STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **035095**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **04/04/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DESERT COVE NURSING CENTER	**1750 WEST FRYE ROAD CHANDLER, AZ 85224**

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 0550 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, staff interview, and policy, the facility failed to ensure one resident's (#20) urinary catheter bag was covered. There were 12 residents with urinary catheters. This deficient practice resulted in the resident's dignity not being maintained. Findings include: Resident #20 was admitted (MONTH) 14, 2014, with [DIAGNOSES REDACTED]. Review of the quarterly MDS assessment dated (MONTH) 17, 2019, revealed the resident had an indwelling urinary catheter in place. During a random observation conducted (MONTH) 4, 2019 at 11:52 a.m., the resident was observed being pushing in a wheelchair down the hall to the dining room by a Certified Nursing Assistant (CNA/staff #69) with the urinary catheter bag uncovered. An interview was conducted immediately with staff #69. The CNA stated that the urinary catheter bag needed a privacy bag and that she was going to go get one. The facility's policy titled Dignity revealed assisting residents in a dignified manner included covering appliances attached to residents.
F 0600 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, facility documentation and policy review, the facility failed to ensure 1 of 2 sampled residents (#258) was free from verbal abuse by a staff member. The deficient practice could result in other residents being verbally abuse. Findings include: Resident #258 was admitted to the facility on (MONTH) 25, (YEAR) with a [DIAGNOSES REDACTED]. The resident was discharged (MONTH) 6, (YEAR). Review of the care plan initiated (MONTH) 25, (YEAR) revealed the resident had urinary and bowel incontinence. Interventions included assisting with toileting as needed and pericare as needed. A nursing note dated (MONTH) 27, (YEAR) revealed the resident was alert and able to make needs known verbally and needed the assistance of 1-2 staff. Review of the facility's investigation report dated (MONTH) 30, (YEAR), revealed that on (MONTH) 28, (YEAR) at approximately 5:20 PM resident #258 reported to the Assistant Director of Nursing (ADON) that she felt verbally abused by a Certified Nursing Assistant (CNA/staff #134) who was caring for her that evening. Resident #258 stated that she called the CNA a [***] when she was told that she would need to wait for care. The CNA answered the resident by stating if she needed to see a [***] all she needed to do was look in the mirror. The report included a CNA (staff #41) was working with staff #134. Staff #134 was placed on suspension pending investigation. The report also included the resident was alert and oriented to time, person and place. The facility's report revealed staff #134 employment was terminated after completion of the investigation. A written statement by staff #134 dated November, 28, (YEAR) revealed that after the resident called her a [***] she replied, if you looked in the mirror you would see the same thing. A written statement by staff #41 dated (MONTH) 29, (YEAR) revealed resident #258 was wet when she and staff #134 answered the resident's call light. Staff #134 asked the resident to please give them a few minutes because they were passing dinner trays. Resident #258 responded, You're a [***] . The statement included the resident was clearly agitated so they left the room. The statement also included staff #41 returned alone to change the resident after the dinner trays were passed. An interview was conducted with staff #41 on (MONTH) 2, 2019 at 9:09 AM. She stated that after the resident called staff #134 a [***] , she immediately went and reported it to the nurse and the ADON. She stated that she did not hear a response from staff #134. She stated that she felt very uncomfortable when the resident called the CNA a name. Staff #41 stated that it made her feel like there had been a previous confrontation between the two. An attempt to contact staff #134 by telephone for an interview was unsuccessful. An interview was conducted with the Director of Nursing (DON/staff #32) on (MONTH) 4, 2019 at 12:51 PM. She stated that if abuse is witnessed, it needs to be reported immediately to a supervisor. The DON stated that if the alleged perpetrator is a staff member, the staff member would be removed from providing care for residents. She stated they would make sure the resident was okay and would contact the family, doctor and the proper agencies. The DON stated that verbal abuse by staff to a resident is not tolerated. The facility's policy for Protection of Resident: Reducing the Threat of Abuse and Neglect, revised on (MONTH) (YEAR) revealed that each resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation of any type by anyone. This includes but is not limited to staff, other residents, consultants, volunteers, staff from other agencies serving our resident, family members, the resident representative, friends or any other individuals. The policy included verbal abuse is the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within hearing distance, regardless of age, ability to comprehend, or disability.
F 0607 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a clinical record review, staff interviews, and policy review, the facility failed to implement their policy, by failing to report an allegation of injury of unknown source, conduct a thorough investigation, and report the results of the investigation to the State Agency for one of two sampled residents (#15). This deficient practice could result in the potential for further abuse. Findings include: Resident #15 was admitted to the facility on (MONTH) 5, (YEAR), with [DIAGNOSES REDACTED]. Review of the quarterly Minimum Data Set (MDS) assessment dated (MONTH) 12, (YEAR) revealed the resident had severely

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 0607 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) impaired cognitive skills for daily decision making and required extensive assistance with all activities of daily living (ADLs). Review of the weekly skin check dated (MONTH) 8, (YEAR) revealed the resident's skin was intact. A nursing note dated (MONTH) 9, 2019 revealed a bruise was noted to the resident's inner left thigh with mild swelling. The note included the nurse practitioner (NP) was notified and an order was obtained for an x-ray to the left lower extremity. The results of the x-ray dated (MONTH) 9, (YEAR) revealed mild [MEDICAL CONDITION] changes. Review of the NP's progress note dated (MONTH) 9, (YEAR) revealed the chief complaint was left hip pain and swelling. The note included the nurses were concerned about the left hip pain and the bruising noted to the internal thigh. The nursing staff reported the resident was experiencing more pain than usual with the left leg movement. The resident was crying out or moaning when passive range of motion was conducted to the left leg. The nursing staff reported that there was no recent trauma to the leg or a fall. The progress note revealed the resident was noted to have [MEDICAL CONDITION] to the left thigh, bruising to the left groin area, and that there was slight joint contraction noted to the left side. The resident seemed more swollen on the left side and the left leg was contracted up and turned outward. The progress note also included the bruising may have been from the use of aspirin and [MEDICATION NAME]. A nursing note dated (MONTH) 29, (YEAR) revealed a Certified Nursing Assistant (CNA) notified the nurse of an old bruise to the left inner thigh. Review of the clinical record and the State Data base revealed no evidence this injury of unknown source was reported to the State Agency or Adult Protective Services (APS). An interview was conducted with a CNA (staff #27) on (MONTH) 3, 2019 at 8:08 a.m. Staff #27 stated that CNAs are to observe the resident's skin during routine care and showers. Staff #27 stated that if bruising is identified, the nurse is to be notified as soon as possible. An interview was conducted on (MONTH) 3, 2019 at 10:25 a.m. with a Registered Nurse (RN/staff #74). Staff #74 stated that if a bruise is identified, the resident is immediately questioned as to how the bruise occurred. Staff #74 stated that if the resident is unable to say how the bruise occurred, the Direct of Nursing (DON) is notified and an investigation is conducted. Staff #74 stated that the bruise is assessed which may include the location of the bruise, size and shape, and if swelling or pain is present. Staff #74 stated that bruises can be a sign of abuse. An interview was conducted on (MONTH) 3, 2019 at 3:17 p.m. with the Director of Nursing (DON/staff #32). The DON stated the CNAs complete skin checks during routine care and the nursing staff complete weekly skin checks. The DON stated that if a new skin condition is identified, the nurse will notify the family and the provider. She stated that the nurse will further investigate the origin of the skin condition which may be a bruise. The DON stated the nurse will ask the resident how the bruise occurred and that if the resident is unable to say, an investigation is initiated. She stated that the nurse will also ask the staff caring for the resident about the bruise. The DON further stated that if the cause is unable to be determined via the investigation, the injury or bruise is considered to be an injury of unknown source. The DON stated that if it is an injury of unknown source then the family, Adult Protective Services (APS), the State Agency, and the provider are notified within two hours. She stated that the investigation will include staff and family interviews. She stated that the results of the investigation are then reported to the State Agency within 5 days. On (MONTH) 3, 2019 at 3:45 p.m. the DON (staff #32) stated that there were no incident reports or investigations conducted for the bruise identified on the resident's inner thigh. A follow up interview was conducted on (MONTH) 4, 2019 at 12:34 p.m. with the DON (staff #32). The DON stated the NP evaluated the resident after the bruise was identified and noted a contracture with weakness to the left side and joint swelling. The DON stated that due to the NP's evaluation, it was determined no additional investigation was needed. Review of the facility's policy dated (MONTH) 20, (YEAR) titled Protection of Residents: Reducing the Threat of Abuse and Neglect revealed the purpose of the policy is to minimize the threat of abuse and neglect by incorporating clear-out policies and practices that demonstrate a hardline, zero tolerance approach to resident abuse. Per policy, the facility is to identify abuse and exploitation of residents including but not limited to identifying and understanding the different types of abuse and possible indicators, such as; injury that is suspicious because the source of injury is not observed or the extent or location of the injury is unusual. The policy included possible signs of sexual abuse include an unexplained pelvic injury and/or bruising of the genitals or inner thighs. The policy defines injuries of unknown source when both of the following criteria are met; the injury that was not observed by anyone or the source of the injury could not be explained by the resident and the injury is suspicious because of the extent of the injury or the location of the injury, such as, the injury is located in an area not generally vulnerable to trauma or the number of injuries observed at one particular point in time or incidences of injuries over time. The policy further revealed all personnel are to promptly report any incident or suspected incident of resident abuse, neglect, and injuries of unknown source to their immediate supervisor or facility representative. In addition, it is the facilities policy that reports of abuse including injuries of unknown source are promptly and thoroughly investigated and the administrator or director of nursing will complete a written summary of the findings of the investigation and report the findings to the State Agency within 5 days.
F 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a clinical record review, staff interviews, and policy review, the facility failed to ensure an allegation of injury of unknown source was reported to the required agencies within the required timeframes for one of two sampled residents (#15). This deficient practice could result in the potential for further abuse. Findings include: Resident #15 was admitted to the facility on (MONTH) 5, (YEAR), with [DIAGNOSES REDACTED]. Review of the quarterly Minimum Data Set (MDS) assessment dated (MONTH) 12, (YEAR) revealed the resident had severely impaired cognitive skills for daily decision making and required extensive assistance with all activities of daily living (ADLs). A nursing note dated (MONTH) 9, 2019 revealed a bruise was noted to the resident's inner left thigh with mild swelling. The note included the Nurse Practitioner (NP) was notified and an order for [REDACTED]. Review of the NP's progress note dated (MONTH) 9, (YEAR) revealed the chief complaint was left hip pain and swelling. The note included the nurses were concerned about the left hip pain and the bruising noted to the internal thigh. The nursing staff reported the resident was experiencing more pain than usual with the left leg movement. The resident was crying out or moaning when passive range of motion was conducted to the left leg. The nursing staff reported that there was no recent trauma to the leg or a fall. The progress note revealed the resident was noted to have [MEDICAL CONDITION] to the left thigh, bruising to the left groin area, and that there was slight joint contraction noted to the left side. The resident seemed more swollen on the left side and the left leg was contracted up and turned outward. The progress note also included the bruising may have been from the use of aspirin and [MEDICATION NAME]. The results of the x-ray dated (MONTH) 9, (YEAR) revealed mild [MEDICAL CONDITION] changes. A nursing note dated (MONTH) 29, (YEAR) revealed a Certified Nursing Assistant (CNA) notified the nurse of an old bruise to the left inner thigh. Review of the clinical record and the State Data base revealed no evidence this injury of unknown source was reported to the State Agency or Adult Protective Services (APS). An interview was conducted with a certified nursing assistant on (MONTH) 3, 2019 at 8:08 a.m. (CNA/staff #27). Staff #27 stated CNAs are to observe the resident's skin during routine care and showers. Staff #27 stated if bruising is identified the nurse is to be notified as soon as possible. An interview was conducted on (MONTH) 3, 2019 at 10:25 a.m. with a Registered Nurse (RN/staff #74). Staff #74 stated if a bruise is identified, the resident is immediately questioned as to how the bruise occurred. Staff #74 stated that if the resident is unable to say how the bruise occurred, the Direct of Nursing (DON) is notified. An interview was conducted on (MONTH) 3, 2019 at 3:17 p.m. with the DON (staff #32). The DON stated that if a new skin

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F 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) condition is identified, the nurse will notify the family and the provider. She stated that the nurse will further investigate the origin of the skin condition which may be a bruise. The DON stated the nurse will ask staff and the resident how the bruise occurred and that if the resident is unable to say, an investigation is initiated. The DON further stated that if the cause is unable to be determined via the investigation, the injury or bruise is considered to be an injury of unknown source. The DON stated that if it is an injury of unknown source then the family, Adult Protective Services (APS), the State Agency, and the provider are notified within two hours. A follow up interview was conducted on (MONTH) 4, 2019 at 12:34 p.m. with the DON. The DON stated the nurse practitioner (NP) evaluated the resident after the bruise was identified and that due to the NP's evaluation, it was determined no additional investigation was needed. Review of the facility's policy dated (MONTH) 20, (YEAR) titled Protection of Residents: Reducing the Threat of Abuse and Neglect revealed the facility is to identify abuse and exploitation of residents including but not limited to identifying and understanding the different types of abuse and possible indicators, such as; an injury that is suspicious because the source of injury is not observed or the extent or location of the injury is unusual. The policy included possible signs of sexual abuse may include unexplained pelvic injury and/or bruising of the genitals or inner thighs. The policy defines injuries of unknown source when both of the following criteria are met; the injury that was not observed by anyone or the source of the injury could not be explained by the resident and the injury is suspicious because of the extent of the injury or the location of the injury, such as, the injury is located in an area not generally vulnerable to trauma or the number of injuries observed at one particular point in time or incidences of injuries over time. The policy further revealed all personnel are to promptly report any incident or suspected incident of resident abuse, neglect, and injuries of unknown source to their immediate supervisor or facility representative. The policy revealed the facility must ensure that all alleged violations involving abuse, neglect, including injuries of unknown source are to be reported to the State Agency immediately, but not later than 2 hours after the allegation is made and the allegation is to be reported to APS where state law provides jurisdiction. The policy further revealed failure to do so will mean that the facility is not in compliance with the federal regulations.
F 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a clinical record review, staff interviews, and policy review, the facility failed to ensure an injury of unknown source was thoroughly investigated and the results of the investigation were reported to the State Agency within the required timeframe for one of two sampled residents (#15). The deficient practice could result in the potential for further abuse. Findings include: Resident #15 was admitted to the facility on (MONTH) 5, (YEAR), with [DIAGNOSES REDACTED]. Review of the quarterly Minimum Data Set (MDS) assessment dated (MONTH) 12, (YEAR) revealed the resident had severely impaired cognitive skills for daily decision making and required extensive assistance with all activities of daily living (ADLs). A nursing note dated (MONTH) 9, 2019 revealed a bruise was noted to the resident's inner left thigh with mild swelling. The note included the nurse practitioner (NP) was notified and an order for [REDACTED]. Review of the NP's progress note dated (MONTH) 9, (YEAR) revealed the chief complaint was left hip pain and swelling. The note included the nurses were concerned about the left hip pain and the bruising noted to the internal thigh. The nursing staff reported the resident was experiencing more pain than usual with the left leg movement. The resident was crying out or moaning when passive range of motion was conducted to the left leg. The nursing staff reported that there was no recent trauma to the leg or a fall. The progress note revealed the resident was noted to have [MEDICAL CONDITION] to the left thigh, bruising to the left groin area, and that there was slight joint contraction noted to the left side. The resident seemed more swollen on the left side and the left leg was contracted up and turned outward. The progress note also included the bruising may have been from the use of aspirin and [MEDICATION NAME]. The results of the x-ray dated (MONTH) 9, (YEAR) revealed mild [MEDICAL CONDITION] changes. A nursing note dated (MONTH) 29, (YEAR) revealed a Certified Nursing Assistant (CNA) notified the nurse of an old bruise to the left inner thigh. An interview was conducted on (MONTH) 3, 2019 at 10:25 a.m. with a Registered Nurse (RN/staff #74). Staff #74 stated that if a bruise is identified, the resident is immediately questioned as to how the bruise occurred. Staff #74 stated that if the resident is unable to say how the bruise occurred, the Direct of Nursing (DON) is notified and an investigation is conducted. Staff #74 stated that bruises can be a sign of abuse. An interview was conducted on (MONTH) 3, 2019 at 3:17 p.m. with the Director of Nursing (DON/staff #32). The DON stated the CNAs complete skin checks during routine care and the nursing staff complete weekly skin checks. The DON stated that if a new skin condition is identified, the nurse will notify the family and the provider. She stated that the nurse will further investigate the origin of the skin condition which may be a bruise. The DON stated the nurse will ask staff and the resident how the bruise occurred and that if the resident is unable to say, an investigation is initiated. The DON further stated that if the cause is unable to be determined via the investigation, the injury or bruise is considered to be an injury of unknown source. She stated that the investigation will include staff and family interviews. She stated that the results of the investigation are then reported to the State Agency within 5 days. On (MONTH) 3, 2019 at 3:45 p.m. the DON (staff #32) stated that there were no incident reports or investigations conducted for the bruise identified on the resident's inner thigh. A follow up interview was conducted on (MONTH) 4, 2019 at 12:34 p.m. with the DON. The DON stated the nurse practitioner (NP) evaluated the resident after the bruise was identified and that due to the NP's evaluation, it was determined no additional investigation was needed. Review of the facility's policy dated (MONTH) 20, (YEAR) titled Protection of Residents: Reducing the Threat of Abuse and Neglect revealed the purpose of the policy is to minimize the threat of abuse and neglect by incorporating clear-cut policies and practices that demonstrate a hardline, zero tolerance approach to resident abuse. Per policy, the facility is to denitrify abuse and exploitation of residents including but not limited to identifying and understanding the different types of abuse and possible indicators, such as; injury that is suspicious because the source of injury is not observed or the extent or location of the injury is unusual and possible signs of sexual abuse include an unexplained pelvic injury, bruising of the genitals or inner thighs. The policy defines injuries of unknown source when both of the following criteria are met; the injury that was not observed by anyone or the source of the injury could not be explained by the resident and the injury is suspicious because of the extent of the injury or the location of the injury, such as, the injury is located in an area not generally vulnerable to trauma or the number of injuries observed at one particular point in time or incidences of injuries over time. The policy further revealed reports of abuse including injuries of unknown source are promptly and thoroughly investigated and the administrator or director of nursing will complete an incident report and a written summary of the findings of the investigation including but not limited to review of the incident report, an interview with the person reporting the incident, interviews with witnesses, an interview with the resident, review of the medical record, interviews with staff members on all shifts having contact with the resident at the time of incident, an interview with the roommate, and all circumstances surrounding the incident and report the findings to the State Agency within 5 days.
F 0641 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, staff interviews and the Resident Assessment Instrument (RAI) manual, the facility failed to ensure Minimum Data Set (MDS) assessments were accurate for two residents (#58 and #208). The census was 66. The deficient practice could affect residents' continuity of care. Findings include: -Resident #58 was admitted on (MONTH) 12, 2019, with [DIAGNOSES REDACTED]. The physician's orders [REDACTED]. A review of the nursing discharge summary progress notes dated (MONTH) 2, 2019 revealed the resident was discharged home.

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F 0641 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) Review of the discharge MDS assessment dated (MONTH) 2, 2019, revealed the resident was discharged to an acute hospital. An interview was conducted with the MDS coordinator (staff #51) on 04/04/19 at 08:53 AM. Staff #51 stated that she obtains information for the MDS assessment from the nurses, certified nursing assistants, therapy, residents and families. She stated that resident #58 was discharged home and that the discharge MDS assessment was an error. During an interview conducted with the Administrator (staff #132) on 04/04/19 at 09:24 AM, the Administrator stated that the expectation is that the MDS assessments are accurate and that an inaccurate assessment is not acceptable. -Resident #208 was admitted to the facility on (MONTH) 6, (YEAR), with [DIAGNOSES REDACTED]. Review of the physician's orders [REDACTED]. A nursing note dated (MONTH) 16, (YEAR), revealed the resident was discharged to another nursing facility. However, the discharge MDS assessment dated (MONTH) 16, (YEAR), revealed the resident was discharged to the community. An interview was conducted on (MONTH) 3, 2019 at 8:42 a.m. with the MDS Coordinators (staff #51 and staff #88). The coordinators stated that they worked together and shared duties to complete the MDS assessments. They stated that they followed the RAI manual to code the MDS assessments. Staff #51 stated that the resident's discharge MDS assessment should have been coded that the resident went to another facility not to the community. The RAI manual instructs to review the resident's clinical record for documentation of the discharge location. The RAI manual also includes that it is required that the assessment accurately reflects the resident's status and that the importance of accurately completing and submitting the MDS assessment cannot be over emphasized.
F 0655 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, resident and staff interviews, and policy review, the facility failed to ensure a summary of the baseline care plan was provided to three residents (#15, #38, #25) and/or the residents' representatives and failed to ensure a baseline care plan was developed within 48 hours for three residents (#59, #209, #317). The sample size was 20. The deficient practice could result in residents' care needs not being met. Findings include: -Resident #15 was admitted to the facility on (MONTH) 5, (YEAR), with [DIAGNOSES REDACTED]. Review of the baseline care plan revealed the care plan was developed on (MONTH) 5, (YEAR), which included the resident's advance directive status, communication status, Activities of Daily Living (ADL) status, fall risk status, and the resident's impaired cognitive ability related to dementia. Review of the admission Minimum Data Set (MDS) assessment dated (MONTH) 12, (YEAR) revealed the resident scored a 5 on the Brief Interview for Mental Status (BIMS), indicating the resident had severe cognitive impairment. Review of the clinical record revealed no evidence that a summary of the resident's baseline care plan had been provided to the resident's legal representative. -Resident #38 was admitted to the facility on (MONTH) 6, (YEAR), with [DIAGNOSES REDACTED]. The baseline care plan included the resident's communication status, ADL status, fall risk, hydration, and nutritional status. Review if the admission MDS assessment dated (MONTH) 13, (YEAR) revealed the resident scored a 13 on the BIMS, indicating the resident was cognitively intact. Review of the clinical record revealed no evidence that a summary of the resident's baseline care plan had been provided to the resident. An interview was conducted on (MONTH) 4, 2019 at 11:40 a.m. with a licensed practical nurse (LPN/staff #128). Staff #128 stated the admission nurse will develop a baseline care plan upon admission. Staff #128 stated the baseline care plan includes diagnoses, wounds, ADLs, and other care needs. Staff #128 stated the care plan is developed within 24-48 hours of admission. Staff #128 further stated the charge nurse or Director of Nursing (DON) will print a copy of the baseline care plan and review it with the resident or resident representative. The LPN stated the resident or representative will then sign a copy which will be kept in the medical record and a copy will be given to the resident or the resident's representative. An interview was conducted on (MONTH) 4, 2019 at 12:34 p.m. with the DON (staff #32). The DON stated that on admission, the admitting nurse is responsible for developing a baseline care plan inclusive of advance directives, diagnoses, potential and actual skin breakdown, and falls. The DON further stated a copy of the baseline care plan is reviewed and given to the resident or representative within 48 hours and a signed copy is kept for the clinical record. A copy of the signed baseline care plan was requested for residents (#15 and #38). At 2:11 p.m., the DON stated the signed copies of the baseline care plans for the two residents (#15 and #38) were unable to be located. -Resident #25 was admitted on (MONTH) 24, (YEAR), with [DIAGNOSES REDACTED]. Review of the baseline care plan dated (MONTH) 24, (YEAR), included the resident's advance directive status, ADL status, communication status, medications, fall risk status, and oxygen therapy. Review of the admission MDS assessment dated (MONTH) 31, (YEAR) revealed a score of 10 on the BIMS which indicated the resident had moderate impaired cognition. The nurse progress note dated (MONTH) 12, (YEAR), revealed the resident had a medical power of attorney (MPOA). Continued review of the clinical record revealed no evidence that a summary of the resident's baseline care plan had been provided to the resident's legal representative. During an interview conducted with the resident's MPOA on (MONTH) 2, 2019 at 1:18 p.m., the MPOA stated that even after multiple requests, no information had been provided regarding the resident's care plan. An interview was conducted with Director of Social Services (staff #112) on (MONTH) 3, 2019 at 1:37 p.m. Staff #112 stated the baseline care plans are initiated upon admission by the nurse. She stated that the case managers and nurses review the care plans with the residents' representatives. An interview was conducted with the Director of Nursing (DON/staff #32) on (MONTH) 3, 2019 at 2:02 p.m. The DON stated that the Assistant Director of Nursing (ADON) was the one responsible for making sure the baseline care plans were complete and reviewing the care plans with the resident and/or the resident's representative. Staff #32 stated the ADON was no longer at the facility. -Resident #59 was admitted to the facility on (MONTH) 14, 2019 with a [DIAGNOSES REDACTED]. Review of the clinical record did not reveal a baseline care plan for resident #59. An interview was conducted with the Medical Records Director (staff #56) on (MONTH) 3, 2019 at 11:40 AM. Staff #56 stated a baseline care plan was never developed for resident #59 and that the resident was not there long enough for the comprehensive care plan. An interview was immediately conducted with a Licensed Practical Nurse (LPN/staff #106). She stated the floor nurse develops the baseline care plan on admission and that it should be completed in 24 hours. An interview was conducted with the Director of Nursing (DON/staff #32) on (MONTH) 3, 2019 at 1:44 PM. The DON stated the baseline care plan is developed by the floor nurse on admission and should be completed within 24 hours. She stated that she did not know what had happened with the baseline care plan for resident #59. The DON stated she was very involved with the family and actually thought she had completed that one herself. -Resident #209 was admitted to the facility on (MONTH) 27, 2019 with [DIAGNOSES REDACTED]. Review of the baseline care plan revealed the resident's care plan had been initiated but not completed. The focus for pain was left blank in the area of the specific type of pain. It was also left blank in the area that states what the pain is related to. No goals were in place and the care plan contained only one intervention which included evaluating the effectiveness of pain interventions. An interview was conducted with the DON on (MONTH) 4, 2019 at 12:51 PM. The DON stated the nurse that does the admission is responsible for making sure the baseline care plan is complete. She also stated that chart reviews are regularly conducted. After viewing the care plan for resident #209, the DON stated that the care plan was not complete. -Resident #317 was admitted (MONTH) 24, 2019, with [DIAGNOSES REDACTED].

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DESERT COVE NURSING CENTER	**1750 WEST FRYE ROAD CHANDLER, AZ 85224**

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0655 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 4) During an initial observation conducted of the resident on (MONTH) 1, 2019 at 11:09 a.m., the resident was observed to have oxygen on at 2 liters per nasal cannula. Review of the clinical record did not reveal a physician's orders [REDACTED]. Further review of the clinical record did not reveal a baseline care plan had been developed for oxygen therapy. An interview was conducted with a Licensed Practical Nurse (LPN/staff #120) on (MONTH) 4, 2019 at 1:25 p.m. The LPN stated that a physician's orders [REDACTED]. Review of facility's policy regarding baseline care plan revealed the baseline care plan will be developed for every resident within 48 hours of admission to provide an initial set of instructions needed to provide effective and person-centered care of the resident that meet professional standards of care. The policy also included reviewing the baseline care plan and the physician orders [REDACTED].
F 0686 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**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 reviews, staff interviews, and policy review, the facility failed to ensure barrier cream was consistently applied to one of three sampled residents (#15) and failed to ensure three of three sampled residents (#15, #208, and #308) with pressure ulcers consistently received treatment and services consistent with professional standards of practice. The deficient practice could result in the development and worsening of pressure ulcers. Findings include: -Resident #15 was admitted to the facility on (MONTH) 5, (YEAR), with [DIAGNOSES REDACTED]. Review of the baseline care plan initiated on (MONTH) 5, (YEAR) revealed the resident was at risk for skin break down related to immobility and incontinence. The goal was for the resident to maintain intact skin. Interventions included keeping the skin clean and dry after each incontinence episode, a pressure reducing mattress, completing weekly skin checks, and providing treatments as ordered. Review of the quarterly Minimum Data Set (MDS) assessment dated (MONTH) 12, (YEAR) revealed the resident had severely impaired cognitive skills for daily decision making and required extensive assistance with all activities of daily living (ADLs). The MDS assessment included the resident had no unhealed pressure ulcers but was at risk for pressure ulcer development. The Braden Scale dated (MONTH) 22, (YEAR) revealed a score of 15 indicating the resident was at mild risk for pressure ulcer development. Review of the weekly skin checks revealed no evidence of pressure ulcers prior to (MONTH) 24, (YEAR). A weekly skin check dated (MONTH) 25, (YEAR) revealed the resident's skin remained intact, however, there was a non-blanchable area noted to the sacrum. Review of the physician orders [REDACTED]. A weekly skin check dated (MONTH) 15, (YEAR) revealed the sacrum was red and barrier cream was applied. The Treatment Administration Record (TAR) for (MONTH) (YEAR) revealed no evidence [MEDICATION NAME] cream was applied during the day shift on (MONTH) 20, (YEAR). Review of the progress notes for (MONTH) 20, (YEAR) revealed no evidence the cream was administered or refused by the resident. A weekly skin check dated (MONTH) 22, (YEAR) revealed there was redness to the left and right buttock. Review of the weekly skin checks for (MONTH) (YEAR) revealed the resident's skin remained intact with no new findings. Review of the TAR for (MONTH) (YEAR) revealed the [MEDICATION NAME] cream was applied as ordered. A communication note dated (MONTH) 29, (YEAR) revealed that while changing the resident's brief, the resident's family identified and notified the nurse of an opening to the resident's left buttock. The note included the Assistant Director of Nursing (ADON) was notified and an order for [REDACTED].>Review of the physician orders [REDACTED]. The first documentation of the wound measurements was a health status note dated (MONTH) 3, 2019 that the open area to the left buttock measured 0.5 centimeters (cm) in length by 0.4 cm in width and 0.2 cm in depth. The note included the wound treatment was provided and the wound nurse was notified. However, the note did not include a description of the wound. Review of the weekly skin check for (MONTH) 6, 2019, revealed the resident had an open area to the left gluteal fold. A health status note dated (MONTH) 9, 2019 revealed the Nurse Practitioner (NP) communicated to the wound nurse to have the wound care team follow the resident for the stage two pressure ulcer to the left buttock. Review of the nursing health status notes for (MONTH) 9, 2019 revealed the family refused to let staff reposition and change the resident. The notes included the nurse was concerned and spoke to the family about the wound and repositioning the resident and that the family showed no concern for the wound. A care plan was initiated on (MONTH) 9, 2019 and revised on (MONTH) 22, 2019 for the stage two pressure ulcer to the left ischium. The goal was for the resident to have intact skin, be free from redness, and for the pressure ulcer to show signs of healing and remain free from infections. Interventions included using two staff with repositioning, keeping the bed flat to reduce shearing, observing and reporting changes in skin status, and following policies for prevention and treatment of [REDACTED]. Review of the Care conference notes dated (MONTH) 11, 2019 revealed the family was upset that the CNAs were coming into the resident's room in the middle of the night to reposition and change the resident. The note included the family was informed of the increased risk to the skin and the detrimental effect of not changing positions. The weekly skin check for (MONTH) 12, 2019 revealed there was an open area to the left gluteal fold. Review of the quarterly MDS assessment dated (MONTH) 12, 2019 revealed the resident had severely impaired cognitive skills for daily decision making and required extensive assistance with all ADLs. The assessment included the resident had a stage two unhealed pressure ulcer. Further review of the clinical record from (MONTH) 29, (YEAR) through (MONTH) 14, 2019 revealed no thorough assessment of the pressure ulcer which included a description of the wound bed, any drainage, the surrounding skin, or any odor. A skin/wound note dated (MONTH) 15, 2019 revealed the resident had a stage three left ischium ulcer measuring 0.6 cm in length by 0.7 cm in width with minimal slough with mild drainage. The note included the resident had an alternating pressure mattress present on the bed and a Roho cushion in the wheelchair. Review of the provider's progress note dated (MONTH) 15, 2019, revealed the wound was a ischial ulceration with an irregular shaped superficial ulceration extending to the subcutaneous tissue with minimal slough, mild granulation, mild serous drainage, and no peri-wound inflammation. Review of the weekly skin check for (MONTH) 20, 2019 revealed the resident had an open area/wound. The weekly skin check for (MONTH) 25, 2019 revealed there was no new finding. Review of the TAR for (MONTH) 2019 revealed no evidence the [MEDICATION NAME] cream was applied on the day shift on (MONTH) 14,16, 25, and 28 and the evening shift of (MONTH) 25, 2019. Review of the progress notes for these dates revealed no evidence the cream was administered or refused by the resident. Additional review of the TAR for (MONTH) 2019 revealed no evidence the left ischium treatment was provided as ordered on (MONTH) 14, 16, 21, 23, and 25, 2019. Review of the progress notes for these dates revealed no evidence treatment was administered or refused by the resident. The weekly pressure ulcer tracking report dated (MONTH) 29, 2019 revealed the pressure ulcer to the left ischium measured 0.4 cm in length by 0.3 cm in width by 0.1 cm in depth. The report included the wound was a superficial ulceration extending through the subcutaneous tissue with no odor, minimal slough, and mild drainage. Review of the provider's progress note dated (MONTH) 5, 2019 revealed the bilateral ischial ulceration was 100 percent re-[MEDICATION NAME] and had resolved. Review of a wound note dated (MONTH) 5, 2019, revealed the ulcer had resolved and to continue applying the cream to the buttock as ordered. The TAR dated (MONTH) 2019 revealed no evidence the [MEDICATION NAME] cream was applied on the day shift on (MONTH) 1, 7, and the 22, 2019. Review of the progress notes for the corresponding dates revealed no evidence the cream was administered or refused by the resident. The TAR dated (MONTH) 2019 revealed no evidence the [MEDICATION NAME] cream was applied on the day shift on (MONTH) 11,

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NAME OF PROVIDER OF SUPPLIER **DESERT COVE NURSING CENTER**		STREET ADDRESS, CITY, STATE, ZIP **1750 WEST FRYE ROAD CHANDLER, AZ 85224**	

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F 0686 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 5) 2019. Review of the progress notes for (MONTH) 11, 2019 revealed no evidence the cream was administered or refused by the resident.An interview was conducted on (MONTH) 3, 2019 at 10:25 a.m. with a Register Nurse (RN/staff #74). Staff #74 stated that once a wound is identified, the nurse will notify the doctor and obtain a treatment order. Staff #74 stated the wound nurse will stage, measure, and assess the wound weekly. The RN stated that the nurses complete the weekly skin assessments and administer the treatments. She also stated that the nurses are to document wound treatment on the TAR and that if it is not documented on the TAR, it is assumed the treatment was not provided. An interview was conducted on (MONTH) 4, 2019 at 8:20 a.m. with the wound nurse (staff #107). Staff #107 stated that the wound nurse is notified when a new skin opening is identified. Staff #107 stated that the wound nurse will obtain a treatment order and assess and measure the wound weekly. Staff #107 also stated that the wound provider will assess and determine the stage of a pressure ulcer. Staff #107 stated the administration of a treatment is record on the TAR by the nurse. On (MONTH) 4, 2019 at 10:37 a.m., the Director of Nursing (DON/staff #32) stated that all copies of the wound assessments and documentation for this resident had been provided. During an interview conducted on (MONTH) 4, 2019 at 12:34 p.m. with the DON (staff #32), the DON stated that the nurses complete the weekly skin checks and the wound nurse completes the weekly pressure ulcer measurements and assessments along with the wound doctor. The DON further stated treatments administered to the resident are documented on the TAR. -Resident #208 was admitted to the facility on (MONTH) 6, (YEAR), with [DIAGNOSES REDACTED]. The resident was discharged on (MONTH) 16, (YEAR). Review of the admission nursing assessment dated (MONTH) 7, (YEAR), revealed the resident had skin tears on the right elbow, right trochanter, and left and right shoulders. The assessment also included the resident had a wound on the coccyx and scars on the front of the right and left knees. The admission assessment did not include any documentation of skin breakdown on the resident's heels. Review of the care plan dated (MONTH) 8, (YEAR), revealed the resident was at risk for skin integrity breakdown. The goal was for the resident to maintain intact skin with no skin breaks. Interventions included a pressure reducing mattress, treatments as ordered, and weekly skin checks. Review of the resident's wound assessments revealed an assessment described as a first observation dated (MONTH) 8, (YEAR) which described a stage 2 pressure ulcer located on the resident's sacrum. The assessment did not include any wounds on the resident's heels. A skin/wound note dated (MONTH) 9, (YEAR), stated, Patient's skin checked for a second time .a stage 2 ulcer to the right heel noted. New orders put in place . Review of the clinical record revealed no evidence of an initial wound assessment for the resident's right heel wound. The physician's orders [REDACTED]. heel to be cleansed and dressed daily. Review of the Treatment Administration Record (TAR) for (MONTH) (YEAR), revealed the resident received treatments for the right heel wound daily from (MONTH) 9 through (MONTH) 14, (YEAR), and on (MONTH) 16, (YEAR). The treatment was not documented on the TAR as being provided to the resident's right heel on (MONTH) 15, (YEAR). Review of the 5 day MDS assessment dated (MONTH) 13, (YEAR), revealed the resident had one stage 2 unhealed pressure ulcer present on admission. A provider's progress note dated on the day of the resident's discharge on (MONTH) 16, (YEAR), revealed the resident was receiving an evaluation of the right heel blister and coccyx ulcer which were present on admission. However there was no documentation of the right heel wound in the resident's admission assessments. Although the resident was discharged from the facility on (MONTH) 16, (YEAR), a wound assessment signed (MONTH) 22, (YEAR), revealed the resident had an unstageable deep tissue injury on the right heel. The assessment described the wound as a small intact blister and a small area of purplish discoloration. The wound assessment did not include the presence of any slough tissue or necrotic tissue and/or eschar. The assessment included the wound was present on admission; however there was no documentation of the right heel wound in the resident's admission assessments. An interview was conducted on (MONTH) 4, 2019 at 8:20 a.m., with a Licensed Practical Nurse (LPN/wound nurse/staff #107). She stated that the admission nurse was responsible for completing a full skin assessment when a resident was admitted to the facility. The LPN stated that if the admission nurse identifies a wound, the nurse would leave a note for her to complete a wound assessment. She said a second full skin assessment would also be conducted within 24 hours of admission by herself, the ADON, or the DON. She stated that the wound on the resident's right heel was present on admission because it was not the type of wound that could have developed in 3 days. The LPN said the resident's right heel had significant eschar, and that this amount of eschar would indicate the wound was chronic. She stated the wound documentation, including the provider's initial assessment, measurements, and documentation of the eschar was located in the paper records, not the electronic record. An interview was conducted on (MONTH) 4, 2019 at 8:57 a.m., with the Medical Records Director (staff #56). She stated there were no additional skin assessments, wound assessments, or provider progress notes in the paper records that had not already been provided. Review of the clinical record revealed no evidence of any other wound assessments for the resident's right heel wound. An interview was conducted on (MONTH) 4, 2019 at 12:34 p.m., with the DON (staff #32). She stated the expectation was that the admitting nurse would complete a skin assessment and notify the wound nurse of any areas of concern. She said the wound nurse would follow up and obtain any needed orders for pressure ulcer treatment. The DON stated the expectation is that pressure ulcer treatments be documented on the TAR, and if the documentation was missing it would not be possible to know if the treatment had been provided. She said the the wound provider would assess wounds, make recommendations, and document progress notes. The DON stated that the wound nurse would also complete weekly wound measurements and document along with the provider progress notes. -Resident #308 was admitted on (MONTH) 2, (YEAR), with [DIAGNOSES REDACTED]. Review of the pressure ulcer status records dated (MONTH) 2, (YEAR), revealed the resident was admitted with a sacral deep tissue injury measuring 18.5 centimeters (cm) x 7.0 cm, a right heel deep tissue injury measuring 7 cm x 4 cm, and a left heel deep tissue injury measuring 2 cm x 1.5 cm. Review of care plans dated (MONTH) 2, (YEAR), revealed a care plan for active infection of the wound as evidenced by abnormal culture with a goal that the wound infection will be resolved. Interventions included administering medications as ordered. The admission Minimum Data Set (MDS) assessment dated (MONTH) 9, (YEAR), revealed the resident scored a 15 on the Brief Interview for Mental Status (BIMS) indicating the resident was cognitively intact. The MDS assessment included the resident had 3 unstageable pressure ulcers Review of a physician progress notes [REDACTED]. A physician order [REDACTED]. However, review of the Medication Administration Record [REDACTED]. Review of the nurse progress note dated (MONTH) 18, 2019, revealed the pharmacist was contacted regarding the [MEDICATION NAME] trough level. The note included that according to the pharmacist the resident should have been on [MEDICATION NAME] 1 gram every 12 hours. The note also included the patient was given [MEDICATION NAME] 1 gram once a day beginning on 2/14/18. An interview was conducted with a RN (staff #74) on (MONTH) 3, 2019 at 12:37 p.m. The RN stated that if the pharmacist is recommending IV [MEDICATION NAME] 1 gram twice a day, a physician's orders [REDACTED]. During an interview conducted on (MONTH) 4, 2019 at 2:23 p.m. with the DON (staff #32), Administrator (staff #132), and the clinical resource nurse, staff #32 stated that if a physician's orders [REDACTED]. Review of the facility's policy regarding Pressure Ulcer/Injury Prevention and Management revealed a comprehensive skin assessment on admission and re-admission may identify pre-existing signs of possible deep tissue damage already present. The policy revealed measures to maintain and improve the resident's tissue tolerance to pressure are implemented in the plan of care and included minimizing skin exposure to incontinence using skin barriers and proper positioning and turning at least every 2-4 hours. The policy included that when skin breakdown occurs, it requires attention and a change in the plan of care to appropriately treat the resident. Review of the facility's policy titled General Dose Preparation and Medication Administration revealed that prior to

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F 0686 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 6) administration of a medication, staff should take all measures required by facility policy and applicable law including but not limited to confirming that the MAR indicated [REDACTED]
F 0688 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.** **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 2 out of 2 sampled residents (#25 and #26) received the recommended Restorative Nursing Assistant (RNA) services. The deficient practice could result in a reduction in range of motion. Findings include: Resident #26 was admitted to the facility on (MONTH) 31, (YEAR) with a [DIAGNOSES REDACTED]. Review of the clinical record revealed a Rehabilitation/Restorative Care Referral Form from Physical Therapy dated (MONTH) 12, (YEAR), for a restorative program 3 x weekly for 12 weeks. Review of the Restorative Care Flow Sheets (MONTH) 13, (YEAR) through (MONTH) 29, 2019 revealed the resident received one 15 minute session on (MONTH) 21, (YEAR). The quarterly Minimum Data Set (MDS) assessment dated (MONTH) 2, 2019 revealed the resident required extensive assistance for Activities of Daily Living (ADLS). The assessment also included the resident received no Restorative Nursing Assistance (RNA) during the look-back period. Review of the Restorative Care Flow Sheet for (MONTH) 2019 revealed no documentation except for one entry on (MONTH) 26 that the resident had refused due to a headache. The Restorative Care Flow Sheet for (MONTH) 2019 revealed the resident received one 15 minute session on (MONTH) 8. The sheet included two refusals, one on (MONTH) 5 and one on (MONTH) 21. The sheet also included the resident was out of the facility on (MONTH) 7. An interview was conducted with a RNA (staff #66) on (MONTH) 2, 2019 at 3:18 PM. The RNA stated that she has a caseload of 15 on the maintenance program. She stated that because of the case load of 15, she is unable to provide RNA services to them all in one day but that she tries to get to as many residents as she can. The RNA stated that she has a flow sheet in a book for each resident on the maintenance program. She stated that she uses the flow sheets to keep track of each session. She stated that they have a meeting with skilled therapy once a month where it is determined which residents will remain on the maintenance program and who will not. The RNA stated resident #26 is still on her caseload for maintenance. -Resident #25 was admitted on (MONTH) 24, (YEAR), with [DIAGNOSES REDACTED]. The admission MDS assessment dated (MONTH) 31, (YEAR) revealed the resident required extensive assistance with transfers and walking in the room. Review of the clinical record revealed a therapy referral dated (MONTH) 6, (YEAR) for RNA services 3 times a week for 4 week for transfers, active ROM and ambulation. Review of the Restorative Care Flow Sheet for (MONTH) (YEAR) revealed the resident only received 15 minutes of RNA services on (MONTH) 20, (YEAR). Review of the Restorative Care Flow Sheet for (MONTH) 2019 only revealed the resident's refusal of RNA services on (MONTH) 3, 2019 due to leg pain. An interview was conducted with the Director of Rehabilitation services (staff #29) on (MONTH) 3, 2019 at 11:31 a.m. She stated that before a resident is discharged from therapy, they will review and recommend RNA services if it is appropriate for that resident. Staff #29 stated they did write a maintenance RNA program for resident #25 when the resident was discharged from therapy. During an interview conducted with RNA (staff #66) on (MONTH) 3, 2019 at 11:48 a.m., the RNA stated that when therapy discharges a resident from their services, therapy will write a recommendation for RNA services if appropriate for the resident. She stated that the recommendation will include what services to provide and the frequency and duration of the RNA services. Staff #66 said she has a book that contains a flow sheet for each of the residents on the RNA maintenance program that she uses to keep track of each RNA session. She stated that they have a meeting with Therapy once a month and that during the meeting, it is determined which residents will remain on the RNA maintenance program and who will not. The RNA stated that resident #25 received RNA services once in (MONTH) and once in January. She stated that the resident was supposed to receive RNA services 3 times a week, but that the services were not provided to the resident 3 times a week. An interview was conducted with the Director of Nursing (DON/staff #32) on (MONTH) 3, 2019 at 2:02 p.m. The DON stated the expectation is that RNA provides the recommended RNA services. She stated that if Therapy recommends RNA services 3 times week, she expects RNA to provide RNA services 3 times a week. The DON also stated that the expectation is that the RNA document any resident refusals. Review of the facility's policy on Restorative Nursing revealed the facility is responsible for providing restorative programs that will maintain and/or improve each resident abilities in reaching the highest practicable level of physical, mental and psychosocial functioning.
F 0695 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record reviews, resident and staff interviews, and policy review, the facility failed to ensure 3 of 3 sampled residents (#s 317, 311, and 38) who needed oxygen therapy, were provided such care, consistent with professional standards of practice. There were 9 residents receiving oxygen therapy. The deficient practice could result in respiratory complications. Findings include: -Resident #317 was admitted (MONTH) 24, 2019, with [DIAGNOSES REDACTED]. During an initial observation conducted of the resident on (MONTH) 1, 2019 at 11:09 a.m., the resident was observed to have oxygen on at 2 liters per nasal cannula. Another observation was conducted of the resident on (MONTH) 4, 2019 at 8:41 a.m. The resident was observed sleeping in bed with oxygen on at 2 liters per nasal cannula. However, review of the clinical record did not reveal a physician's order for oxygen or that the resident's oxygen saturations were checked or that there was a care plan for oxygen therapy. During an interview conducted with the resident on (MONTH) 4, 2019 at 11:09 a.m., the resident stated that staff tried weaning her off oxygen but was unsuccessful. She stated that she was informed by staff that the physician said she has to receive oxygen continuously. The resident was observed receiving oxygen at 2 liters per nasal cannula. During an interview conducted with health information staff (#25) on (MONTH) 4, 2019 at 1:15 p.m., staff #25 stated that the clinical record did not have documentation of oxygen saturations. An interview was conducted with a Licensed Practical Nurse (LPN/staff #120) on (MONTH) 4, 2019 at 1:25 p.m. The LPN stated that a physician's order is needed for a resident to receive oxygen therapy. She also stated that oxygen therapy is care planned and the resident's oxygen saturations are checked once a shift. The LPN stated that resident #317 is receiving oxygen therapy. After reviewing the resident's clinical record, the LPN stated that it does not look like there is an order for [REDACTED]. -Resident #311 was admitted on (MONTH) 26, 2019, with a [DIAGNOSES REDACTED]. An observation was conducted of the resident on (MONTH) 1, 2019 at 9:32 a.m. The resident was observed sitting in the wheelchair receiving oxygen at 2 liters via nasal cannula. An observation was conducted of the resident on (MONTH) 4, 2019 at 9:58 a.m. The resident was observed sleeping in bed receiving 2 liters of oxygen via nasal cannula. Review of nursing skilled documentation dated (MONTH) 26, 2019, revealed the resident had no labored breathing with O2 saturation at 97% on 2 Liter via Nasal cannula. Review of the admission Minimum Data Set (MDS) assessment dated (MONTH) 2, 2019, revealed the resident was not receiving oxygen therapy.

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F 0695

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

(continued... from page 7)
Review of a nurse progress note dated (MONTH) 3, 2019, stated Patient given scheduled SVN with good relief, the patient had even non labored breaths with O2 sat at 97 on 2L via nasal cannula. The patient had no complained of pain or respiratory distress.
However, review of the clinical record did not reveal a physician's order for oxygen or a care plan for oxygen.
An interview was conducted with a LPN (staff #120) on (MONTH) 4, 2019 at 1:37 p.m. The LPN stated the resident is receiving oxygen. After reviewing the clinical record, the LPN stated that there was no physician's order for oxygen or oxygen saturations and that there was no care plan for oxygen. She stated that there should be orders for oxygen therapy and a care plan for oxygen.
During an interview conducted with the Director of Nursing (DON/staff # 32) and the Administrator (staff #132) with the clinical resource nurse present on (MONTH) 4, 2019 at 2:23 p.m., the DON stated that if a resident was admitted on oxygen therapy, there has to be a physician's order for the oxygen and it has to be care planned.
-Resident #38 was admitted to the facility on (MONTH) 6, (YEAR), with [DIAGNOSES REDACTED].
Review if the quarterly Minimum Data Set (MDS) assessment dated (MONTH) 21, 2019 revealed the resident scored a 9 on the Brief Interview for Mental Status BIMS, indicating the resident had moderate cognitive impairment. The assessment included the resident was receiving oxygen therapy.
Review of the care plan revised on (MONTH) 6, (YEAR) revealed the resident had oxygen therapy related to [MEDICAL CONDITION] with a goal to have no signs or symptoms of poor oxygen absorption. Interventions included to observe for signs and symptoms of respiratory distress, oxygen settings at 2- 3 liters via nasal cannula, and to given medications as ordered.
Review of the physician's orders revealed an order dated (MONTH) 25, 2019 for oxygen at 2 liters per minute via nasal cannula as needed to keep oxygen saturation at 90 percent or above.
During an initial observation conducted of the resident on (MONTH) 1, 2019 at 11:02 a.m., the resident was observed to have oxygen on at 3 liters per nasal cannula.
An interview was conducted on (MONTH) 4, 2019 at 9:56 a.m. with a LPN (staff #128). The LPN stated that a physician's order is needed for a resident receiving oxygen therapy and that the oxygen is to be administered as ordered. After observing resident #38, the LPN stated that the resident is receiving oxygen at 3 liters via nasal cannual and the physician's order is for 2 liters via nasal cannula. The LPN further stated that the oxygen is not being administered according to the order.During an interview conducted with the DON (staff #32) on (MONTH) 4, 2019 at 12:34 P.M., the DON stated that the oxygen therapy should be administered according to the physician's order.
Review of the facility's policy regarding physician orders revealed that medications, therapy, and any treatments may not be administered to the resident without a written order from the attending physician.

F 0725

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Many

Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.

Based on resident and staff interviews, facility documentation, and policy review, the facility failed to ensure there was sufficient nursing staff to meet the needs of residents. This deficient practice resulted in residents' needs not being met. The census was 64.
Findings include:
During the initial phase of the survey, 7 out of 19 residents identified concerns of not having enough staff. Residents reported that they waited up to 2 hours for call lights to be answered, they did not receive scheduled restorative treatments, and they had family members stay all day to help provide needed care. Residents also stated that they were left in soiled briefs or on bedpans anywhere from 40 minutes to 2 hours after requesting assistance. They stated that staffing was worse on the weekends and when staff members called off work.
Review of the Resident Council minutes for January, February, and (MONTH) 2019, revealed the residents had expressed concerns about sufficient staffing at each meeting. Residents expressed concerns about call light wait times up to 1 hour, long call light wait times at meal times and bed time, not enough staffing on nights and weekends, and other residents calling out for help at night.
A Resident Council interview was conducted on (MONTH) 4, 2019 at 10:00 a.m. The residents stated that there was not enough staff, and that the staff appeared exhausted. The residents said call light wait times could be as long as two hours. They stated that when they asked staff for assistance, the staff replied I don't have time or I am too busy. Regarding staff treatment, the residents stated we are an entity to check off a box. They also stated that during the survey period, the facility was putting on a show.
Review of the facility assessment dated (MONTH) 26, 2019, revealed the facility's general approach to ensure sufficient staff to meet the needs of the residents at any given time included 2.16 nurse aides per patient day.
The nursing staff information postings for (MONTH) 1-31, 2019, revealed the facility had an average census of 66 residents, with the census ranging from 60 to 76 residents. The average number of hours worked by Certified Nursing Assistants (CNA) who provided direct care to residents was 117.4 hours per day. The average number of CNA hours per patient day was 1.77, which was lower than 2.16 stated in the facility's assessment. There were 27 days for the month of (MONTH) 2019 that the number of direct care CNA hours worked per patient day was less than 2.16.
Review of the staff sign-in sheets and staff payroll records revealed the following for both wings:
-On (MONTH) 10, 2019, 4 CNAs signed in for the 2:30 p.m. through 10:30 p.m. shift. However, review of the staff payroll records for (MONTH) 10, 2019, revealed that 3 CNAs worked in the facility during the 2:30 p.m. through 10:30 p.m. shift.
-On (MONTH) 17, 2019, 5 CNAs signed in for the 2:30 p.m. through 10:30 p.m. shift. However, review of the staff payroll records for (MONTH) 17, 2019, revealed 3 CNAs worked in the facility during the 2:30 p.m. through 10:30 p.m. shift.
-On (MONTH) 31, 2019, only 2 CNAs signed in and worked in the facility for the 2:30 p.m. through 10:30 p.m. shift, according to staff sign-in sheets and payroll records.
An interview was conducted on (MONTH) 2, 2019 at 08:54 a.m. with a resident's representative. The representative stated that the resident was not receiving regular toileting care. The representative also said the resident required assistance with feeding, and that staff would leave the meal tray in front of the resident without uncovering and setting up the tray and without providing assistance with feeding.
During an interview conducted with a staff member on (MONTH) 4, 2019 at 8:44 a.m., the staff member stated that the reason treatments including restorative services were not provided was because of insufficient staffing.
An interview was conducted on (MONTH) 4, 2019 at 10:18 a.m., with another staff member. The staff member was aware that residents were complaining about long call light wait times. The staff member stated that there is not enough staff to answer call lights timely. The staff member stated that if staff is asked to work over a 16 hour shift and they say no, there would be a negative response. The staff member stated that residents' showers have been omitted in order to complete other assigned resident care. The staff member also said that sometimes management would help deliver meal trays, but that they would leave the tray on the bedside table without setting up the meal and making sure the resident was able to eat.
An interview was conducted on (MONTH) 4, 2019 at 10:56 a.m., with the Staffing Coordinator/Central Supply Director (staff #53). She stated that staffing was based primarily on the facility census. She also stated that the facility did not use registry staff. She stated the basic staffing strategy for CNAs was to have 2 CNAs on the west wing and 4 to 5 CNAs on the east wing, for a total of 6 to 7 CNAs in the facility at any time to provide direct care.
Review of the facility's Staffing policy revealed the facility would maintain adequate staff on each shift to meet residents' need. The policy further stated the facility utilized the Facility Assessment as the foundation to determine staffing levels necessary to ensure that residents' needs were met.

F 0726

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DESERT COVE NURSING CENTER	**1750 WEST FRYE ROAD CHANDLER, AZ 85224**

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 0726 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 8) Based on interviews, personnel record review, facility assessment review, and policy, the facility failed to ensure 2 out of 6 sampled nursing staff (staff #94 and #127) possessed the competencies and skills needed to care for residents' needs. The deficient practice could result in delayed care and inadequate care for residents. The facility census was 64. Findings include: Review of the Facility assessment dated (MONTH) 26, 2019, revealed that over the past year or during a typical month, 18.52% of the facility's residents required clinically complex care, and 23.7% of the facility's residents had reduced physical function. The Facility Assessment stated that the staff competencies needed to care for residents would include medication administration, labs, diabetes management, IV therapy, ostomy care, infection control, tube feeding, respiratory care, wound care, lifts/transfers, vital sign collection, resident assessment, identification of changes in condition, perineal care, behavioral management, resident rights, abuse and neglect, quality of life, resident dignity, dementia management, and activities of daily living. The Assessment included that staff competencies would be determined through staff education in the form of return demonstration, quizzes, or Health Care Academy (online training). -Review of the personnel record for a Registered Nurse (RN/staff #94), revealed a hire date of (MONTH) 12, 2014, for full time employment. The staff member attended in-service training on (MONTH) 17, (YEAR) for the topic [DIAGNOSES REDACTED] Protocol and Procedure, and on (MONTH) 31, (YEAR) for the topic Implementation of Acute Care Plan for Antibiotics/Infection. The duration of these in-service trainings was not listed. Staff #94 also completed 0.5 hours of online training for Safer Sharps Training on (MONTH) 24, (YEAR). Review of the personnel record for staff #94 revealed no other evidence of training or in-services. The personnel record contained no evidence of a comprehensive evaluation for nursing skills and competencies upon hire or annually thereafter. -Review of the personnel record for a Certified Nursing Assistant (CNA/staff #127) revealed a hire date of (MONTH) 15, (YEAR). The staff member attended in-service training on (MONTH) 6, (YEAR) for the topic Clinical, on (MONTH) 24, (YEAR) for the topic PCC Training, and on (MONTH) 21, 2019 for the topics Abuse, and Providing Care. The duration of these in-service trainings were not listed. Staff #127 also completed 1 hour of online training for Code of Conduct Refresher on (MONTH) 22, 2019. Review of the personnel record for staff #127 revealed no other evidence of training or in-service. The personnel record contained no evidence of a comprehensive evaluation for skills and competencies upon hire or annually thereafter. An interview was conducted on (MONTH) 4, 2019 at 10:18 a.m., with an anonymous staff member. The staff member stated that the facility did not provide in-services or staff education for over a year. The staff member said that during that time, the only training staff received was through annual online modules. An interview was conducted on (MONTH) 4, 2019 at 11:23 a.m., with the Director of Nursing (DON/staff #32) and the Executive Director (ED/staff #132). Staff #32 stated that both nurses and CNAs were checked for skills and competencies upon hire. She stated that one-on-one education would be provided if concerns were identified. Staff #132 stated that she could not locate skills checklists for staff #94 and staff #127 to confirm that these staff had the required skills. She also stated that she could not locate any other documentation on skills or training for staff other than what was already provided. Review of the facility's policy regarding In-service Education revealed that all facility staff should be educated upon hire, annually , or as indicated thereafter on the following topics to include but not limited to: communication, residents rights, abuse, neglect, exploitation, procedures for reporting allegations, dementia management, abuse prevention, Elder Justice Act, compliance and ethics, quality assurance and performance improvement, infection control, behavioral health, care of the cognitively impaired, privacy, dignity, and confidentiality. The policy further stated that staff in-service education topics would be determined in part by annual skills evaluations. The policy included that the Staff Development Coordinator/designee will be responsible for maintaining training records in the learning management system or records for live in-service trainings.
F 0732 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Post nurse staffing information every day.** Based on staff interview, review of facility documentation, and policy review, the facility failed to ensure current nurse staffing information was posted on a daily basis. Findings include: An observation conducted on (MONTH) 1, 2019 at 7:55 a.m. of the posted nurse staffing information located inside the front entrance of the facility revealed the posted nurse staffing information was dated (MONTH) 30, 2019. An observation was conducted on (MONTH) 2, 2019 at 9:11 a.m. of the posted nurse staffing information. The posted nurse staffing information was dated (MONTH) 1, 2019. An interview was conducted with the receptionist (staff #126) on (MONTH) 3, (YEAR) at 12:44 p.m. She stated that she was responsible for posting the nurse staffing information during the weekdays, and the weekend receptionist was responsible for posting the nurse staffing information on the weekends. She stated that the staffing coordinator would place the staffing sheets for the weekends in her mailbox on Friday, and the weekend receptionist would post the weekend nurse staffing information based on those sheets. She stated that a staffing sheet for (MONTH) 31, 2019 was not created and placed in her mailbox on Friday, so it was not updated and posted on (MONTH) 31, 2019. Review of the facility's policy on staffing revealed the facility must post the nurse staffing information on a daily basis at the beginning of each shift.
F 0741 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, personnel record review, facility assessment review, and policy review, the facility failed to ensure 6 out of 6 sampled nursing staff (staff #2, #20, #59, #94, #102, and #127) had the competencies to provide behavioral health and dementia care to residents. The deficient practice could result in inadequate care for 15 residents in the facility who had [DIAGNOSES REDACTED]. The census was 64. Findings include: Review of the Facility assessment dated (MONTH) 26, 2019, revealed that common [DIAGNOSES REDACTED]. Types of care that the facility's resident population required and that the facility provided included: mental health and behavioral care, psycho/social/spiritual support, and assistance with activities of daily living. The Facility Assessment stated that the staff training and/or education competencies necessary to provide the level and types of support and care needed for the resident population included: staff education in the form of return demonstration, quizzes, or Health Care Academy (online training) for behavioral management, quality of life, resident dignity, dementia management, and activities of daily living.-Review of the personnel record for a Certified Nursing Assistant (CNA/staff #2) revealed a hire date of (MONTH) 1, 2008. The personnel record contained a form titled Competency/Skills Checklist dated (MONTH) 28, (YEAR). The checklist included a performance level of 4 out of 4 for the following categories: Skills: answers call lights promptly and leaves within reach, routinely makes rounds, assists with feeding, assists patients with bathing, assists with personal hygiene, documents activities of daily living appropriately Reports to Nurse: any unusual behavior. Further review of the personnel record did not reveal any other evidence of training for dementia care or behavioral health management. -Review of the facility's staff list revealed a Licensed Practical Nurse (LPN/staff#20) had a hire date of (MONTH) 1, 2006. Review of the facility's employee files revealed there was no personnel record for staff #20. -Review of the personnel record for a LPN (staff#59) revealed a re-hire date of (MONTH) 13, 2012. Review of the personnel record revealed no evidence of training for dementia care or behavioral management. -Review of the personnel record for a Registered Nurse (RN/staff#94) revealed a hire date of (MONTH) 12, 2014. Review of the personnel record revealed no evidence of training for dementia care or behavioral management. -Review of the personnel record for a RN (staff#102) revealed a hire date of (MONTH) 2, (YEAR). Review of the personnel record revealed no evidence of training for dementia care or behavioral management.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0741 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 9) -Review of the personnel record for a CNA (staff#127) revealed a hire date of (MONTH) 15, (YEAR). Review of the personnel record revealed no evidence of training for dementia care or behavioral management. An interview was conducted on (MONTH) 2, 2019 at 8:54 a.m., with an anonymous resident representative. The representative stated that they felt they were not able to leave the resident because the resident was confused and unable to push the call light. The representative stated that when they did leave the resident, they would return to find the resident in a wet brief. The representative stated the resident required assistance with feeding, and that they would stay to assist the resident with feeding because, no one else does. An interview was conducted on (MONTH) 3, 2019 at 1:36 p.m., with the Executive Director (ED/staff # 132). She stated that nursing staff received orientation upon hire, and annual training requirements thereafter. She said some training was live, on-site at the facility, and some training was online for a variety of topics. She said she would provide documentation of online training for the selected staff members. She stated the Director of Nursing and Human Resources were responsible for ongoing staff training. A follow-up interview was conducted on (MONTH) 4, 2019 at 9:56 a.m., with the ED (staff #132). She stated that upon hire, all staff were given written training materials on Code of Conduct, which would cover the topics of integrity, resident rights, privacy, fraud, financial abuse, and doing the right thing. Additionally, all staff were required to complete an annual online refresher course for Code of Conduct. She stated that she was not able to access any other documentation of online training for staff other than for Code of Conduct, and she was not able to provide any other documentation of staff training other than what had already been provided. An interview was conducted on (MONTH) 4, 2019 at 10:18 a.m., with an anonymous staff member. The staff member stated that the facility did not provide in-services or staff education for over a year. The staff member said that during that time, the only training staff received was through annual online modules. Review of the facility's policy regarding In-service Education revealed that the Executive Director is responsible for ensuring all facility staff are educated upon hire, annually, or as indicated thereafter on the following topics to include: dementia management, behavioral health, and care of the cognitively impaired. The policy further stated that in-service education topics related to specific needs of the facility, its residents and associates will be determined by a needs assessment based on annual skills evaluation, associate requests, and outcomes measures of performance improvement activities. The staff development coordinator/designee will be responsible for maintaining training records in the learning management system or records for live in-service trainings. If training is conducted in a live session, the records shall include the following: -Name and title of presenter -Date of presentation -Title of subject presented -Description of content -Signatures of those attending -Any state specific required documentation
F 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation, staff interviews, and policy and procedures, the facility failed to ensure food items in the freezer were sealed and/or dated. The deficient practice could result in a potential for food borne illness. Findings include: -An observation of the kitchen freezer was conducted with the Dietary Manger (staff #14) on 04/01/19 at 07:56 AM. A plastic bag containing hash browns was observed open to air and a plastic bag of raw hamburger patties was observed without a label or an opened date. An interview was conducted with staff #14 on 04/03/19 at 11:02 AM. Staff #14 stated that hamburgers were served the day before and that staff must have left a package unlabeled. He also stated that the hash browns were made that morning and that the open bag in the freezer should have been resealed after being used. Staff #14 stated that it is his expectation that all food be properly labeled and stored at all times. An interview was conducted with the Administrator (staff #132) on 04/04/19 at 09:24 AM. The Administrator stated that the raw hamburger patties should be labeled and the hash browns should not be left open to air in the freezer. She added that she finds this to be unsatisfactory practice. A review of the facility's policy for Freezer Food Storage, revised in (MONTH) of (YEAR), revealed that frozen food storage stock items are to be properly sealed and labeled.
F 0849 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and facility documents, the facility failed to ensure a written agreement with hospice was signed by an authorized representative of the facility before hospice care was furnished to any resident including one sampled resident (#17). There were five residents receiving hospice services. Findings include: Resident #17 was admitted (MONTH) 11, (YEAR) with [DIAGNOSES REDACTED]. The admission Minimum Data Set assessment dated (MONTH) 18, (YEAR) revealed the resident was receiving hospice care. Review of the facility's written Hospice Inpatient Services Agreement effective (MONTH) 11, (YEAR), revealed the agreement was signed by the hospice representative, however, the agreement was not signed by the facility's authorized representative.During an interview conducted with a Licensed Practical Nurse (staff #59) on 04/03/19 at 9:37 AM, the LPN stated that the hospice staff visits resident #17 at least weekly and that they document their visits in the hospice book. An interview was conducted with the Business Office Manager (staff #61) on 04/03/19 at 2:15 PM. Staff #61 stated that the facility agreement with hospice was signed by the hospice's representative, but was never signed by the facility's representative. She stated that it must have been overlooked. She added that the agreement should have been signed by both representatives in order to be valid. An interview with the Administrator (staff #132) was conducted on 04/04/19 at 9:24 AM. The Administrator stated that the agreement was in place before she took over the position and she assumed it was signed and valid. She stated that it was overlooked.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on personnel record reviews, staff interviews and policy and procedures, the facility failed to ensure that 4 out of 10 sampled staff members (#2, #20, #59 and #115) had current evidence of freedom from [MEDICAL CONDITION] (TB). The deficient practice could result in the potential exposure of infectious TB. Findings include: -Review of the personnel record for staff #2 (Certified Nursing Assistant) revealed a hire date of (MONTH) 1, 2008, for full time employment. A chest x-ray report dated (MONTH) 1, (YEAR), revealed staff #2 was free of TB. Further review of the personnel record for staff #2 revealed no additional evidence that staff #2 was free of TB, after (MONTH) 1, (YEAR). -Review of the facility's staff list revealed that staff #20 (Licensed Practical Nurse) was hired on (MONTH) 1, 2006, for full time employment. Review of the facility's employee files revealed there was no personnel record for staff #20. -Review of the personnel record for staff #59 (Licensed Practical Nurse) revealed a hire date of (MONTH) 13, 2012, for full time employment. A chest x-ray report dated (MONTH) 19, (YEAR), included no evidence of active TB. A form titled [MEDICAL

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 10) CONDITION] Assessment completed on (MONTH) 7, (YEAR), revealed the employee did not have symptoms of TB. The form was signed by the employee, however it was not signed by a medical provider -Review of the personnel record for staff #115 (dietary aide) revealed a hire date of (MONTH) 8, (YEAR), for full time employment. A chest x-ray report dated (MONTH) 26, (YEAR), included no evidence of active TB. A form titled [MEDICAL CONDITION] Assessment completed on (MONTH) 8, (YEAR), revealed the employee did not have symptoms of TB. The form was signed by the employee, however it was not signed by a medical provider. An interview was conducted on (MONTH) 2, 2019 at 3:24 p.m., with the Human Resources Director (staff #123). She stated she believed that when a staff member had a chest X-ray that was negative for TB, they did not need to provide any additional documentation for 5 years. She stated that she did not realize that all employees were required to be screened for TB annually. An interview was conducted on (MONTH) 3, 2019 at 1:36 p.m., with the Interim Executive Director (staff #132). She stated that every staff member needed TB screening upon hire and annually thereafter. She stated that she expect staff members will provide current TB screening immediately or they would be removed from the schedule and not be able to return to work until they were able to provide current TB screening. An interview was conducted on (MONTH) 4, 2019 at 9:33 a.m., with the Human Resources Director (staff #123). She stated that she had not been able to find a personnel record for staff #20 since (MONTH) (YEAR), when she had conducted a full audit of the personnel files. She stated that she informed the Executive Director of the missing personnel file at that time. She stated that she asked members of the facility management team for current documentation of a nursing license, CPR certification, and [MEDICAL CONDITION] testing for staff #20, and she was told by the Assistant Director of Nursing, the Director of Nursing, and other members of management that they were sure these items existed, and they would get her the documents. She stated that she used online verification to confirm the nursing license for staff #20, but she was not able to verify CPR certification or [MEDICAL CONDITION] testing. She stated she was currently in the process of creating a new personnel file for staff #20, and the staff member would not be allowed to return to work until the personnel file was current and complete. Review of the facility's policy for [MEDICAL CONDITION] Screening for Associates revealed that all staff are screened for TB at the time of hire, annually, and when exposed to infected individuals. Staff with a history of a positive reaction to TB skin testing would be required to bring documentation from their private physician or the local health department of their work-up following conversion, or the facility will follow state-specific guidelines.
F 0947 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.** Based on personnel record reviews, staff interviews, and policy and procedures, the facility failed to ensure that 2 out of 2 sampled Certified Nursing Assistants (CNA/staff #2 and staff #127) received in-services and training for at least 12 hours per year. The deficient practice failed to ensure the continuing competence of the CNAs. Findings include: -Review of the personnel record for staff #2 revealed a hire date of (MONTH) 1, 2008. Review of the training for staff #2 from (MONTH) (YEAR) through (MONTH) (YEAR), revealed 1 hour of online training completed on (MONTH) 22, (YEAR), for Code of Conduct Refresher. Review of the training for staff #2 from (MONTH) (YEAR) through (MONTH) (YEAR), revealed 1 hour of online training completed on (MONTH) 22, (YEAR), for Code of Conduct Refresher. The staff in-service sign-in sheets for (MONTH) 24, (YEAR) PCC Training, and (MONTH) 6, (YEAR) Clinical revealed the CNA attended but did not include the duration of each in-service. Review of the personnel record for staff #2 revealed no other evidence of training for (MONTH) (YEAR) through (MONTH) (YEAR), or for (MONTH) (YEAR) through (MONTH) (YEAR). -Review of the personnel record for staff #127 revealed a hire date of (MONTH) 15, (YEAR). Review of the training for staff #127 from (MONTH) (YEAR) through (MONTH) 2019, revealed staff #127 attended staff in-service on (MONTH) 24, (YEAR) PCC Training, and on (MONTH) 6, (YEAR) Clinical. The duration of each in-service was not documented. The record included staff #127 received 1 hour of online training on (MONTH) 22, 2019 for Code of Conduct Refresher. The record also included staff #127 attended a staff in-service on Abuse on (MONTH) 21, 2019. The duration of the in-service was not documented. Review of the training for staff #127 from (MONTH) (YEAR) through (MONTH) (YEAR), revealed staff #127 attended staff in-service on (MONTH) 24, (YEAR) and (MONTH) 6, (YEAR). The topic of the (MONTH) in-service was called PCC Training and the (MONTH) in-service was called Clinical. The duration of each in-service was not documented. Review of the personnel record for staff #127 revealed no other evidence of in-service or training from (MONTH) (YEAR) through (MONTH) 2019, or from (MONTH) (YEAR) through (MONTH) (YEAR). An interview was conducted on (MONTH) 4, 2019 at 10:18 a.m., with an anonymous staff member. The staff member stated that staff did not have in-services or meetings for more than a year. The staff member stated that competency check lists had not been done yearly, and that no education had been given to CNAs regarding resident perineal care, infection control, and hand washing for more than a year. The staff member stated that during this time the only training was through online modules. An interview was conducted on (MONTH) 4, 2019 at 11:23 a.m. with the DON (staff #32) and the Interim Executive Director (staff #132). Staff #32 stated that CNAs received orientation and training for skills upon hire. She also stated that staff in-services had been conducted monthly so far in 2019. Staff #132 stated she could not locate any other documentation on training in (YEAR) for the CNAs other than what was provided. She stated that she believed the required training had been done, but she did not have the documentation. Review of the facility's In-service Education policy revealed that all facility staff should be educated upon hire, annually , or as indicated thereafter on the following topics to include but not limited to: communication, residents rights, abuse, neglect, exploitation, procedures for reporting allegations, dementia management, abuse prevention, Elder Justice Act, compliance and ethics, quality assurance and performance improvement, infection control, behavioral health, care of the cognitively impaired, privacy, dignity, and confidentiality. The policy further stated CNA training must be sufficient to ensure continuing competence and be no less than 12 hours per year. In-service hours would be calculated from (MONTH) through December. If training was conducted in a live session, the records should include the following: -Name and title of presenter -Date of presentation -Title of subject presented -Description of content -Signatures of those attending -Any state specified required documentation