STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035132	A. BUILDING _____ B. WING _____	03/14/2019

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CORONADO HEALTHCARE CENTER	**11411 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 0552 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that residents are fully informed and understand their health status, care and treatments.** **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 one of seven sampled residents (#22) and/or their representative was informed of the risks and benefits of psychoactive medications, prior to administration. The deficient practice can result in the resident and/or the resident representative not being aware of the benefits and the potential adverse side effects of taking psychoactive medications. Findings include: Resident #22 was admitted on (MONTH) 18, (YEAR) with [DIAGNOSES REDACTED]. Review of the clinical record revealed a physician's orders [REDACTED]. The Medication Administration Record [REDACTED]. The admission Minimum Data Set assessment dated (MONTH) 25, (YEAR) revealed a BIMS (Brief Interview for Mental Status) score of 7, which indicated the resident had severe cognitive impairment. The assessment also included the resident received antipsychotic and antidepressant medications during the 7 day look-back period. However, no evidence was found in the clinical record that the resident's representative was informed of the risks and benefits of these medications until (MONTH) 17, (YEAR). An interview was conducted with a licensed practical nurse (LPN/staff #470) on (MONTH) 12, 2019 at 2:28 p.m. The LPN stated all psychoactive medications must have an informed consent signed prior to the administration of the medications. She stated the resident and/or the resident's responsible party are informed of the indication, risks, benefits and side effects associated with the use of the medication and that the information is on the consent form. She said if the resident is not alert and oriented and does not have family or a responsible party available to sign the consent, she will inform the physician who together with the medical director will give consent and sign the consent form. During an interview conducted with the Director of nursing (DON/staff #215) on (MONTH) 12, 2019 at 3:25 p.m., she stated a consent form that includes information and explanation of the risks, benefits and side effects associated with the use of any [MEDICAL CONDITION] medications must be signed by the resident or the resident's responsible party prior to the resident receiving the medications. The DON stated that if the resident is unable to sign the consent form and does not have family or a responsible party to sign the consent, two physicians must sign the consent before the medication can be administered to the resident. The facility's policy regarding [MEDICAL CONDITION] Drug Use revealed the Social Services designee shall review new admissions for any physician's orders [REDACTED].
F 0578 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and review of policies and procedures, the facility failed to ensure the physician's order accurately reflected one resident's (#125) advance directive. The resident census was 175. This deficient practice could result in residents receiving emergent services, which are not in accordance with their wishes. Findings include: Resident #125 was admitted on (MONTH) 12, 2019 and readmitted on (MONTH) 23, 2019, with [DIAGNOSES REDACTED]. An admission MDS (Minimum Data Set) assessment dated (MONTH) 19, 2019, revealed a BIMS (Brief Interview for Mental Status) score of 13 which indicated the resident was cognitively intact. Review of the clinical record revealed an advance directive statement dated (MONTH) 23, 2019, signed by the resident, that the resident was a DNR (Do Not Resuscitate) status. However, review of the physician's orders dated (MONTH) 23, 2019, revealed the resident was a full code which included CPR (cardiac-pulmonary resuscitation). On (MONTH) 11, 2019 at 11:55 a.m., an interview was conducted with a LPN (Licensed Practical Nurse/staff #151). After reviewing the resident's advance directive and the physician's order, the LPN stated that she would have to follow up and fix it. Staff #151 stated the planners, are responsible for ensuring code status is complete. During an interview conducted with the Director of Nursing (DON/staff #215) on (MONTH) 11, 2019 at 12:18 p.m., the DON stated the case managers and/or the charge nurses are supposed to ensure documentation of advance directives accurately reflects the residents' wishes. The facility's policy regarding advance directives revealed staff would assist the resident in completing the desired document, if the resident expressed a desire to execute an Advance Directive. The policy included Advance Directive documents are completed and included in the resident's health record upon admission and that a physician's telephone order can be used for No CPR or DNR.
F 0641 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based clinical record review, staff interview, and the RAI (Resident Assessment Instrument) manual, the facility failed to ensure that a MDS (Minimum Data Set) assessment for one of three sampled residents (#158) was accurate. This deficient practice has the potential to affect continuity of care. Findings include: Resident #158 was admitted on (MONTH) 3, (YEAR), with [DIAGNOSES REDACTED]. Review of the clinical record revealed a physician's orders [REDACTED]. The nursing discharge summary note dated (MONTH) 11, (YEAR) included the resident was being discharged to another facility per the resident's family request. However review of the discharge MDS assessment dated (MONTH) 11, (YEAR), revealed the resident was discharged to an acute hospital. During an interview conducted with the MDS Coordinator (staff #97) on (MONTH) 12, 2019 at 4:50 p.m., staff #97 stated that

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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 0641 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) she obtains information and/or data from the documentation in the clinical record such as the nursing progress notes, therapy notes, and nursing assessments to ensure that she codes the MDS assessments accurately. After reviewing the clinical record, the MDS Coordinator stated that the discharge MDS assessment should have reflected the resident was discharged to another facility. The RAI manual instructs to review the clinical record including the discharge plan and discharge orders for documentation of a resident's discharge location. The manual also included .the importance of accurately completing and submitting the MDS cannot be over-emphasized . and that Federal regulations require the assessment accurately reflects the resident's status.
F 0645 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**PASARR screening for Mental disorders or Intellectual Disabilities** **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 a referral for a PASARR (Pre-Admission Screening and Resident Review) level II determination was obtained timely for two of four residents (#119 and #9). This deficient practice could result in residents not receiving the appropriate level of services. Findings include: -Resident #9 was admitted on (MONTH) 25, (YEAR), with [DIAGNOSES REDACTED]. The PASARR level I screening dated (MONTH) 25, (YEAR), revealed the resident had no primary [DIAGNOSES REDACTED]. Review of the admission Minimum Data Set (MDS) assessment dated (MONTH) 2, (YEAR), revealed the resident had a [DIAGNOSES REDACTED]. Review of the care plan initiated (MONTH) 15, (YEAR), revealed the resident was at risk for impaired cognitive function or impaired thought processes related to a history of [MEDICAL CONDITION]. A psychiatry progress note dated (MONTH) 25, (YEAR) included the resident reported a decrease in auditory hallucinations (AH). The PASARR level I screening dated (MONTH) 3, (YEAR) revealed the resident had a primary [DIAGNOSES REDACTED]. The screening also included a referral was necessary for a PASARR Level II determination for mental illness. The annual MDS assessment dated (MONTH) 4, (YEAR) revealed [MEDICAL CONDITION] was coded as a diagnosis. Review of the social services progress note dated (MONTH) 6, (YEAR) revealed a request for a PASARR Level II was faxed. Despite documentations that the resident had a [DIAGNOSES REDACTED]. -Resident #119 was admitted on (MONTH) 12, 2014 with [DIAGNOSES REDACTED]. The physician's progress notes from (MONTH) 17, (YEAR) through (MONTH) 12, (YEAR) included a [MEDICAL CONDITION] disorder with plans to continue the [MEDICAL CONDITION] medication and psychiatry follow up. A psychiatry progress note dated (MONTH) 1, (YEAR) included a [DIAGNOSES REDACTED]. Review of the annual MDS assessment dated (MONTH) 25, (YEAR), revealed the resident had [DIAGNOSES REDACTED]. The quarterly MDS assessment dated (MONTH) 18, (YEAR) included [DIAGNOSES REDACTED]. It also included the resident received antipsychotic medication during the 7 day look-back period. However, despite documentation of [MEDICAL CONDITION] and [MEDICAL CONDITION] disorder, no evidence was found that a PASARR level I (which included a referral for a PASARR level II) had been completed for this resident until (MONTH) 31, (YEAR). A social services note dated (MONTH) 4, 2019 revealed a PASARR level II was faxed. During an interview conducted with the social worker (staff #2) on (MONTH) 11, 2019 at 11:15 a.m., she stated that residents will not be admitted until the PASARR level I screening is completed. She said that when the resident's stay at the facility is longer than 30 days, another PASARR level I screening is completed and if a level II evaluation is recommended, she will send the request to the State PASARR coordinator. Staff #2 stated that she conducts monthly checks and reviews of requests made, conducts follow-up calls and documents the information in the clinical record. The social worker stated that she could not recall when, but last year the facility made a sweep and screened all the residents at the facility for a PASARR Level I. In an interview conducted with the Director of Nursing (DON/staff #215) on (MONTH) 12, 2019 at 3:25 p.m., she stated the social worker is responsible for ensuring that residents at the facility has PASARR level I screening and for following up on Level II evaluations. She stated that the admissions staff ensures a Level I screening was completed upon admission. The DON did not say why residents #9 and #119 did not have a PASARR level II evaluation. She stated that they made a sweep last year of all the residents to ensure a Level I screening was completed. The facility's policy on Pre-Admission Screening and Resident Review (PASARR) stated, .Nursing Facilities (NF) must complete a Level I PASARR screening, or verify that a screening has been conducted, in order to identify Mental Illness (MI) and/or an Intellectual Disability (ID) prior to initial admission of individuals to a NF bed . The policy also stated, If it is later determined that the admission will last longer than 30 consecutive days, a Level I PASARR screening must be completed as soon as possible or within 40 calendar days of the admitted . The policy included that it is the responsibility of the NF to make referrals for Level II PASARR evaluations if determined necessary.

F 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure services provided by the nursing facility meet professional standards of quality.** **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 that two of ten sampled residents (#73 and #307) were administered pain medication according to the parameters ordered by the physician. The deficient practice could result in residents not receiving medications as ordered. Findings include: -Resident #73 was admitted on (MONTH) 24, (YEAR), with [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. The admission MDS (Minimum Data Set) assessment dated (MONTH) 31, (YEAR) revealed a BIMS (Brief Interview for Mental Status) score of 14, which indicated the resident had intact cognition. The MDS also included the resident received scheduled and as needed pain medications. A care plan regarding pain dated (MONTH) 15, (YEAR) revealed the resident had acute/chronic pain. Interventions included conducting a pain assessment every shift and medicating the resident following the pain scale. Review of the Medication Administration Records (MARs) for October, (MONTH) and (MONTH) (YEAR), revealed the resident was administered [MEDICATION NAME] for a pain level of 8 on (MONTH) 30, for a pain level of 6 on (MONTH) 1, for a level of 5 on (MONTH) 5 and 6, and for a pain level of 7 on (MONTH) 10. -Resident #307 was admitted on (MONTH) 6, (YEAR), with [DIAGNOSES REDACTED]. The nursing admission record dated (MONTH) 6, (YEAR), included the resident was alert and oriented to time, place, person and was able to follow simple commands. Review of the clinical record revealed a physician's orders [REDACTED]. The care plan regarding pain dated (MONTH) 8, (YEAR) included the resident had acute/chronic pain related to a fractured left hip. Interventions included conducting a pain assessment every shift and medicating the resident following the pain scale. However, review of the MAR for (MONTH) (YEAR) revealed the resident was administered [MEDICATION NAME] 5 mg for a pain level of 9 on (MONTH) 7 and for a pain level of 7 on (MONTH) 9 and 10. During an interview conducted with a Licensed Practical Nurse (LPN/staff #126) on (MONTH) 11, 2019 at 10:50 a.m., she stated pain medications should be administered as ordered. The LPN stated that if the resident's pain level is outside of the ordered parameters, she would administer the medication and then call the physician. An interview was conducted with another LPN (staff #47) on (MONTH) 12, 2019 at 2:28 p.m. Staff #47 stated that all medications and/or treatments should be administered as ordered by the physician, which includes following the parameters ordered. The LPN stated that if the resident's pain level is outside of the parameter order for the medication, she would notify the physician and would not administer the medication. During an interview conducted with the Director of Nursing (DON/staff #215) on (MONTH) 12, 2019 at 3:25 p.m., she stated her expectation is that the nurses follow standards of practice when it comes to medication and treatment administration. The DON stated that medications and treatments, including pain parameters are expected to be followed, as ordered by the physician.

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F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) A facility's policy on Pain Management stated, Residents are provided and receive care and services needed according to established practice guidelines. Review of the facility's policy on Physician order [REDACTED].in accordance with the resident's plan of care.
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 clinical record reviews, staff interviews, and policy review, the facility failed to ensure two of two sampled residents (#'s 457 and 207) were provided and/or offered showers. The resident census was 175. This deficient practice could result in residents not being provided hygiene care and services. Findings include: -Resident #207 was admitted to the facility on (MONTH) 27, (YEAR) with [DIAGNOSES REDACTED]. The resident was discharged on (MONTH) 15, (YEAR). Review of a care plan dated (MONTH) 28, (YEAR) revealed the resident had self care deficit related to activities of daily living (ADL) and personal hygiene. Interventions included conversing with the resident while providing the necessary care and encouraging participation to the fullest extent possible. The admission Minimum Data Set (MDS) assessment dated (MONTH) 4, (YEAR) revealed a score of 14 on the Brief Interview for Mental Status (BIMS) which indicated the resident had no cognitive impairment. The assessment included the resident was totally dependent on staff for bathing. Review of the Certified Nursing Assistant (CNA) bathing Flowsheet for (MONTH) (YEAR) revealed bathing did not occur for this resident on (MONTH) 27, 28, 29, 30, and 31, (YEAR). Review of the clinical record and nursing notes revealed no evidence the resident had been offered a bath or shower and refused, or that baths or showers had been provided. Review of the (MONTH) (YEAR) CNA ADL Flowsheet revealed documentation the resident was provided a shower on (MONTH) 3, (YEAR). For the remaining 12 days the resident resided at the facility, there was no evidence a bath or shower had been offered or provided. In addition, there was no evidence in the nursing notes that the resident had been offered or provided a bath or shower. The Administrator (staff #219) stated on (MONTH) 7, 2019 at 12:46 p.m., that she could not locate paper shower sheets for resident #207 for (MONTH) and (MONTH) (YEAR). An interview was conducted with a CNA (staff #141) on (MONTH) 6, (YEAR) at 12:52 p.m. Staff #141 stated a resident is scheduled two times a week for a bath or shower. The CNA stated the shower/bath schedule is kept in a binder at nursing station on each unit. The CNA stated that when a resident is provided a bath or shower, the form is completed and placed back in the binder for the nurse to review. Staff #141 stated that if a bath or shower is offered and the resident refuses, the refusal is documented on the shower form and in the electronic chart. -Resident #457 was admitted on (MONTH) 12, (YEAR) with [DIAGNOSES REDACTED]. Review of the care plan initiated (MONTH) 14, (YEAR) revealed the resident had a self-care performance deficit and required assistance. The goal was that the resident would maintain his current level of function for grooming and personal hygiene. Interventions included encouraging the resident to participate to the fullest extent possible with each interactions. The admission MDS assessment dated (MONTH) 19, (YEAR) revealed a BIMS score of 14 which indicated the resident had intact cognition. The assessment also included the resident required extensive assistance with bed mobility, limited assistance with transfer and personal hygiene, and physical help limited to transfer only with bathing. Review of the task documentation for showers revealed the resident received one shower the week of (MONTH) 24 to 30, no showers the week of (MONTH) 8 to14, and no showers the week of (MONTH) 15 to 21, (YEAR). The clinical support staff (staff #216) stated on (MONTH) 6, 2019 at 8:15 a.m., they were unable to locate any shower sheets for this resident. Review of the progress notes did not reveal any further documentation of showers provided or refused. An interview was conducted with a CNA (staff #184) on (MONTH) 6, 2019 at 1:08 p.m. She stated that there is shower schedule for each resident and that each resident is scheduled for two showers a week. She stated that she documents a shower with how much assistance the resident required in the electronic record. The CNA stated that if the resident is independent for showers, a shower sheet would still be completed and the nurse would sign the shower sheet. The CNA also stated that all residents require at least supervision and set up and that no resident, including independent residents, should be left alone in the shower room. She stated that if a resident refuses a shower, the resident is asked to sign the sheet that he/she refused the shower. After reviewing the task documentation, the CNA stated that if there are no shower sheets, there would be no documentation that the resident was offered or received showers. An interview was conducted with a CNA (staff #23) on (MONTH) 6, 2019 at 3:00 p.m. She stated that there is a shower schedule and that each resident receives two showers a week. The CNA stated that she documents a shower on the paper shower form and in the electronic record. She stated that if a resident refuses a shower, she would offer a shower again. She stated if the resident refuses a second time, she would notify the nurse. She also stated that if the resident refused a third time, she would have the resident sign that he/she refused and why on the shower sheet. The CNA stated that she would also document the refusal in the electronic record. During an interview conducted with a Licensed Practical Nurse (LPN/staff #3) on (MONTH) 7, 2019 at 10:41 a.m., she stated that residents are scheduled for 2 showers a week. The LPN stated that if a resident refuses a shower, the CNA notifies the nurse. She stated the nurse would speak with the resident to find out why the resident refused the shower. She stated that if a resident still declined the shower, she would mark refused on the shower sheet and have the resident sign the sheet. The LPN stated that if the CNA did not chart a shower in the electronic record and there is no shower sheet, she would not be able to say whether a resident received a shower or if a shower was offered. An interview was conducted with the Administrator (staff #219) on (MONTH) 7, 2019 at 12:45 p.m. She stated that the short term residents do not have a set in stone shower schedule because many of them shower independently. She stated that her expectation is that residents' requests and personal hygiene needs be met. The Administrator stated that a resident should be offered a shower on the scheduled shower days and there should be documentation that the resident received the shower or refused the shower. Review of the facility's policy regarding ADL services revealed residents who are unable to carry out ADL's will receive necessary services to maintain grooming and personal hygiene. The policy also included residents are given the appropriate treatment and services to maintain or improve his/her abilities.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, staff and resident interviews and policy review, the facility failed to ensure that one of two sampled resident's (#113) with a wound had thorough wound assessments completed, and that the wound assessments were documented. The deficient practice could result in wounds not being monitored for deterioration and healing. Findings include: Resident #113 was admitted on (MONTH) 10, 2019, with [DIAGNOSES REDACTED]. An Initial Admission Record dated (MONTH) 10, 2019 included the resident did not have any skin problems on admission. Admission physician orders dated (MONTH) 10, 2019 included for weekly skin checks on the night shift, every 7 days. Review of a physician admission progress note dated (MONTH) 11, 2019 revealed documentation under the assessment section that the resident had a sacral abscess, status [REDACTED]. A care plan dated (MONTH) 11, 2019 included for potential/actual impairment to skin integrity related to generalized

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F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) weakness, deconditioning and protein malnutrition. The care plan also included the resident had a sacral abscess on (MONTH) 28, which was to be assessed by the wound nurse. Review of the wound nurse's note dated (MONTH) 11, 2019 revealed a skin assessment was completed and that the resident's skin was intact. A weekly Skin Evaluation dated (MONTH) 17, 2019 included the resident's skin was intact. A review of the admission MDS (Minimum Data Set) assessment dated (MONTH) 17, 2019, revealed the resident had a BIMS (Brief Interview for Mental Status) score of 10, which indicated moderate cognitive impairment. The MDS assessment further documented that the resident did not have any skin problems. Review of a physician's progress note dated (MONTH) 18, 2019 revealed under the assessment section that the resident had a sacral abscess, status [REDACTED]. A wound nursing note dated (MONTH) 23, 2019 revealed the resident reported that she had an old abscess on her coccyx area, which had reopened. Per the note, the wound was assessed and drainage was noted from the area. The physician was informed and gave an order for [REDACTED].>A physician's order dated (MONTH) 23, 2019 included for Bactrim DS tablet 800-160 mg (milligrams) 1 enterally bid (twice a day) for 10 days for abscess. Review of the clinical record revealed there was no documentation that an assessment of the coccyx/sacral wound was completed, which included a description of the wound and drainage. Review of a weekly Skin Evaluation dated (MONTH) 24, 2019 revealed the resident had an abscess to the coccyx and was started on an antibiotic, and the wound team was to evaluate. A nursing note dated (MONTH) 24, 2019, documented that the resident's skin color was normal and that the resident was receiving oral antibiotic treatment for [REDACTED]. A provider assessment dated (MONTH) 26, 2019, documented the resident has a spontaneous rupture of a buttock abscess and the resident reports that it is chronic and drains at times. The plan was for wound care to buttock abscess, monitor for symptoms of infection and to continue to use Bactrim. The note included the resident's wound healing has improved. However, there was no assessment of the condition of the buttocks wound on this note. Additional physician orders included the following: February 26: Bactrim DS 800-160 mg 1 enterally, two times a day for abscess on coccyx until (MONTH) 3. February 26-27: Bactrim DS 800-160 mg 1 by mouth, two times a day for abscess on coccyx until (MONTH) 7, 2019. February 27, 2019: Bactrim DS 800-160 mg 1 via [DEVICE], two times a day for abscess on coccyx until (MONTH) 7, 2019. According to the MAR for (MONTH) 2019, the resident did not receive two doses of the Bactrim on (MONTH) 25, and received only 1 dose on (MONTH) 26. Review of an Infectious Disease Initial Note by the Nurse Practioner (NP) dated (MONTH) 28, 2019, revealed that the NP was being asked to see the resident regarding starting Bactrim for a presumed abscess on the sacrum. The note included the resident had developed a sacral abscess which had spontaneously drained on (MONTH) 28, 2019 (while in hospital). The note further included that from asking around the Bactrim was for a closed sacral furuncle versus an abscess that is now self-limiting. The note did not include an assessment of the sacral area/abscess. Another provider assessment dated (MONTH) 4, 2019 documented the resident had an acute, cutaneous abscess. The plan was for wound care to buttock abscess, monitor for symptoms of infection and to continue the Bactrim. The note included the resident's wound healing has improved. The note did not include an assessment of the buttock abscess. A late entry physician's progress note dated (MONTH) 8, 2019 documented under the assessment section that the resident had a sacral abscess, status [REDACTED]. A weekly Skin Evaluation dated (MONTH) 9, 2019 included the following: no other skin issues at this time. Further review of the clinical record revealed there was no documentation that the sacral abscess wound was thoroughly assessed to include a description of the wound and drainage, nor any measurements from the time of admission through (MONTH) 9, 2019. There was also no documentation when the sacral abscess had actually healed. An observation of the resident's skin was conducted on (MONTH) 12, 2019 at 11:55 p.m., with a registered nurse (staff #41/who oversees the wound department). Observation of the resident's buttocks/coccyx area revealed the skin was intact and there were no open wounds. During the observation, the resident stated that she had an abscess on her bottom, but it's gone now. She said that she does not have any sores right now. Following the observation, staff #41 stated that when residents are admitted with wounds or develops one in the facility, the nurse is to assess it and document it on the nursing assessment. She said the nurse is to document if there is an open area, any dressing, drainage and describe the wound. She said the nurses do not measure or stage a wound as the wound nurse does this the following day. She said the nurse is to notify the wound nurse regarding any wounds and the wound nurse usually sees the resident the next day. She said the wound nurse completes a full skin assessment and if a wound is present, it is to be documented on either the pressure ulcer assessment or on the non pressure ulcer assessment. She said the assessment should include measurements, a description of the wound, any drainage and if any signs/symptoms of infection. She said the wound assessments are all documented in their computer system. She said the wound team consists of the wound Doctor and a nurse practitioner (NP), and that they make rounds three times a week and measure wounds 1-2 times per week. Staff #41 stated that the wound team have their own electronic documents for the assessments and those are sent to medical records and are scanned into the medical record. An interview was conducted on (MONTH) 12, 2019 at 2:31 p.m. with the Director of Nursing (DON/staff #215), who stated that the initial skin assessments included the resident's skin was intact and the nurses document by exception. Documentation was requested regarding any assessments of the resident's wound, however; she was unable to locate any additional wound assessment documentation. Review of the facility policy regarding Wound Management revealed the nurse is to complete a comprehensive admission assessment/evaluation to identify any alterations in skin integrity, develop comprehensive care plans if indicated and complete weekly head to toe skin assessments, with follow up as applicable. The policy included that once a wound has been identified, assessed and documented, nursing shall administer treatment to each affected area, per the physician's order.
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **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 one (#207) of three sampled residents with pressure ulcers, was provided physician ordered treatment. There were 11 residents in the facility who were identified as having pressure ulcers. The deficient practice could result in delayed wound healing or worsening of the pressure ulcer. Findings include: Resident #207 was admitted to the facility on (MONTH) 27, (YEAR) with [DIAGNOSES REDACTED]. The resident was discharged on (MONTH) 15, (YEAR). A weekly pressure ulcer form dated (MONTH) 29, (YEAR), revealed the resident had a Stage 2 pressure ulcer located on the right buttock. Review of the clinical record revealed a physician's orders [REDACTED]. A care plan dated (MONTH) 29, (YEAR) regarding the stage 2 pressure ulcer included an intervention to administer treatments as ordered. A review of the Treatment Administration Record (TAR) for (MONTH) (YEAR) revealed no evidence the pressure ulcer treatment was provided on Tuesday, (MONTH) 10, (YEAR). Review of the nursing notes revealed no evidence the pressure ulcer treatment was provided or refused on (MONTH) 10, (YEAR). An interview was conducted with a Licensed Practical Nurse (LPN/staff #151) on (MONTH) 7, 2019. Staff #151 stated all physician orders [REDACTED]. She stated that if a resident refuses the treatment, it must be documented on the TAR or in the nursing notes. The LPN also stated that if the treatment was not documented, it was not done. During an interview conducted with the Administrator (staff #219) on (MONTH) 7, 2019 at 12:45 p.m., she stated all nurses are to administer treatments as ordered by the physician. Staff #219 stated the nurses are to document the treatment provided or document the resident refused. The facility's policy regarding wound management and pressure ulcers revealed that it is their policy that a resident with a pressure ulcer receives necessary treatment and services to promote healing. The policy included the nursing staff shall

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	035132	A. BUILDING _____ B. WING _____	03/14/2019

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4) administer treatment per the physician's orders [REDACTED].
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, resident and staff interviews and policy review, the facility failed to ensure one of one residents (#73) sampled on [MEDICAL TREATMENT] received ongoing assessments and monitoring, as ordered by the physician. The facility had seven residents who were receiving [MEDICAL TREATMENT] services. The deficient practice could result in [MEDICAL TREATMENT] related complications not being identified and treated timely. Findings include: Resident #73 was admitted on (MONTH) 24, (YEAR), with [DIAGNOSES REDACTED]. The initial admission record dated (MONTH) 24, (YEAR) included the resident was alert and oriented to time, place and person. It also included the resident received [MEDICAL TREATMENT] and had a AV (arteriovenous) shunt on the right upper extremity. The physician admission progress note dated (MONTH) 26, (YEAR) included the resident was alert and oriented x 4, had [MEDICAL CONDITION] and was on [MEDICAL TREATMENT]. The admission MDS (Minimum Data Set) assessment dated (MONTH) 31, (YEAR) included a BIMS (Brief Interview for Mental Status) score of 14, indicating the resident was cognitively intact. It also coded that the resident was receiving [MEDICAL TREATMENT]. Review of the recapitulation of physician's orders [REDACTED]. -Monitor AV shunt site for bruit and thrill every shift. Document (+) for present and (-) for not present (start date was (MONTH) 24, (YEAR)). -Monitor AV access site for signs and symptoms of infection every shift. Document any redness, swelling, pain, fever, oozing (+) present (-) not present (start date was (MONTH) 24, (YEAR)). -Post [MEDICAL TREATMENT] AV shunt site access care: Remove pressure dressing 2-4 hours after [MEDICAL TREATMENT]. If bleeding occurs, apply 4 x 4 until bleeding stops. If unable to stop bleeding, notify the physician (start date was (MONTH) 24, (YEAR)). Review of the clinical record revealed these orders continued to be active until (MONTH) 28, 2019, and were transcribed onto the MAR (medication administration record) from (MONTH) 24, (YEAR) through (MONTH) 28, 2019. Review of the MAR's from (MONTH) 24, (YEAR) through (MONTH) 28, 2019 revealed the following: -In the boxes for monitoring the AV shunt site for bruit, thrill and for signs and symptoms of infection, there were check marks instead of (+) for presence or (-) for absence, as ordered by the physician. -For post [MEDICAL TREATMENT] AV shunt site access care, the boxes were marked with an X. Further review of the clinical record from (MONTH) 24, (YEAR) through (MONTH) 28, 2019 revealed inconsistent documentation of the presence of bruit and thrill on the days that the resident did not have [MEDICAL TREATMENT]. Continued review of the clinical record revealed no documentation that the AV shunt site was monitored for signs and symptoms of infection and that the post [MEDICAL TREATMENT] AV shunt site care was administered as ordered by the physician on [MEDICAL TREATMENT] days and on the days when the resident did not go to [MEDICAL TREATMENT]. There was also no evidence found in the clinical record that the physician was notified or of the reasons why these orders were not administered. In an interview conducted on (MONTH) 3, 2019 at 12:20 p.m., resident #73 stated she goes to [MEDICAL TREATMENT] every Tuesday, Thursday and Saturday. She stated that staff does not check the [MEDICAL TREATMENT] on a daily basis. She said that staff checks her [MEDICAL TREATMENT] only on the days when she goes to [MEDICAL TREATMENT]. An interview with a licensed practical nurse (LPN/staff #153) was conducted on (MONTH) 6, 2019 at 11:21 a.m. Staff #153 stated that AV shunts should be checked before and after [MEDICAL TREATMENT]. She said that shunts should be checked every shift on and off [MEDICAL TREATMENT] days and documented in the MAR. In an interview with another LPN (staff #91) conducted on (MONTH) 11, 2019 at 11:56 a.m., she stated that AV shunts are monitored for the presence/absence of bruit and thrill and for signs and symptoms of infection. During an interview with the Director of Nursing (DON/staff #215) conducted on (MONTH) 12, 2019 at 3:25 p.m., she stated residents on [MEDICAL TREATMENT] should be checked for the presence and absence of bruit and thrill, for signs and symptoms of infection every shift, and that the findings will be documented in the clinical record. She stated when the nurse checks and initials the boxes in the MAR, it means that the AV shunt was monitored. When asked about marking the boxes in the MAR indicated [REDACTED]. Review of the policy titled, [MEDICAL TREATMENT] (Renal) Pre and Post Care revealed to assist residents in maintaining homeostasis pre and post-[MEDICAL TREATMENT] and to assess and maintain patency of [MEDICAL TREATMENT] access. The policy also included that the [MEDICAL TREATMENT] should be assessed upon return to the facility for patency, for any unusual redness or swelling and for post [MEDICAL TREATMENT] AV shunt access care as ordered.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record reviews, staff interviews and policy review, the facility failed to ensure that intravenous (IV) medications on one of four medication carts for 4 residents (#58, #418, #458 and #460) were stored secured in a locked storage area. The deficient practice could result in the potential for misappropriation of resident's medications. Findings include: -Resident #58 was admitted (MONTH) 1, 2019, with [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. -Resident #418 was admitted on (MONTH) 1, 2019, with [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. -Resident #458 was admitted on (MONTH) 27, 2019, with a [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. -Resident #460 was admitted on (MONTH) 1, 2019, with [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. An observation was conducted on (MONTH) 5, 2019 at 7:50 a.m., of the Phoenix South Medication cart #2. On top of the cart, there were four bags of IV medications. During this observation, the nurse (Licensed Practical Nurse/LPN/staff #3) was observed to leave the IV medications on top of the cart two different times and entered resident rooms. Other staff members were observed in the hallway when the IV medications were unsecured. The IV medications which were left on top of the cart were as follows: linezolid solution 600 mg for resident #58, [MEDICATION NAME] solution 500 mg for resident #418, [MEDICATION NAME] sodium solution 2 gm for resident #458, and [MEDICATION NAME] HCL solution 1 gm for resident #460. An interview was conducted with staff #3 on (MONTH) 5, 2019 at 8:09 a.m. She stated that she is not to leave pills on the cart. She stated that IV's are a medication and should be kept in the medication cart drawer, and that it was a mistake. She stated that the IV medications left on the cart would present the risk that someone could take the medications. An interview was conducted with the Director of Nursing (DON/staff #215) on (MONTH) 5, 2019 at 1:05 p.m. She stated that any medication on the medication cart needs to be under lock and key, if the nurse is not present at the cart. She stated that if medications were left unattended on the cart, it poses a risk that the medications could be misplaced, taken or utilized elsewhere. She stated that the medications left unattended on the cart did not meet policy or her expectations. Review of the policy for Medication Access and Storage revealed to store all drugs and biologicals in locked compartments and that only licensed nurses, the consultant pharmacist and those lawfully authorized to administer medications are allowed access to medications. The policy further noted that medication rooms, carts, and medication supplies are locked or

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F 0761 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 5) attended by persons with authorized access.
F 0777 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide or obtain x-rays/tests when ordered and promptly tell the ordering practitioner of the results.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed clinical record review, staff interviews and policy review, the facility failed to ensure that a STAT chest x-ray was obtained as ordered by the physician for one resident (#307). The deficient practice has the potential to adversely affect care or treatment. Findings include: Resident #307 was readmitted on (MONTH) 6, (YEAR), with [DIAGNOSES REDACTED]. The initial admission record dated (MONTH) 6, (YEAR) included the resident was alert and oriented to time, place, person and was able to follow simple commands. The NP (nurse practitioner) progress note dated (MONTH) 8, (YEAR) included the resident was alert and oriented x 4. The note included [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. According to the MAR (medication administration record) for (MONTH) 12, (YEAR), the resident had a temperature of 99.4 degrees Fahrenheit. A physician's orders [REDACTED]. A late entry NP progress note dated (MONTH) 12, (YEAR) at 4:42 p.m. included that the NP was notified in the morning that resident was more somnolent than usual. Physical examination included the resident had no acute distress but not able to get comfortable. Neurological examination included the resident was awake and alert, followed some commands, but speech was slurred. The note included altered mental status, with unclear etiology. A nursing progress note dated (MONTH) 12, (YEAR) at 5:40 p.m. revealed the resident's speech was slurred and mentation was altered and that the resident was monitored hourly throughout the shift. Per the clinical record documentation, the resident was admitted to the hospital on (MONTH) 13, (YEAR). Further review of the clinical record revealed there was no evidence that the STAT chest x-ray was done as ordered. During an interview with a licensed practical nurse (LPN/staff #153) conducted on (MONTH) 6, 2019 at 11:21 a.m., she stated that she was on shift when resident had the change in condition. She stated the NP ordered a STAT chest x-ray, which was done. An interview with medical records staff (staff #112) was conducted on (MONTH) 7, 2019 at 2:03 p.m. She stated there was no record of any chest x-ray which was done for resident #307. An interview with another LPN (staff #47) was conducted on (MONTH) 12, 2019 at 2:28 p.m. Staff #47 stated when she receives a STAT order, she will transcribe it in the electronic record, complete a requisition form and call the laboratory. She said depending on what company the request was made and forwarded to, the turnaround time is between 1 and 4 hours for a STAT order. She stated she will follow up in an hour to ensure receipt of the order and requisition; and if the STAT order was not done after the turnaround time, she would call right away and inform them of the STAT order again. In an interview with the Director of Nursing (DON/staff #215) conducted on (MONTH) 12, 2019 at 3:25 p.m., she stated the window period for STAT laboratory orders including chest x-rays is 4 hours and that it should be done by then. She stated that she expects the nurses to follow up on the requests. Further, she stated the STAT chest x-ray ordered for resident #307 was not done and she does not know the reason why. Review of the policy regarding Physician order [REDACTED].in accordance with the resident's plan of care.