STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035288	A. BUILDING _____ B. WING _____	11/07/2019

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COPPER HEALTH ORO VALLEY	1119 EAST RANCHO VISTOSO BLVD ORO VALLEY, AZ 85755

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 observations, clinical record review, resident and staff interviews and policies and procedures, the facility failed to ensure that one (#123) of twelve sampled residents was assessed prior to self-administration of a medication. The census was 25 residents. The deficient practice could result in residents unsafely administering medications. Findings include: Resident #123 was admitted to the facility on (MONTH) 26, 2019 with [DIAGNOSES REDACTED]. Review of a Brief Interview for Mental Status (BIMS) note dated (MONTH) 28, 2019 revealed the resident's BIMS score was 15, which indicated intact cognition. During an interview conducted with the resident on (MONTH) 4, 2019 at 12:10 p.m., a bottle of [MEDICATION NAME] (antacid) and a couple of pills were observed on a table in the resident's room. The resident stated that she self-administers the [MEDICATION NAME], but has licensed facility staff administer her the rest of her medications. During another interview with the resident on (MONTH) 6, 2019 at 9:31 a.m., a full bottle of [MEDICATION NAME] was observed on her nightstand. The resident stated that she self-administers the [MEDICATION NAME] because of upper gastric issues and that she sometimes took the medication twice a day. Review of the clinical record revealed that the resident did not have a physician's orders [REDACTED]. An interview was conducted with the Director of Nursing (DON/staff #123) on (MONTH) 6, 2019 at 11:03 a.m. Staff #123 stated that residents are able to self-administer medications, as long as they are able to pass an assessment that they know what the medication is for, possible side effects, and the resident must be alert and oriented. Staff #123 stated that if a resident was assessed to be able to safely self-administer medications, the medication should be kept in a locked container in the resident's room. Staff #123 further stated that the facility's focus for the resident's health is to get better and not have to worry about when to take their medications. Review of the facility's policy regarding Self-Administration of Medications dated (MONTH) 1, 2019, revealed Residents in our facility who wish to self-administer their medications may do so, if it is determined that they are capable of doing so. As part of their overall evaluation, the staff and practitioner will assess each resident's mental and physical abilities, to determine whether a resident is capable of self-administering medications .Self-administered medications must be stored in a safe and secure place, which is not accessible by other residents .Staff shall identify and give to the Charge Nurse any medications found at the bedside that are not authorized for bedside storage .
F 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**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 clinical record review, staff interviews, review of the Resident Assessment Instrument (RAI) manual and policy review, the facility failed to ensure that a resident centered comprehensive care plan was developed for one (#14) of twelve sampled residents and was revised to reflect changes. The deficient practice could result in inadequate care planning, which may have a negative impact on resident's quality of life and care. Findings include: Resident #14 was admitted to the facility on (MONTH) 29, 2019, with [DIAGNOSES REDACTED]. Review of the clinical record revealed the resident was assessed to be alert and oriented, with some memory deficits. A care plan identified a focus area related to diabetes. The goal was that the resident would have no complications related to diabetes through the next review date. Included on the care plan were only two interventions as follows: 1) Avoid exposure to extreme hot or cold and 2) Diabetes medication as ordered by the physician and to monitor and document for side effects and effectiveness. Review of the Order Listing Report for (MONTH) 2019 through (MONTH) 30, 2019 revealed orders for Humalog 100 unit/ml, inject per sliding scale two times a day for diabetes. The admission orders [REDACTED]. According to the admission Minimum Data Set (MDS) assessment dated (MONTH) 6, 2019, the resident was assessed to require extensive assistance with transfers, eating and hygiene. The MDS also included the resident had a [DIAGNOSES REDACTED]. Further review of the care plan revealed it was not person centered, as the care plan did not include any specific care and services related to insulin sliding scale/glucose monitoring, insulin adminstration, monitoring for any specific labs, and it did not address the need to monitor for any adverse side effects including [DIAGNOSES REDACTED] (low glucose levels) and [MEDICAL CONDITION] (high glucose levels). Review of the (MONTH) 2019 Medication Administration Record [REDACTED]. A physician's orders [REDACTED]. According to the (MONTH) 2019 MAR, the documentation showed that the sliding scale insulin coverage had been discontinued as ordered. Further review of the care plan revealed no evidence that the care plan had been revised to reflect that the blood glucose testing for sliding scale insulin had been discontinued, due to the stability of the resident's blood glucose levels. An interview was conducted with a Licensed Practical Nurse (staff #34) on (MONTH) 7, 2019 at 10:17 a.m., who stated that the MDS nurse would be responsible to develop a care plan. Staff #34 stated the resident had been stable with her blood glucose levels, so the physician discontinued the order on (MONTH) 23, 2019. Staff #34 further stated there was nothing on the resident's care plan regarding the monitoring for symptoms of [DIAGNOSES REDACTED] or [MEDICAL CONDITION]. Staff #34 said she was unsure regarding the intervention listed on the care plan for the resident to avoid exposure to the extreme heat or cold, as the current weather no longer had either extreme. Staff #34 stated the current care plan did not reflect the fact that the resident no longer needed the twice daily blood glucose testing for the sliding scale and that this indicated the resident was doing well with diabetes. Staff #34 also said that the care plan was not comprehensive and specific to the resident's needs An interview was conducted with the Director of Nursing (staff #2) on (MONTH) 7, 2019 at 1:59 p.m. Staff #2 stated a care plan for a resident with diabetes should include the potential side effects of all diabetic medications and insulin, what method was to be used to monitor the disease and medications, the frequency of the monitoring, and general signs and symptoms of [DIAGNOSES REDACTED] and [MEDICAL CONDITION]. Staff #2 stated that all nurses know how to revise a care plan. Staff #2 said when the sliding scale was discontinued, the care plan should document what method would now be used to monitor for any signs or symptoms of [DIAGNOSES REDACTED] and [MEDICAL CONDITION]. Review of a facility policy regarding Comprehensive Care Plans revealed the following: An individualized comprehensive care

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 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) plan that includes measurable objectives and timetables to meet the resident's medical, nursing, and psychological needs is developed for each resident on admission. Our facility's care plan/interdisciplinary team, in coordination with the resident and family develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident is expected to attain. The care plan is based on a thorough assessment that includes but is not limited to the MDS. Each resident's care plan is designed to: 1) Incorporate identified problem areas. 2) Incorporate risk factors associated with the identified problems. 3) Build on the resident's strengths. 4) Reflect the resident's wishes regarding care and treatment goals. 5) Reflect treatment goals, timetables, and objectives in measurable outcomes. 6) Identify the professional services that are responsible for each element of care. 7) Aid in preventing or reducing declines in the resident's functional status or functional level. 8) Enhance the optimal functioning of the resident. 9) Reflect currently recognized standards of practice for problem areas and conditions. 10) Care plan interventions are designed after careful consideration of the relationship between the resident's problem and their causes. 11) When possible, interventions address the underlying sources of the problem area rather than addressing only the triggers or symptoms. 12) Identifying problem areas and their causes, and developing interventions that are targeted and meaningful to the resident are interdisciplinary processes that require careful data gathering, proper sequencing of events, and complex clinical decision making. 13) Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change. The care plan/interdisciplinary team is responsible for the review and updating of care plans. According to the the RAI manual the following was included: Section NO350: Insulin. Planning for care: Orders for insulin may have to change depending on the resident's condition (e.g., fever or other illnesses) and/or laboratory results. Monitor for adverse effects of insulin injections. Monitor HbA1c and blood glucose levels to ensure appropriate amounts of insulin are being administered.
F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**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 observations, clinical record review, staff interviews and policy review, the facility failed to ensure that one (#123) of twelve sampled residents was assessed to ensure safe operating of a curling iron independently. The deficient practice could result in residents being injured from the use of electrical devices. Findings include: Resident #123 was admitted to the facility on (MONTH) 26, 2019 with [DIAGNOSES REDACTED]. Review of a Brief Interview for Mental Status (BIMS) note dated (MONTH) 28, 2019 revealed the resident's score was 15, which indicated intact cognition. During an interview conducted with the resident on (MONTH) 4, 2019 at 12:10 p.m., a curling iron was observed on the resident's bedspread on top of her bed. When touched by the surveyor, the curling iron was noted to be extremely hot. The resident stated that she had not used the curling iron yet today. The resident said the facility's beautician told her she shouldn't have the curling iron in her room, but other staff allow it. During another interview with the resident on (MONTH) 6, 2019 at 9:31 a.m., the resident stated that she needed to plug in her curling iron as she was getting ready to leave the facility for an appointment. Review of the clinical record revealed there was no evidence that the resident was assessed for the safe use of a curling iron. An interview was conducted with the Director of Nursing (DON/staff #2) on (MONTH) 6, 2019 at 11:03 a.m. Staff #2 stated that when admitted , residents are given an inservice as to what type of items are acceptable to have in their rooms. Staff #2 stated that after the inservice, staff conduct walking rounds and if a safety hazard is observed in a resident's room, staff will ask the resident to remove the item. Staff #2 stated that there was no way to ensure that a curling iron would not be a fire hazard or that the resident would not burn herself. He also stated that residents should be assessed for safe use of a curling iron and he was not aware that this resident had one. Staff #2 further stated that if a resident was alert and oriented and able to demonstrate that the curling iron could be used safely, then it should be put away after use. Review of the facility's policy, Electrical Safety for Residents dated (MONTH) 1, 2019 revealed the resident will be protected from injury associated with the use of electrical devices, including electrocution,[MEDICAL CONDITION] fire. The policy included to orient the resident to basic electrical safety precautions as part of the admission process, and reinforce the following guidelines with the resident as indicated and/or appropriate. Some of the guidelines included the following: ensure that hands are dry before using an electrical device; do not use electrical devices while standing on a wet floor; pull electrical cords out by the plug and never yank the cord; and report electrical devices if they cause even minor shocks.