmed the facility sent the transfer information but failed to document the reason why R16 was not transferred to the behavioral health facility as planned. Social Worker 4 in interview on 03/13/19 at 2:30 PM confirmed the facility failed to assess the resident's mood, behaviors and psychosocial well-being upon admission and with frequent medical examinations and possible ingestion of chemicals. Social Worker 4 stated, R16 had a Ceremony to assist with mood, behaviors and psychosocial well-being, and confirmed the facility failed to determine the extent of benefit to the resident. Attempt to interview attending physician on 03/14/19 was unsuccessful.
F 0755 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility failed to assure expired medication was discarded and failed to discard Insulin within the required time frame after opening for resident 48. This deficient practice had the potential for nursing staff administering ineffective medication. Findings include: 1. [DATE] at 07:34 AM. During observation of medication storage task with Staff 20 the following was found: Household 2 medication room in the locked storage cabinet: One bottle of UTI-Stat liquid expired ,[DATE]; One bottle of [MEDICATION NAME]-liquid ([MEDICATION NAME] Sodium) the manufacturer's expiration date read ,[DATE]; however the pharmacy label had Use By: [DATE]. When asked what the facility did when there was such a discrepancy; Staff 20 stated it should have been destroyed as well as the UTI-Stat. Medications that are expired should be destroyed. 2. [DATE] at 07:52 AM, in the medication refrigerator was a plastic box with dividers to hold insulin for individual residents. Resident 48's Insulin- Detemir ([MEDICATION NAME]) 100 U/ml injectable had an open date of [DATE], expired [DATE]. Reorder date [DATE] and pickup date [DATE]. When shown the above container, Staff 20 stated [MEDICATION NAME] can be kept for 45 days after opening. ([DATE] would have been the 45th day). When asked why this had not been discarded, when asked what they did with the medication that had been delivered on [DATE], Staff 20 said they kept what they had until the new one came and it should be delivered any time. [DATE] at 08:29 AM, Staff 20 provided copies of the MEDICATION CHECK-IN LOG Dated [DATE]. Resident 48's Insulin Detemir ([MEDICATION NAME]) 100U/ml had been delivered to facility on [DATE]. Staff 20 stated she did not know where the new vial was. Staff 20 provided a list of MEDICATIONS WITH SHORTENED EXPIRATION DATES with manufacturer's instructions as follows: [MEDICATION NAME] (brand name); Insulin detemir injection; .Vials .expire 42 days after opening/puncturing . 3. [DATE] at 10:51 AM, The Household 2 - B wing, observations of the treatment room and cart with Staff 21 revealed the following: One open suture kit with tweezers in cupboard; The emergency cart had 4 of 4 packets of [MEDICATION NAME] Zinc ointment that expired ,[DATE]. 4. Review of R38's Physician Orders, dated (MONTH) 2019 identified [MEDICATION NAME] 2.5 MG give 0.5 tablet by mouth at bedtime for agitation. The date of the original order was [DATE]. Review of R38's Electronic Medication Administration Record [REDACTED]. The EMAR documentation dated [DATE] identified R38 refused his dose of [MEDICATION NAME]. Further review of the EMAR identified from [DATE] to [DATE], the facility still did not have the medication available to administer to the resident. Observation and interview on [DATE] at 7:27 AM with Licensed Practical Nurse (LPN)12 identified the House Hold (HH) 2 medication cart did not have any [MEDICATION NAME] medication in the cart. LPN12 indicated by looking at the EMAR, documentation identified R38 did not receive [MEDICATION NAME] last night, [DATE], because the medication was not available. LPN12 indicated she could not find any documentation if the medication had been ordered or not. Interview on [DATE] at 9:10 AM with the facility's[NAME] Clerk, revealed she was sometimes responsible for ordering residents' medication from the pharmacy when the refill expired, however, nurses were mainly responsible for ordering medications. The[NAME] Clerk revealed if the refill of a medication had expired, she would contact the resident's physician to obtain an order. The[NAME] Clerk indicated the nurse should have contacted her by email or using a communication form last night to make her aware of the need to order the medication. The[NAME] Clerk stated she did not receive any notification to order R38's medication until the Assistant Director of Nursing (ADON) came to her this morning and asked her to order the medication. The ward clerk further stated she had verbally communicated with the nurses that medication should be reordered when a resident was down to seven doses. Subsequent interview on [DATE] at 11:45 AM with LPN12 revealed after completing her morning medication pass, she attempted to refill R38's [MEDICATION NAME], however, was unable to refill the medication because the refill had expired. LPN12 indicated she immediately notified the ADON. LPN12 stated, Normally the night shift nurse would attempt to refill the medication and if the refill had expired, the nurse would complete a communication form letting the day shift know a new order from the physician would need to be obtained. Interview on [DATE] at 7:31 AM with Registered Nurse (RN)20 revealed she was assigned to R38 on [DATE] from 6:30 PM until 6:30 AM. RN20 revealed R38 did not receive [MEDICATION NAME] that evening at bedtime because the resident was out of the medication. RN20 revealed if a resident needed a medication reordered, and had a refill, the night shift nurse would call the refill in, however, if there were not any refills available, the nurse would notify the day shift who would then communicate to the ward clerk that an order was needed. RN20 stated she thought she had documented she communicated the resident was out of [MEDICATION NAME], but she did not. Interview on [DATE] at 8:18 AM, with the ADON revealed R38's attending physician could not talk to the survey team because he had a full schedule of patients to see and he would not be available for interview until next week. Subsequent interview on [DATE] at 8:53 AM, with the facility's[NAME] Clerk revealed prior to [DATE], she had not been notified of R38 needing an order for [REDACTED]. Subsequent interview on [DATE] at 9:29 AM with the ADON identified it was her expectation when R38 was out of medication, the night shift nurse would communicate with the day shift nurse, herself, the DON or the ward clerk. The ADON stated medication should have been reordered when there was only seven days of the medication left, however, with psychiatric medications, the pharmacy would not refill it that soon. The ADON further stated it was important medication to be ordered prior to running out to ensure the medication was at the facility when needed. Interview on [DATE] at 12:21 PM with the Medical Director revealed it was his expectation the facility nurses would have followed the rules and residents' medications would have been on hand. The Medical Director revealed if an order for [REDACTED]. Interview on [DATE] at 4:08 PM, with the Director of Nursing (DON) revealed it was her expectation the nurses would not have let R38 run out of medication. A policy related to ordering medication was requested on [DATE] at 4:36 PM, however, a policy was received from the facility. Interview, on [DATE] at 4:18 PM, with RN29 revealed she did recall giving R38 his last dose of [MEDICATION NAME] on [DATE]. Continued interview revealed she was usually pretty good about reordering the medication, but she may not have reordered it that night. Further interview revealed she was supposed to call and reorder the medication over the phone, but if the refill was expired, she would get a memo to the ward clerk who would communication with the physician and get a new order. Review of the policy titled, Medication Administration read in pertinent part as follows: .17. Prior to administration, the medication and dosage schedule on the resident's MAR indicated [REDACTED].the physician's

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F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 8) orders [REDACTED]. Facility personnel will contact PharmcareUSA if any discrepancies are noted .
F 0756 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.** Based on record review and staff interview, the facility failed to ensure the drug regime was conducted at least monthly by pharmacy for one of five residents (R) 30 reviewed for unnecessary medication. Findings Include: Interview and review of R30's medical record on 03/14/19 at 12:14 PM with[NAME] Clerk17 confirmed the pharmacy failed to conduct a monthly drug regime review for September, October, (MONTH) and (MONTH) (YEAR).[NAME] Clerk17 was unable to explain why the reviews were not conducted. The facility was unable to provide a policy related to the pharmacy requirement to conduct monthly drug reviews for each resident.
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.** Deficiency Text Not Available
F 0759 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure medication error rates are not 5 percent or greater.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility failed to assure their medication error rate was below 5%. The observed medication error rate was 26.92%. Several residents received the wrong dose of a medication; one resident received medication at the wrong time and one resident was not given a medication. Findings include: Medication pass task was observed beginning on 03/12/2019 at 04:05 PM and concluded on 3/13/2019 at 09:42 AM. The following was observed: 3/12/2019 at 04:05 PM on Household-1 medication cart and on 3/13/2019 AM on Household-2 medication cart. A total of 26 medications were given and there were seven errors - this equates to 26.92% error rate. Residents 58, 6, 14, 3 and 24 all received one tablet of Calcium-Vitamin D tablet 600-200 mg/unit from a house stock container. Review of each of the five residents' physician's orders revealed one tablet of Calcium-Vitamin D tablet 600-400 mg/unit orally once per day was supposed to be given. When informed about this Staff 10 and 11 stated, We use up what we have. They stated they had not informed the physician of this error. 03/12/19 at 04:26 PM, the following medication was given to Resident 3 who complained of knee pain at the time of evening medication pass: [MEDICATION NAME] 325 mg- 2 tablets. Review of the physician's orders for (MONTH) 2019 read as follows: [MEDICATION NAME] tablet- give 650 mg at bedtime for pain/fever related to [MEDICAL CONDITION] of knee; AND give 650 mg as needed for pain/fever as needed order for every morning only. 03/14/19 at 09:00- AM, during an interview; when asked about the [MEDICATION NAME] as needed for Resident 3, Staff 35 reviewed the physician's orders and validated the as needed [MEDICATION NAME] was only to be given in the morning. Staff 35 reviewed the Medication Administration Record [REDACTED]. 03/13/19 at 08:11 AM Resident 35 was not given a dose of [MEDICATION NAME] Sodium 100 mg capsule. During an interview at the time Staff 11 stated they ran out of the [MEDICATION NAME] Sodium 100mg capsules. Staff called another nurse at the other nurse's station who said they did not have any capsules. During observation of medication storage on 3/14/2019, there was [MEDICATION NAME] Sodium 100 mg tablets and liquid available. When asked why Staff 11 did not use either of these, she stated the order said capsules. When asked if she had contacted the physician to see if the resident could have the medication in a different form, she said no. When asked how they reordered house stock medication she said when the resident's individual bottle or unit dose card of OTC medication was running low one of the nurses placed the medication on a reorder list and used house stock of OTC medications until the individual prescription was refilled. Staff 11 stated the facility is short on medications sometimes. During a telephone interview with the medical director on 3/15/2019 at 12:20 PM, when informed about the above situation with [MEDICATION NAME] Sodium, he said the staff should have called the physician to notify of the lack of capsules and received approval to use the tablet or liquid. Review of the facility policy titled Adverse Consequences and Medication Errors (not dated or numbered) read in pertinent part as follows: .5. A 'medication error' is defined as the preparation or administration of drugs or biological which is not in accordance with the physician's orders, manufacturer specifications, or accepted professional standards and principles of professional(s) providing services. 6. Examples of medication errors include: a. Omission- a drug is ordered but not administered .g. Wrong time, h. Failure to follow manufacturer instructions .

F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** The facility failed to discard potentially hazardous food (PHF) by the expiration/use by date. In addition one refrigerator (household 1) had a thermometer that did not read the correct temperature. This deficient practice resulted in the potential for food borne illness for residents or staff eaten contaminated food. Findings Include: 03/11/19 at 09:00 AM, a brief initial tour of kitchen was conducted with Staff 14 and Staff 15. The following was observed: Observed walk in refrigerator; the following items were outdated: One packet of Swiss cheese single wrapped slices. The packet was open and there were a few slices missing. There was no open date on the packet. One open bag grated yellow cheese wrapped with plastic wrap. There was an open date of 2/14/2019; however there was no use by or expiration date. Four and one quarter packets of American cheese single wrapped slices with a use by date of 3/9/2019. The following packages of sandwich meat were outdated: Roast beef use by date 2/28/2019; Luncheon meat; Turkey breast and Ham use by date 3/9/2019 Three of five containers of sour cream, open date 1/31/2019 with use by date 2/28/2019. One of five containers of whipped cream cheese had an expiration date 3/5/2019. 03/13/19 at 03:41 PM, when asked about the items outdated on 3/11/2019, Staff 8 stated the staff told her about this and they threw out the items. They should have been thrown out on the use by date. 03/14/19 at 07:11 AM, observation of Household 1 resident refrigerator revealed the thermometer read 20 degrees. There was container of boxed juice beverage and two containers of Jello in this refrigerator. Neither were frozen. The temperature logs taped to the outside of the refrigerator indicted temperature range was 20 -28 degrees for 3/1/2019 through 3/14/2019. 03/14/19 at 08:22 AM, when informed Staff 6 about the reading in Household 1 refrigerator, he checked with the non-touch thermometer which read 28 degrees. The internal thermometer read 20 degrees. He placed a second internal thermometer to compare readings. Review of the Refrigerator Temp & Maintenance Log included directions to Report to Supervisor/Maintenance when recorded

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F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 9) temperatures are not adequate.
F 0837 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility.** Based on interview and record review the Governing Body failed to ensure the appointed or designated person or persons is responsible for establishing and implementing policies, procedures and programs and are effectuating safe operations of the skilled nursing facility. The Governing Body's failure to ensure safe management and operations of the facility contributes to continued noncompliance with the Medicare Longterm Care regulations, could potentially jeopardize the overall healthcare of any resident in the facility and may contribute to directly or indirectly to resident harm. Findings include: 1. Cross refer to the Emergency Preparedness regulations E0001 failure to have an Emergency Preparedness Program 2. Cross refer to the Immediate Jeopardy findings at F0689 Accident Hazardous. 3. Cross refer to the findings at F0580 Notification of Changes 4. Cross refer to the findings at F0838 lack of a Facility Assessment. 5. Cross refer to the findings at F0684 related to facility knowledge of concerns with area ambulance service and lack of an alternate plan. 6. Cross refer to the findings at F0867 lack of effective Quality Assessment Performance Activities 7. Cross refer to the findings at F0880 and F0881 lack of an Infection Control Program and Antibiotic Stewardship Program. 8. The CASPER 3 report was provide to the Acting Administrator at the time of the Entrance Conference on 03/11/2019. The CASPER 3 reports provides a history of the facility's noncompliance over the last 4 survey cycles. The report was explained to the Acting Administrator and licensed nurses (LN) 1, 2 and 5. The report shows a historical trend of repeated deficiencies most notably at: *Development of Comprehensive Care Plans *Drug Regimen Free from Unnecessary Drugs *Accident Hazardous *Infection Control and *Quality Assessment and Assurance. 9. On 03/14/2019 during an interview with Human Resource staff 28 she indicated to her knowledge the Administrator did not need a license to be the skilled nursing home administrator; he had been the administrator for years. In the presence of Staff 28 the Administrator's, and several nursing and other administrative staff's files were reviewed for education, licensure requirements, evaluations and qualifications. The comments within the employee evaluations had no comments on considerations to improve the facility's historical pattern of noncompliance with the Center's for Medicare and Medicaid regulatory requirements. 10. On 03/14/2015 attempts were made to contact Officers of the Navajoland Nursing Home Board of Directors. One of the board members returned the call and indicated they were made aware of the facility's concerns via quarterly meeting and though communication with the administrator. There were no specific comments regarding onsite visits to the facility, how the board had oversight or input into the all hazards Facility Assessment and/or oversight regarding the historical trend of continued noncompliance with some of the same basic Medicare regulatory requirements.
F 0838 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies.** Based on interview the facility failed to generate a facility assessment. Failure to generate a facility assessment taking into consideration the population served, the facility's physical and staffing limitations could potentially jeopardize the well-being of any resident with specific needs that may beyond the capabilities of the facility. Finding include: 1. On 03/11/2019 during the Entrance Conference with Licensed Nurse (LN) 1, LN2 and LN 5 they acknowledged that the skilled nursing facility has no Facility Assessment. A brief explanation was provided regarding the Facility Assessment and how the assessment may identify training needs that could be associated with infection control and or emergency preparedness was discussed. Some of the factor that were conveyed that needed to be considered in the Facility Assessment (with an all-hazardous approach) are: *the number of residents, their acuity and care needs *staffing types, competencies and training requirements *common infections within the facility *common or potential emergencies and/or disasters the facility/staff my encounter *the physical environment and possible equipment needs/limitations *transportation needs and/or limitations Again it was acknowledged by the aforementioned staff that the facility did not have an existing Facility Assessment. 2. During an interview with Administrator on 03/13/2019 he acknowledged he was creating the Facility Assessment.
F 0840 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and review of the facility's policy, it was determined the facility failed to notify the physician for one of 36 sampled residents (Resident (R) 38, who refused to take an antipsychotic medication. Findings include: Review of the facility's policy titled, CNH Policy for Medication Administration undated, revealed the physician was to be notified when a dose of medication had not been given. Continued review of the policy revealed if a regularly scheduled mediation was refused, the caregiver administering the medication would enter the correct documentation in the Electronic Medical Record (EMR.) Review of R38's Physician Orders, dated (MONTH) 2019, revealed the resident was ordered a half [MEDICATION NAME] 2.5 MG give 0.5 tablet by mouth at bedtime for agitation. The date of the original order was 01/09/19. Review of R38's Electronic Medication Administration Record [REDACTED].) Review of the Nursing Progress Notes, dated (MONTH) 2019, revealed no documentation the physician was notified of the resident refusing his medication. Review of R38's (MONTH) 2019 EMAR, revealed as of 03/14/19, the resident had refused his medication of [MEDICATION NAME] five out of the six days the facility had the resident's medication on hand (03/01, 03/02, 03/03, 03/05,03/07.) Review of the Nursing Progress Notes, dated (MONTH) 2019, failed to reflect the physician was notified of the resident's refusing the medication. Interview, on 03/15/19 at 7:31 AM, with Registered Nurse (RN) revealed R38 refused to take [MEDICATION NAME] while she was assigned as his nurse, however, she did not notify the resident's physician after each refusal. Interview on 03/15/19 at 8:18 AM, with the Assistant Director of Nursing (ADON) revealed R38's attending physician could not talk to the survey team because he had a full schedule of patients to see and he would not be available for interview until next week. Subsequent interview on 03/15/19 at 9:29 AM with the ADON revealed it was her expectation for nurses to try more than once

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F 0840 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 10) when R38 refused his medication of [MEDICATION NAME]. The ADON stated she would expect her nurses to follow their policy and notify the physician each refusal. The ADON further stated it was important the physician would have been notified. Interview, on 03/15/19 at 12:21 PM with the Medical Director revealed it was his expectation the nurses would have followed the facility's policy and notified the resident's physician about the resident refusing medications. Interview, on 03/15/19 at 4:08 PM with the Director of Nursing (DON) revealed it was her expectation the nurses would have followed the facility's policy and procedure about residents refusing medications and notified the physician. Interview on 03/15/19 at 4:18 PM with RN29 revealed when R38 refuses his medication, she documents that he refused in the progress notes. RN29 indicated the documented progress note is in a communication with the physician and the physician reviews the documentation every 60 days when he is at the facility. RN29 stated she was aware of the policy about notifying the physician, however, she did not know it meant to notify him after each missed dose, but thought it meant to notify the physician during the 60-day evaluation.
F 0867 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to operationalize its Quality Assessment Performance Improvement (QAPI) plan. Failure to effectively operationalize the QAPI may lead to missed opportunities to correct potentially negative outcomes. Findings include: On 03/13/2019 the Quality Assessment and Assurance (QAA)/Quality Assurance and Performance Improvement (QAPI) reports were reviewed. Within the reports there was NO department or individual assigned or delegated the responsibility to generate a specific plan or strategy to address the continued noncompliance of the facility with the Medicare regulatory requirements. The data consisted of narrative reports without benchmarks, there was no trending of collected information and no specific narrative on analysis. On that same date the undated eight page Chinle Nursing Home QAPI Program was reviewed. Within the QAPI Program Scope it indicates the facility QAPI plan addresses Clinical Care, Quality of Life and Resident Choice. Within Clinical Care the plan states - monitor existing QI/QM (Quality Index/Quality Measure) results, internal monitors for falls, medication errors, pressure ulcers, incident reports, infection reports. The Q[NAME] (Quality of Care) Team will discuss telephonically monthly with Medical Director and others to address care concerns. Within the same document under Guidelines for Governance and Leadership it states a. The community advisory board and administration are responsible and accountable for developing, leading, and closely monitoring a QAPI Program. b. The Board of Directors (BOD) and CEO ensures the Quality program is adequately resourced. On 03/14/2019 the Infection Control (IC) Practitioner was interview in the presence of Licensed Nurse (LN) 1 and LN 2. LN 5 is the IC practitioner and is also the Leader/Director for the facility QAPI Program. She acknowledged she spends less than fifty percent of her duty time with infection control and some of her other duty time is absorbed with functioning as a staff nurse as needed, providing direction and/or care as the Wound Care Nurse, assisting with scheduling/staffing in addition to being the Quality Leader and Infection Control Practitioner. During the interview a request was made to see any electronic or paper data showing the facility has been collecting and analyzing data with benchmarks, associated with facility or QM/QI concerns, implementing some type of changes or actions in attempts to improve outcomes of care and monitoring the results of those actions to determine if additional changes or actions were deemed to be necessary. As of the survey exit date NO historical data regarding the aforementioned request or related to any high risk, high volume or problem prone activities or situations was provided. On 03/15/2019 the facility policy titled Quality Assessment and Assurance - Policy and Procedure was reviewed. On the bottom of page 3 of that document it indicates the document was last reviewed by the facility in (MONTH) 2012. Within the same document (still on page 3) it has the Procedure for Subcommittees and reports to QAA Meetings. The reviewed QAPI reports submitted by the facility are reflective of the Procedure for Subcommittee reports. The reviewed reports consist of a list of prescribed items to address in the committee reports and does not demonstrate a systematic analysis with systematic actions that have been monitored over time do determine (with benchmarks) if the actions taken have led to improved outcomes of care. The facility failed to assure that known problems with the community Emergency Medical Service (EMS) was addressed in their QAPI/QAA meetings to provide alternate plan when EMS could not respond timely to an emergency. This failure resulted in one resident (resident 59) having to wait at least four to eight hours for emergency service when he had a hypoxic event and [MEDICAL CONDITION]. Cross reference F684 Facility staff failed to contact a physician when Resident 59 developed a hypoxic event 15 hours after he had fallen and approximately four (4) hours after experiencing pain and difficulty moving his leg. In addition when the EMS failed to respond to the facility staff calls for emergency aide for approximately four (4) hours, the physician was not notified. In addition the facility failed to plan for alternative method to handle emergency situations when the community EMS was not able to consistently provide prompt response to calls. 03/15/19 at 12:20 PM, on a phone interview: When asked if he was aware of the delay in EMS response for Resident 59; The Medical Director stated he was not aware of the extent of the delay of services for this resident; however he was aware that the Chinle EMS system sometimes responded late. He stated that the facility did not know what else they could do about it. In regards to Resident 59's situation; he stated the night shift nurse should have notified the physician when the resident had pain and couldn't move his leg on 1/6/2019 at 03:09 AM. They should have called the emergency room and spoke with the doctor at the hospital for direction. When informed that Staff 20 informed the surveyor that she was told they were told not to call the attending physician or the medical director at night; he stated that the Chinle hospital (CCHCF) ER doctors cover for night shift and weekends and they do speak directly to the facility nurses. When informed of the resident's 02 sat levels at 6:55 AM of 63-74% and the nurse's response to apply O2 at 3 l/min via nc; he said that was an inadequate dose and they should have taken the resident directly to the ER when EMS was not available. He said that they should have put the resident in a wheelchair and taken him across the parking lot to the ER. When asked if the facility had discussed the EMS slow response time in QAPI the Medical Director stated he did not think so. 03/15/19 at 02:15 PM, during an interview when asked how often the EMS was late responding to their calls, Staff 5 stated it happened pretty often; however it usually was not as bad as it was for Resident 59. When asked if they had included this issue in their QAPI meetings or plan, Staff 5 stated everyone was aware of the problem; however they did not discuss it because they did not think they could do anything about it. When asked for a list of calls made to the EMS and their response time, Staff 5 stated the facility did not keep track of that information. Review of the CNH QAPI Program read in pertinent part as follows: II. Scope .b. Our QAPI plan addresses: i. Clinical Care- .internal monitors for falls .incident reports . The Q[NAME] (Quality of Care) Team will discuss telephonically monthly with Medical Director and others to addresscare concerns c. We will use the performance prioritization sheet to identify areas of improvement and rank them by factors such as prevalence, risk .responsiveness From this we will determine our process Improvement Projects (PIP). Our focus will also be on how we can create innovative best practices .
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure it established and maintained an infection prevention and control program designed to provide a sanitary environment to help prevent the development and transmission of communicable diseases and infections. Failure to monitor, track and trend infections within the facility may contribute to the development of healthcare acquired infections among the residents, staff and visitors. Findings include:

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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 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 11) 1. On 03/14/2019 near 7:00AM concurrent observations and interviews occurred with laundry staff 16 in the laundry area. Staff # 16 was observed separating dirty linen, she had on gloves but did not have on a clothing protector gown. She removed her gloves but did not wash her hands immediately however she did finally sanitized her hands. Staff 16 was questioned regarding appropriate Personal Protective Equipment (PPE), she opened the PPE storage area and described what PPE she should be wearing in the laundry; she acknowledged she should be wearing a cover gown when separating dirty linen. Later that same date additional observations of the laundry occurred. Both Housekeeping staff 16 and 18 were in the laundry area in the vicinity of the washers. Neither staff had on clothing protectors. Staff 16 was being re-interviewed and Staff 18 was being observed filling one of the washers with dirty lines with gloved hands. Staff 18 filled the washer with the linens, started the washer, removed her gloves and left the laundry area. She did not washer or sanitize her hands when departing the laundry. Staff 16 acknowledged staff 18 should have washed or sanitized her hands before departing the laundry area. 2. On 03/13/2019 the Immunization and Antibiotic Stewardship polices were reviewed. On 03/14/2019 near 11:30AM the Infection Control (IC) Practitioner was interviewed in the presence of Licensed Nurse (LN) 1 and LN 2. LN 5 is the IC practitioner for the facility. During the interview a request was made to see any electronic or paper data showing the facility was monitoring, tracking, and trending the different types of infections within the facility. Additionally, the facility was requested to show and explain how the collected data could be possibly used after analyzed to implement actions to prevent the spread of possible infections among the residents and staff. That is, the collection of the aforementioned data may help the facility identify a concerns such as mapping to show clusters of potential or real infections such as urinary tract infections, skin infections, pneumonia's. Analysis of the collected data may help the facility identify more questions or concerns associated with the use of PPE or hand hygiene and may lead to learning opportunities. As of the survey exit date no electronic or paper data was provided by the facility to demonstrate the facility was plotting, monitoring, tracking, and trending real or potential infections in the facility as a means to control and prevent the spread of infections. An additional request was made to see any written or electronic data showing that the current Infection Control Policies and/or Program had an annual review and was approved or revised if indicated. As of the survey exit date no data was provided. On that same date a request was made to see any electronic or paper list of reportable diseases (such as airborne [MEDICAL CONDITION] or any highly contagious disease) that the facility may need to report any agency within the Navajo Nation. LN5 reported that no list exist and no list was provided as of the survey exit date. No data associated with common historical infections within the facility or in the community was requested as the LN 5 acknowledged during the interview that the Facility Assessment had not been completed.
F 0881 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Implement a program that monitors antibiotic use.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure it completely established and maintained its antibiotic stewardship program. Failure to completely operationalize the facility antibiotic stewardship which includes protocols and a system to monitor antibiotic use may contribute to antibiotic resistance and/or healthcare acquired super-infections due to prolong and/or inappropriate use of antibiotics. Findings include: 1. On [DATE] the Immunization and Antibiotic Stewardship policy was reviewed. On [DATE] near 11:30AM the Infection Control (IC) Practitioner was interview in the presence of Licensed Nurse (LN) 1 and LN 2. LN 5 is the IC practitioner for the facility. She acknowledged she had no recent formal or informal training related to infection control. She also acknowledged she spends less than fifty percent of her duty time with infection control. Some of her other duties involve being the Quality Leader, functioning as a staff nurse as needed, providing direction and/or care as the Wound Care Nurse, assisting with scheduling/staffing and so on. During the interview a request was made to see any electronic or paper data showing the facility has been monitoring, tracking and trending of the different types of infections within the facility. A request was also made for the facility show and explain how the aforementioned data may be used to help control and prevent the spread of infections within the facility. As of the survey exit date NO data was provided. The facility policy regarding Antibiotic Stewardship states: An ASP (Antibiotic Stewardship Program) team will be established to be accountable for the stewardship activities. The ASP team will consist of the Medial Director, Administrator, and Director of Nursing, Infection Preventions (IP) MDS Coordinator and Pharmacy Consultant. As a team they will: (see items i-v below). i. Review Infections and monitor antibiotic usage patterns on a regular basis. ii. Obtain and review Antibiograms for institutional trends of resistance. iii. Monitor multi-drug resistance organism's (MRSA, VRE, ESBI, CRE etc (SIC) and ,[MEDICAL CONDITION]. difficult (SIC) infections. iv. Report monthly or quarterly as appropriate, the number of antibiotics prescribed (e.g., days-of therapy) and other standardized metrics per protocol. v. Include a separate report section for the number of residents on antibiotics that did not meet criteria for active infections. Under Section 5 of the same policy there is verbiage related to Tracking that states b. IP will collect and report data per protocol such as: iii. Number of patients treated with antibiotics who meet McGeer criteria for active infection. c. Pharmacy consultant will review and report antibiotic usage patterns, most specifically recommendations made to prescribers as follow up to quarterly stewardship protocol reporting. On that same date the IC Practitioner was requested to provide the facility Antibiogram. Antibiograms are important tools for health care professionals involved in prescribing empiric antibiotics for suspected bacterial infections. These tools utilize microbiologic data from resident specimens from a nursing facility to estimate prevalence of antibiotic susceptibilities for common bacterial pathogens. They are also an important component of monitoring trends in antimicrobial resistance within a nursing home (Nursing Home Antimicrobial Stewardship Guide Help Clinicians Choose the Right Antibiotic (YEAR), page 2). LN5 stated the facility had NO Antibiogram that was being used by the facility. During the interview there was discussion on how the facility my use McGeer's Criteria to help identify when a patient may meet specific endpoints which may be diagnostic of specific infections. At the end of the interview LN5 was requested to provide and/or show paper or electronic data showing the facility had current, procedures and protocols that had been reviewed and approved by the Medical Director to facilitate appropriate antibiotic use within the facility. As of the survey exit date NO data was provided. 2. Later that same date the records of resident 38 were reviewed; she was one of the 4 residents identified on the Resident Matrix to be on antibiotics. The records reflect she is a [AGE] year old female who was admitted on [DATE]. Some of her multiple [DIAGNOSES REDACTED]. The physician orders [REDACTED]. The physician's orders [REDACTED]. The physician progress notes [REDACTED]. Recurrent UTI: Only one UTI since starting [MEDICATION NAME]. Continue Keflex 250mg daily. On [DATE] LN 5 was questioned on how the facility determined there was a clear indication to continue the antibiotic. Or if the facility had any lab results indicating that the Resident 38 was not colonized with microorganisms in her urine. No data was provided. Resident 38's urine lab results were also reviewed. Her last urine analysis is dated [DATE] and it indicates in the comments that the specimen is not a clean catch and to please resubmit. The last urine culture (test to determine what microorganisms may be growing in the urine and thereby help the practitioner determine appropriate antibiotic use) is dated [DATE]. No other urine lab records exist from (YEAR) to the time of the survey exit. The pharmacy monthly drug regimen review reports for (YEAR) to 2019 were studied . There is no comments or recommendations from the reviewing pharmacist to the nursing staff or the facility regarding the continued use of the antibiotic for greater than one year in the absence of urinary tract infection symptoms. Aside from the continued use of [MEDICATION NAME] the nursing interventions are appropriate in helping prevent urinary tract infection for Resident 38. There is little supporting evidence of the effective operationalization and implementation of the existing Antibiotic Stewardship Program.