STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035173	A. BUILDING _____ B. WING _____	12/13/2018

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CHRISTIAN CARE NURSING CENTER	11812 NORTH 19TH AVE PHOENIX, AZ 85029

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 0554 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Allow residents to self-administer drugs if determined clinically appropriate.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff and resident interviews, and policy review, the facility failed to ensure one resident (#16) was able to self-administer a medication as ordered. Findings include: Resident #16 was admitted on (MONTH) 6, (YEAR), with [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. Review of a medication self-administration safety screen dated (MONTH) 3, (YEAR) revealed the physician ordered Bengay to be self-administered unsupervised and stored at the bedside. The screening included that the interdisciplinary team discussed the review with the Director of Nursing (DON) and felt that the resident was safe to self-administer the medication. The Minimum Data Set (MDS) assessment dated (MONTH) 22, (YEAR), revealed a Brief Interview for Mental Status score of 15, which indicated the resident was cognitively intact. An interview was conducted with the resident on (MONTH) 10, (YEAR) at 9:21 a.m. She stated that she was told it was a State mandate that certain things be removed from her room. The resident stated that her Bengay was taken away last week and that now she has to ask the nurses to administer the cream. She stated that this makes it more difficult for her as she has to interrupt a Certified Nursing Assistant (CNA) or a nurse. An interview was conducted with a Licensed Practical Nurse (LPN/ staff#6) on (MONTH) 13, (YEAR) at 9:44 a.m. She stated that for a resident to administer their own medication, a self-administration assessment would be conducted by the DON, an order would be obtained from the physician, the medication would be placed in a lock box in the room, and a weekly check would be conducted. During an interview conducted with a LPN (staff #46) on (MONTH) 13, (YEAR) at 11:20 a.m., he stated that if a resident desires to self-administer a medication, staff would notify the doctor or the nurse practitioner and obtain an order for [REDACTED].#16 should be able to have her Bengay but that it was taken away and that he does not know who removed it. An interview was conducted with the DON (staff #14) on (MONTH) 13, (YEAR) at 11:34 a.m. He stated that when the facility entered the survey window, staff did a purge and tried to remove anything from resident rooms that State would not allow the residents to have. He stated that it is the right of the resident to self-administer medications and treatments. The DON stated that the facility's process for a resident to self-administration medication is an assessment that the resident knows what the medication is, is able to demonstrate how to administer it, and that the resident understands the nurse needs to be notified when the medication has been administered. He stated that the medication would be kept in a secure location i.e. a locked drawer. The DON stated that resident #16 has an order to self-administer Bengay and that the medication should not have been taken away from her. He acknowledged that staff did not follow their policy or the regulation. The facility's policy regarding self-administration of medication revealed that, if ordered by the physician, residents may be given the opportunity to self-administer their own non-narcotic medications, unless the interdisciplinary team determines the self-medicating would be contraindicated. The policy further included that if the assessment determines that the resident is competent in self-administration of the medication, the physician will be contacted for a self-administration order.
F 0576 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure residents have reasonable access to and privacy in their use of communication methods.** Based on resident and staff interviews and policy and procedure, the facility failed to ensure residents' mail was delivered upon receipt of the mail by the facility. Findings include: On (MONTH) 12, (YEAR) at 2:15 p.m., a meeting was conducted with residents who participated in the Resident Counsel. During the meeting the residents stated that they did not receive any mail delivery on Saturdays and that they believe the weekend mail is held. During an interview conducted with the Activity Director (staff #49) on (MONTH) 12, (YEAR) at 3:10 p.m. He stated that he delivers mail to the residents Monday through Friday. He stated that mail is delivered to residents on Saturdays if an activity assistant is available but that no assistant has been working on Saturday. Staff #49 stated that residents' mail delivered to the facility on Saturdays is left at the security office by the postal worker and that the security staff puts the mail into his mail box and that he delivers the mail to the residents on Monday. An interview was conducted with the Director of Nursing (DON/staff #14) on (MONTH) 13, (YEAR) at 8:35 a.m. He stated that the expectation is that mail will be delivered on the weekend to the residents. The facility's policy regarding mail distribution included that the activity staff or designated volunteer will deliver all mail within a 24 hour period.
F 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview, and review of policy and procedure, the facility failed to ensure that a Do Not Resuscitate (DNR) form for one resident (#40) was signed by a witness. Findings include: Resident #40 was readmitted on (MONTH) 16, (YEAR), with a [DIAGNOSES REDACTED]. Review of the clinical record revealed a Preferred Course of Treatment form signed and dated by the resident's daughter on 1/18/2017, that the resident did not want cardiopulmonary resuscitation measures. A State form titled Prehospital Medical Care Directive (Do Not Resuscitate) dated and signed by the resident's daughter on (MONTH) 18, (YEAR), revealed information for emergency medical technicians (EMTs) or hospital emergency personnel that the resident does not want any resuscitation measures.

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) However, further review of the form, revealed the space for the date and signature of the witness to the Directive was blank.An interview was conducted on (MONTH) 12, (YEAR) at 10:55 a.m. with a Licensed Practical Nurse (LPN/staff #46). The LPN stated that a social worker completes the Do Not Resuscitate (DNR) forms and that a witness signature needs to be obtained for the DNR form to be valid. During an interview conducted on (MONTH) 12, (YEAR) at 10:59 a.m. with the social service worker (staff #1), staff #1 stated that staff members, including nurses should obtain a witness signature when a DNR form is filled out and that this DNR form should have been signed by a witness. An interview was conducted on (MONTH) 12, (YEAR) at 11:58 p.m. with the Director of Nursing (DON) (staff #14). The DON stated that advance directives are discussed with a resident on admission. He stated that if the resident chooses not to be resuscitated, the advance directive forms are completed and the required signatures are obtained. The DON stated that for the directive to be valid, the expectation is that the prehospital medical care directive form contains the required witness signature. The facility's policy regarding Advanced Directives revealed that when the consent for DNR is signed by the resident, family or guardian, the signature must be witnessed by at least one other person.
F 0623 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, the facility failed to send a copy of the transfer notice to the Office of the State Long-Term Care Ombudsman when one resident (#24) was discharged to the hospital. Findings include: Resident #24 was admitted to the facility on (MONTH) 2, (YEAR), with [DIAGNOSES REDACTED]. Review of the clinical record revealed the resident was transferred from the facility and admitted to the hospital for a urinary tract infection on (MONTH) 8, (YEAR). The clinical record revealed no evidence that the Long-Term Care Ombudsman was notified that the resident was transferred to the hospital. An interview was conducted with the social worker (staff #1) on (MONTH) 13, (YEAR) at 1:35 p.m. Staff #1 stated that she notifies the ombudsman daily by email when residents are admitted to the hospital. Staff #1 stated that she sends an email at the end of each day to the ombudsman listing all of the residents who were discharged to the hospital. Staff #1 further stated that she was having trouble locating the email for this resident's transfer. During another interview conducted with the social worker on (MONTH) 13, (YEAR) at 2:00 p.m., the social worker stated that she thought she may have called the ombudsman regarding the resident's transfer to the hospital rather than sending an email. Another interview was conducted with the social worker on (MONTH) 13, (YEAR) at 2:23 p.m. Staff #1 stated that she made a note in her calendar that she called the ombudsman. Staff #1 further stated that the facility recently started sending emails to the ombudsman because they needed a better way of keeping track of the ombudsman notifications. The facility did not have a policy regarding sending a copy of the transfer notice to a representative of the Office of the State Long-Term Care Ombudsman.
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, staff interviews, and policy review, the facility failed to ensure there was provision of showers for one resident (#95). Findings include: Resident #95 was admitted to the facility on (MONTH) 13, (YEAR), with [DIAGNOSES REDACTED]. The resident was discharged on (MONTH) 26, (YEAR). A baseline care plan dated (MONTH) 14, (YEAR) included the resident preferred to have daily showers. An admission care plan revealed the resident had impairment with activities of daily living and required assistance of one staff for bathing. An intervention included the resident would be assisted as needed with showers or baths twice weekly. An admission Minimum Data Set assessment dated (MONTH) 20, (YEAR), revealed a Brief Interview for Mental Status score of 15 which indicated the resident had no cognitive impairment. The Certified Nursing Assistant (CNA) activities of daily living (ADL) flowsheet for (MONTH) (YEAR) revealed a task section for the staff to initial when a shower or bath had either been completed or offered and declined by the resident. For the 14 days the resident resided at the facility there was only one date that the resident had either been offered or provided a shower or bath. There was no documentation the resident had been provided a bath or shower or that the resident had been offered and then declined the shower or bath. A review of the nursing progress notes revealed no documentation regarding showers or baths. An interview was conducted with a Licensed Practical Nurse (staff #46) on (MONTH) 11, (YEAR) at 2:57 p.m. He stated that the goal is to provide residents a shower 24 hours after admission and then schedule showers twice a week. An interview was conducted with the Director of Nursing (DON/staff #14) on (MONTH) 11, (YEAR) at 3:02 p.m. He stated that the policy is for CNAs to document all information about showers and bathing on the CNA ADL flowsheet. The DON stated that if a resident refuses or does not want a shower, it may be offered later. He stated the CNAs will report the refusal to the nurse and document it on the flowsheet. He stated a nurse may include information about a bath or shower in the nursing progress notes. The DON stated all information about a shower or bath has to be documented. An interview was conducted with a CNA (staff#27) on (MONTH) 12, (YEAR) at 12:47 p.m. She stated showers are offered 2 times weekly and if the resident refuses, it is reported to the nurse. The staff further stated information about the shower or bath is documented on the ADL flowsheet. The facility's policy regarding showers and baths included the following: It is the policy of this facility to bathe/shower every resident at a minimum twice a week or more if needed. The policy also included to document in the ADLs the evidence of care.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **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 clinical record reviews, staff interviews, and policy review, the facility failed to ensure hospice services were provided in accordance with professional standards of practice for one resident (#27) and failed to ensure a skin integrity issue was adequately assessed and monitored for one resident (#31). Findings include: Resident #31 was admitted to the facility on (MONTH) 12, (YEAR), with [DIAGNOSES REDACTED]. Review of the admission physician's orders [REDACTED]. [REDACTED]. Cleanse with normal saline. Using a cotton swab, approximate the wound edges. Apply skin prep to the periwound skin. Secure flap with steri strips. Leave open to air unless wound edges could not be approximated, then cover with a non-adherent foam dressing. Change every 3 days until healed. A care plan dated (MONTH) 20, (YEAR) revealed the resident was at risk for impaired skin integrity and trauma to skin. Interventions included weekly head to toe skin assessments on shower days. Physician orders [REDACTED]. Review of the Treatment Administration Record (TAR) for (MONTH) (YEAR) and (MONTH) 1-8, (YEAR), revealed documentation the

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F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) head to toe skin assessment had been completed. There was further documentation to indicate the resident had a skin integrity problem. A skin assessment form dated (MONTH) 8, (YEAR), revealed documentation that a dressing to the left elbow continues to be clean, dry, and intact. Review of the nursing progress notes for (MONTH) and (MONTH) 1-8, (YEAR), revealed no documentation of a skin problem to the left arm. During a family interview conducted on (MONTH) 10, (YEAR) at 11:34 a.m., the family member stated the resident has a bandage on the left inner elbow area. The family member stated the bandage was probably from a previous intravenous needle from when the resident was in the hospital. An interview was conducted with a Licensed Practical Nurse (LPN/staff #46) on (MONTH) 13, (YEAR) at 12:23 p.m. The LPN stated he had just removed the left elbow dressing because there was no date to indicate when the bandage had been previously applied. He stated the resident appears to have a skin tear and that he applied a new dressing. He then displayed the documentation he had placed in the clinical record: Observed skin tear to left elbow region. Dried scab to surrounding area and no drainage or bleeding noted at this time. Staff #46 further stated he implemented the physician's interim orders. An interview was conducted with a charge nurse (LPN/staff #6) on (MONTH) 13, (YEAR) at 12:30 p.m. She stated every skin issue has to be checked and monitored. Staff #6 stated this was not done for resident #31, so there was no way to determine if there had been any progress or deterioration of the skin problem. She further stated it is standard nursing practice that all orders, including skin assessments, be completed and documented. A policy regarding assessment and monitoring for residents at risk for skin integrity issues was requested however the administrative staff stated they did not have a written policy. -Resident #27 was admitted on (MONTH) 1, (YEAR), with [DIAGNOSES REDACTED]. An admission MDS (Minimum Data Set) assessment dated (MONTH) 8, (YEAR) included a BIMS (Brief Interview or Mental Status) score of 13, which indicated the resident was cognitively intact. The MDS assessment also included the resident did not have a condition or chronic disease that would result in a life expectancy of less than six months. A significant change in status MDS assessment dated (MONTH) 29, (YEAR), revealed the resident was receiving hospice. The assessment also included the resident had a condition or chronic disease that would result in a life expectancy of less than six months. Review of the hospice binder revealed the resident was admitted to hospice services on (MONTH) 15, (YEAR) with a medical [DIAGNOSES REDACTED]. However, further review of the clinical record did not reveal a physician's orders [REDACTED]. During interviews conducted on (MONTH) 13, (YEAR) at 12:10 and 12:51 p.m. with the Director of Nursing (staff #14), the Director stated that there should be a physician's orders [REDACTED]. The Director stated that resident #27 did not have a physician's orders [REDACTED]. An interview was conducted on (MONTH) 13, (YEAR) at 1:06 p.m. with a LPN (Licensed Practical Nurse/staff #6). The LPN stated that when a resident is to receive hospice services, a physician's orders [REDACTED]. Staff #6 stated that after hospice has evaluated the resident, a physician's orders [REDACTED]. The LPN stated the nurse will write a care plan for hospice care. The LPN was unable to locate a physician's orders [REDACTED]. A policy and procedure titled Hospice Care included the following: - A physician's orders [REDACTED]. - The MDS/Care plan nurse will care plan the order to admit the resident to hospice care with supporting diagnosis. The care plan will also refer to hospice care plans for comfort and other issues addressed in the care of the resident while under hospice care.
F 0698 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Past noncompliance - remedy proposed** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interviews, the facility failed to ensure there was an order for [REDACTED]. Findings include: Resident #44 was admitted (MONTH) 28, (YEAR), with [DIAGNOSES REDACTED]. A nursing progress note dated (MONTH) 28, (YEAR) included the resident had [MEDICAL CONDITION], had a fistula in the right upper arm, and was on [MEDICAL TREATMENT] Tuesday, Thursday, and Saturday. Nursing notes dated (MONTH) 29, (YEAR) revealed the resident left for [MEDICAL TREATMENT] that morning but did not included a pre and post [MEDICAL TREATMENT] assessment. Review of a physician progress notes [REDACTED]. However, review of the physician's orders [REDACTED]. Review of nursing notes dated (MONTH) 4, (YEAR) did not reveal documentation if the resident received [MEDICAL TREATMENT] or any pre and post [MEDICAL TREATMENT] assessment. The admission Minimum Data Set assessment dated (MONTH) 5, (YEAR) revealed a Brief Interview of Mental Status score of 15, which indicated no cognitive impairment. The assessment included [DIAGNOSES REDACTED]. Review of the care plan dated (MONTH) 6, (YEAR) revealed the resident needed [MEDICAL TREATMENT] related to [MEDICAL CONDITION] with one goal that the resident will have immediate intervention should any signs or symptoms of complications from [MEDICAL TREATMENT] occur and a second goal that the resident will have no signs or symptoms of complications from [MEDICAL TREATMENT]. The care plan included the following interventions -Check and change dressing at access site at right upper arm and observe for signs of infection. -Encourage the resident to go for the scheduled [MEDICAL TREATMENT] appointments on Tuesday, Thursday, and Saturday. -Monitor Vital Signs (every shift and prn). Notify medical doctor of significant abnormalities. -Pre and post [MEDICAL TREATMENT] assessments. Further review of the nursing notes for (MONTH) 6, 8, and 11, (YEAR) revealed the resident had [MEDICAL TREATMENT] but did not reveal documentation of pre and post [MEDICAL TREATMENT] assessments. Review of the (MONTH) and (MONTH) (YEAR) Medication Administration Record [REDACTED]. During an interview conducted with the Director of Nursing (DON/staff #14) on (MONTH) 13, (YEAR) at 12:54 p.m., the DON stated that the resident did not have a physician's orders [REDACTED]. An interview was conducted with a Licensed Practical Nurse (LPN/staff #6) on (MONTH) 13, (YEAR) at 2:13 p.m. She stated the [MEDICAL TREATMENT] is assessed daily by nursing and when the resident returns from [MEDICAL TREATMENT] and is documented in the nurse's skilled note. After reviewing the clinical record, the LPN acknowledged there was no order for [MEDICAL TREATMENT]. An interview was conducted with the DON (staff #14) on (MONTH) 13, (YEAR) at 2:46 p.m. He stated that when a resident is admitted that requires [MEDICAL TREATMENT], the physician should be notified and an order obtained for [MEDICAL TREATMENT]. The DON stated staff sends a packet of information with the resident to the [MEDICAL TREATMENT] facility and that the resident brings back documentation from the [MEDICAL TREATMENT] facility regarding the [MEDICAL TREATMENT], an assessment of the resident's condition, a notation of any issues, as well as a set of vital signs. He stated that a Risks and Benefits of Transport form would be completed for each [MEDICAL TREATMENT] treatment and would include a note of the resident's status on return from [MEDICAL TREATMENT]. However, the DON was unable to locate the forms for this resident. A [MEDICAL TREATMENT] policy was requested and the DON stated that the facility did not have a policy regarding [MEDICAL TREATMENT].
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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policy review, the pharmacist failed to document and report a [MEDICAL CONDITION] medication irregularity to the attending physician, the Medical Director, and the Director of Nursing

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F 0756 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) for one resident (#6). Findings include: Resident #6 was admitted on (MONTH) 10, (YEAR) with a [DIAGNOSES REDACTED]. Review of the physician's orders [REDACTED]. The Medication Administration Record [REDACTED]. A review of the pharmacy recommendations for (MONTH) (YEAR) revealed a recommendation to add how the resident manifests anxiety to the behavioral monitoring related to the [MEDICATION NAME] prn order. Review of the physician's orders [REDACTED]. The MAR for (MONTH) (YEAR) revealed the resident had no side effects and no behaviors of verbalized panic attacks or nervousness. The MAR indicated [REDACTED]. A review of physician and Nurse Practitioner progress notes revealed no rationale for the no end date for the prn [MEDICATION NAME] and did not indicate the duration of the order. A review of pharmacy recommendation reports for October, November, and (MONTH) (YEAR) revealed no recommendations regarding the no end date prn [MEDICATION NAME] order. An interview was conducted with a Licensed Practical Nurse (LPN/ staff #6) on (MONTH) 13, (YEAR) at 2:30 PM. The LPN stated that the pharmacist reviews all resident medications monthly and sends a report to the facility with recommendations for any medication irregularities identified in the review. She stated that she is one of the staff tasked with getting written responses from the physicians to the recommendations and entering any new orders into the system. The LPN also stated that they have a [MEDICAL CONDITION] medication review committee which meets quarterly to discuss all residents with [MEDICAL CONDITION] medication orders and that the consulting pharmacist is a member of the committee. She stated that the committee reviews residents receiving PRN [MEDICAL CONDITION] medications and that for those medications that are not antipsychotics, the physician must evaluate the person face to face before they can renew the medication after 14 days, but there need not be any limit after the initial 14 day review. She stated that resident #6 was evaluated by the physician in a face to face meeting and the medication was renewed with no stop date. During an interview conducted with the Director of Nursing (DON/staff #14) on (MONTH) 13, (YEAR) at 2:30 PM, the DON stated that [MEDICAL CONDITION] PRN medications could only be ordered for 14 days. An attempt was made to interview the consulting pharmacist, but there was no response. The facility's policy titled Pharmacy: Request for Medication Regimen Review revealed that a medication regimen review will be completed to assess whether there is a potential medication related cause, to detect excessive doses, high risk drugs and drug combinations, duplicate therapy, and subsequent communication with nurses and prescribers to address issues identified. The policy included once the pharmacist has completed the medication regimen review form, the form will be placed into the clinical record.
F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policy review, the facility failed to ensure there was adequate indications for the use of [MEDICAL CONDITION] medications for one resident (#4); failed to ensure that GDR (Gradual Dose Reductions) were attempted within the required timeframe or that there was clinical rationale documentation by the physician why GDRs were contraindicated for one resident (#4); and failed to ensure that PRN [MEDICAL CONDITION] medication orders were limited to 14 days unless the prescribing practitioner documented their rationale for extending the medication beyond 14 days and indicated the duration for the PRN order for one resident (#6). Findings include: -Resident #4 was admitted on (MONTH) 29, (YEAR), with [DIAGNOSES REDACTED]. The physician's orders [REDACTED]. The [MEDICAL CONDITION] Care plan dated (MONTH) 30, (YEAR) included the use of Duloxetine and [MEDICATION NAME] for the [DIAGNOSES REDACTED]. The goal was that the resident would have no side effects from the use of the medications. Interventions included monthly drug review by the consulting pharmacists, monitoring for side effects, and medications as ordered. The care plan did not include the use of NPI (non-pharmacological interventions) to address the resident's behaviors. The pharmacy medication regimen review dated (MONTH) 30, (YEAR) included a recommendation to initiate behavioral and side effect monitoring related to Duloxetine use. This review was signed by the physician who agreed to the recommendation. Review of the behavior monitoring records for (MONTH) 1, (YEAR) through (MONTH) 31, (YEAR) revealed the resident had verbalization of sadness on (MONTH) 11 and 12, (YEAR). It also revealed that there were no NPI in place to address the resident's target behaviors. Further review of the clinical record for this timeframe revealed the resident had multiple fall incidents. The pharmacy medication regimen review dated (MONTH) 5, (YEAR) included recommendations to consider the risk versus benefit of Duloxetine and [MEDICATION NAME] which may increase fall risk; and to discontinue or decrease the dose as clinically appropriate. Per the review, the resident was being administered Duloxetine and [MEDICATION NAME] along with three other medications which may increase the resident's fall risk. This form was signed by the physician, who indicated that benefits greater than risks and that the physician did not agree with the pharmacist. Review of the clinical record revealed that the resident had fall incidents on (MONTH) 11 and 12, (YEAR). The quarterly MDS (Minimum Data Set) assessment dated (MONTH) 8, (YEAR), revealed a BIMS (Brief Interview for Mental Status) score of 13 indicating the resident had intact cognition. The assessment included the mood score was 0 indicating the resident had no depression and that the resident was administered antidepressant medications. The assessment also included the resident had 2 or more falls with injury and 2 or more falls without injury. The psych evaluation note dated (MONTH) 29, (YEAR) included the resident was receiving Duloxetine 60 mg by mouth daily and [MEDICATION NAME] 15 mg by mouth at bedtime for depression. Per the documentation, the resident displayed persistent depression .related to difficulty with adjustment . and that the plan included no medication changes. The quarterly MDS assessment dated (MONTH) 8, (YEAR) revealed a BIMS score of 15 indicating the resident had intact cognition. The assessment included the mood score was 1 indicating the resident had minimal depression and that the resident was administered antidepressant medications. The assessment also included the resident had symptoms of poor appetite for 2-6 days and had 2 or more falls without injury. Review of the behavior monitoring for (MONTH) (YEAR) through (MONTH) (YEAR) revealed the resident had 2 episodes of loss of appetite on (MONTH) 1, (YEAR) and had 4 episodes of verbalization of sadness on (MONTH) 12, (YEAR). It did not reveal NPI to address the resident's target behaviors. Further review of the clinical record revealed the resident continued to have fall incidents. The pharmacy medication regimen review dated (MONTH) 24, (YEAR) revealed that resident was on [MEDICATION NAME] (brand name for Duloxetine) and [MEDICATION NAME] (brand name for [MEDICATION NAME]). Per the review, the resident was stable and may be harmed by attempted dose decrease and no dose reduction was recommended. The review also included for the physician to indicate that further GDR attempts were clinically contraindicated and that the resident was at the lowest effective dose due to the potential that the resident's condition will decompensate if the dose is decreased. This form was signed by the physician who agreed with the pharmacist. The pharmacy medication regimen review dated (MONTH) 11, (YEAR) and (MONTH) 24, (YEAR) included the reason for the review was a change of condition related to falls, dizziness, or evidence of impaired coordination. The recommendation was to consider risk versus benefits of Duloxetine and [MEDICATION NAME] which may increase fall risk and to discontinue or decrease the dose as clinically appropriate. Per the review, the resident was taking Duloxetine and [MEDICATION NAME] with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035173	A. BUILDING _____ B. WING _____	12/13/2018

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CHRISTIAN CARE NURSING CENTER	11812 NORTH 19TH AVE PHOENIX, AZ 85029

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 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4) multiple medications which may increase the resident's fall risk. The review for (MONTH) 11, (YEAR) was signed by the physician who did not indicate whether he agreed or disagreed with the pharmacist and wrote on the form to continue to monitor and for the (MONTH) 24, (YEAR) review the physician signed that he agreed that the benefits outweighs the risks. The mood care plan initiated on (MONTH) 18, (YEAR) revealed a potential for decreased in mood related to depression AEB (as evidenced by) verbalization of sadness and loss of appetite. The care plan included the resident was receiving [MEDICATION NAME] and Duloxetine and that the GDR for (MONTH) 13, (YEAR) was contraindicated. The goal was for the resident's mood to improve and for symptoms to become less frequent. Interventions included monitoring for medication effectiveness and the potential for decrease in medications. Review of the pharmacy medication regimen reviews dated (MONTH) 3 and 11, (YEAR) continued to include the reason for the review was a change of condition for falls, dizziness, or evidence of impaired coordination. The recommendation was to consider risk versus benefits of Duloxetine and [MEDICATION NAME] which may increase fall risk; and to discontinue or decrease the dose as clinically appropriate. Per the review, the resident was taking Duloxetine and [MEDICATION NAME] with multiple medications which may increase the resident's fall risk. These forms were signed by the physician, who did not indicate whether he agreed or disagreed with the pharmacists and continued to write that benefits outweighs the risks. The quarterly MDS assessment dated (MONTH) 8, (YEAR), revealed a BIMS score of 13 indicating resident had intact cognition. The mood score was 0 indicating the resident had no depression. Per the MDS assessment, the resident received antidepressant medications and had one fall with injury and 2 or more falls without injury. Review of the pharmacy medication regimen review dated (MONTH) 11, (YEAR), revealed the resident's medications were reviewed due to a recent fall and that the resident was receiving Duloxetine and [MEDICATION NAME] together with other medications which can contribute to the risk of falls. Per the documentation, the resident's behavioral monitoring indicated the resident was not exhibiting signs and symptoms of depression. The recommendation was to consider discontinuing Duloxetine if clinically appropriate and that resident was also receiving [MEDICATION NAME]. This form was signed by the physician, who indicated the benefits outweigh the risks. The documentation did not indicate whether physician agreed or disagreed with the recommendation. A pharmacy review dated (MONTH) 28, (YEAR), revealed the resident's medications were reviewed due to a recent fall and that the resident was receiving Duloxetine and [MEDICATION NAME] together with seven other medications which can contribute to the risk of falls. The recommendation was to taper and discontinue [MEDICATION NAME] if clinically appropriate. This form was signed by the physician who disagreed with the recommendation and continued to write that the benefits were greater than the risks. Review of the behavior monitoring record for (MONTH) (YEAR) through (MONTH) (YEAR), revealed the resident had no episodes of depression. Review of the clinical record for (MONTH) (YEAR) through (MONTH) (YEAR), revealed the resident had multiple fall incidents. The MARs from (MONTH) (YEAR) through (MONTH) (YEAR) revealed the resident was administered the Duloxetine and [MEDICATION NAME] as ordered. The physician's note dated (MONTH) 6, (YEAR), revealed the resident was seen for recurrent falls. The documentation included a plan to reduce medications to see whether this contributed to the resident's falls. Review of the MAR for (MONTH) (YEAR), revealed the Duloxetine was discontinued on (MONTH) 6, (YEAR). Despite the lack of evidence that the resident exhibited signs and symptoms of depression and the repeated pharmacy recommendations to discontinue or taper the dose of Duloxetine and [MEDICATION NAME] to decrease the risk of falls, there was no evidence found in the clinical record that a GDR was attempted, nor documentation by the physician of the clinical rationale as to why a GDR was contraindicated. During an interview conducted with a charge nurse/Licensed Practical Nurse (LPN/staff #6) on (MONTH) 13, (YEAR) at 11:06 a.m., she stated that the pharmacist reviews the residents medications every month and makes recommendations and that the reviews are forwarded to the physician who will agree or disagree with the recommendations. The LPN stated that when a GDR is recommended and the provider agrees with the recommendation, an order is written. The LPN stated that when the physician disagrees with the GDR, the physician will write the reason why he/she does not agree with the GDR. She further stated that the resident had a history of [REDACTED]. After reviewing the clinical record, the charge nurse stated that a GDR for Duloxetine and [MEDICATION NAME] was never attempted because the physician contraindicated the GDR stating that the benefits outweigh the risks. An interview was conducted with a Certified Nursing Assistant (CNA/staff #58) on (MONTH) 13, (YEAR) at 11:53 a.m. Staff #58 stated that she had provided care to the resident and was familiar with the resident. She stated that she had seen the resident cry when she was not feeling well or was in pain but that she had not seen the resident depressed or heard the resident verbalize feelings of sadness. During an interview conducted with the Director of Nursing (DON/staff #14) on (MONTH) 13, (YEAR) at 1:48 p.m., he stated that he, the assistant DON, and the pharmacist meet quarterly to discuss the residents due for a GDR. The DON stated that they review the clinical records and the behavior monitoring records. Staff #14 stated that the physician is informed of the results of the meeting related to possible GDR or discontinuation of medications. He stated that when the pharmacist makes recommendations for a GDR, the physician is informed and will decide whether or not he/she agrees. He stated that if the physician disagrees with the GDR, the physician must document in the clinical record the specific reason why the GDR is contraindicated. The DON further stated that the physician must write something like GDR is not possible because on this date GDR was attempted and such and such happened. The facility's policy regarding Gradual Dose Reductions and Assessment of Psychopharmacologic Medication Use revealed that during the first year GDR attempts will be conducted on all antidepressants in two separate quarters (with at least 1 month between the attempts), unless clinically contraindicated. The policy included a GDR may be considered clinically contraindicated if continued use is in accordance with relevant current standards of practice and the physician has documented the clinical rationale for why any attempted GDR would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder. Based on clinical record review, staff interviews, and policy review, the facility failed to ensure that PRN [MEDICAL CONDITION] medication orders were limited to 14 days unless the prescribing practitioner documented their rationale for extending the medication beyond 14 days and indicated the duration for the PRN order for one resident (#6). Findings include: -Resident #6 was admitted on (MONTH) 10, (YEAR) with a [DIAGNOSES REDACTED]. Review of the physician's orders [REDACTED]. The Medication Administration Record [REDACTED]. Review of the physician's orders [REDACTED]. Review of the MAR for (MONTH) (YEAR) revealed the resident had no side effects and no behaviors of verbalized panic attacks or nervousness. The MAR indicated [REDACTED]. A review of physician and Nurse Practitioner progress notes revealed no rationale for the no end date for the prn [MEDICATION NAME] and did not indicate the duration for the order. An interview was conducted with a Licensed Practical Nurse (LPN/ staff #6) on (MONTH) 13, (YEAR) at 2:30 PM. the LPN stated that they have a [MEDICAL CONDITION] medication review committee which meets quarterly to discuss all residents with [MEDICAL CONDITION] medication orders. She stated that the committee reviews residents receiving PRN [MEDICAL CONDITION] medications and that for those medications that are not antipsychotics, the physician must evaluate the person face to face before they can renew the medication after 14 days, but there need not be any limit after the initial 14 day review. She stated that resident #6 was evaluated by the physician in a face to face meeting and the medication was renewed with no stop date. During an interview conducted with the Director of Nursing (DON/staff #14) on (MONTH) 13, (YEAR) at 2:30 PM, the DON stated that [MEDICAL CONDITION] PRN medications could only be ordered for 14 days.