STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035062	A. BUILDING _____ B. WING _____	**06/05/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DESERT HAVEN CARE CENTER	**2645 EAST THOMAS ROAD PHOENIX, AZ 85016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0552 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that residents are fully informed and understand their health status, care and treatments.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policy review, the facility failed to ensure one of eight sampled residents (#18) and/or their representative was informed of the risks and benefits of psychoactive medications, prior to administration. The deficient practice can result in the resident and/or the resident representative not being aware of the benefits and the potential adverse side effects of taking psychoactive medications. Findings include: Resident #18 was admitted on (MONTH) 27, (YEAR) with [DIAGNOSES REDACTED]. A quarterly Minimum Data Set (MDS) assessment dated (MONTH) 3, (YEAR) revealed a Brief Interview for Mental Status (BIMS) score of 9 which indicated the resident had moderate impaired cognition. Review of the clinical record revealed a physician's orders [REDACTED]. The order was increased to 300 mg daily on (MONTH) 10, (YEAR). The Consultant Pharmacist's Medication Regimen Review dated (MONTH) 30, (YEAR) revealed documentation to ensure consent for [MEDICATION NAME] is obtained and scanned into the Electronic Medical Record. Review of the Medication Administration Record [REDACTED]. However, review of the clinical record did not reveal evidence the resident or the resident's representative had been informed of the risk and benefits of [MEDICATION NAME] prior to administration. Further review of the physician orders [REDACTED]. Review of the MARs for March, April, and (MONTH) 2019 revealed the resident was administered [MEDICATION NAME], and Klonopin as ordered. However, review of the clinical record did not reveal evidence that the resident or the resident's representative had been informed of the risk and benefits of these [MEDICAL CONDITION] medications prior to administration. Additional review of the clinical record revealed a Psychoactive Medication Consent for [MEDICATION NAME], and Klonopin that contained two Licensed Practical Nurses (LPN) witness signatures dated (MONTH) 22, 2019. However, the areas designated Resident/Resident representative Signature or Verbal consent obtained from was blank. An interview was conducted with a LPN (staff #97) on (MONTH) 3, 2019 at 1:32 PM. The LPN stated that informed consent is obtained from the resident or the resident's representative prior to administering [MEDICAL CONDITION] medications. She stated that resident #18 has a family member that is her Power of Attorney and that it is possible that the informed consent for this resident was overlooked. During an interview conducted with the Director of Nursing (DON/staff #84) on (MONTH) 3, 2019 at 1:37 PM, the DON stated the expectation is that an informed signed consent is obtained. The facility's policy titled Antipsychotic Medication Use revealed the resident or their representative will be notified of the need for antipsychotic medication, explain the risks and benefits to treatment, and a signed consent will be obtained prior to the first dose of medication being administered. The policy included if the resident's representative is unavailable to come to the facility to sign the form, a verbal consent may be obtained by two facility licensed personnel. The policy also included this verbal consent will remain in place for 30 days and that after 30 days the signature must be obtained or another verbal consent must be obtained.
F 0622 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed clinical record review, staff interviews, and review of policy and procedures, the facility failed to ensure one sampled resident's (#80) clinical record included the information that was provided to the receiving provider. The deficient practice could result in an unsafe and ineffective transition of care. Findings include: Resident #80 was admitted on (MONTH) 8, (YEAR) with [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. A nursing progress note dated (MONTH) 12, 2019 at 12:52 PM revealed the resident left the facility that morning at 11:50 AM. The note also revealed narcotic and prescription medications were given to the family member and that report was given to the coordinator at the assisted living facility. However, further review of the clinical record revealed no documentation that the following information was provided to the receiving provider: -contact information of the practitioner responsible for the care of the resident, -the resident's representative information including contact information, -Advanced Directive information, -special instructions for ongoing care, -comprehensive care plan goals, -and other necessary information, including a copy of the resident's discharge summary, and any other documentation, as applicable, to ensure a safe and effective transition of care. After a request was made for the information that was provided to the receiving provider, a copy of the post-discharge plan of care obtained by fax from the receiving facility was provided. The document, dated (MONTH) 11, 2019, had been signed by the facility's social services director (staff #132), the activities director (staff #123), and the dietary manager (staff #77) indicating staff were aware of the plan to discharge. However, the document only provided contact information of the practitioner responsible for the care of the resident and stated that a medication list had been attached. A copy of the medication list was not included with the document provided. A discharge summary progress note dated (MONTH) 31, 2019, written by staff #132, revealed the resident was officially discharged from the facility on (MONTH) 12, 2019 around 11:50 AM. The note revealed the resident wanted to have a more independent living situation and that she was assessed to be capable and safe in an assisted living setting. The note

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

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F 0622 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) included the resident and her family member had visited the assisted living facility prior to her move, and that her family member and a friend had come to the facility on (MONTH) 12 to help her move her belongings. The note also included the resident had become quite stable and pleasant during her stay at the facility, and that the resident was able to realize her goal of returning to the more independent setting. An interview was conducted on (MONTH) 4, 2019 at 2:33 PM with a Licensed Practical Nurse (LPN/staff #39). He stated that when a resident is discharged to another facility, the process includes completing a discharge summary, contacting the resident's case-worker to make them aware and gathering copies of pertinent documentation such as the resident's face-sheet and a list of their medications. He said he also calls the other facility and gives them report, and then documents a progress note with all the details and the time of discharge. The LPN stated he was involved in the discharge process of resident #80. The LPN stated that he remembered calling the facility she was transferred to. He said he thought he completed a discharge summary, but was unsure of where that information might be. The LPN also stated that the discharge happened very quickly and that he thought he had taken care of all the discharge requirements. The LPN said he usually follows the facility's discharge checklist. An interview was conducted on (MONTH) 5, 2019 at 8:56 AM with the Director of Nursing (DON/staff #84). The DON stated that his expectation is that the nursing discharge documentation include the date and time of discharge, the resident's general condition of health, any treatments the resident is receiving, the resident's destination, who they went with, that the belongings went with them, a list of essential individuals who had been notified, whether or not medications were sent, and whether education for medications were provided. He said that a copy of the discharge summary goes with the resident and one stays with the clinical record. The DON stated that the Interdisciplinary Team provides input to the discharge summary. He stated that resident #80's discharge summary may have been dropped due to the fact that it was a rapid discharge. The facility's policy regarding Discharging the Resident revealed that if the resident is being discharged to another facility, ensure that a transfer summary is completed and telephone report is called to the receiving facility. The policy included assessing and documenting the resident's condition at discharge, including a skin assessment. The policy also included recording other information in accordance with facility policy and professional standards of practice in the clinical record.
F 0660 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Plan the resident's discharge to meet the resident's goals and needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and review of policy and procedures, the facility failed to ensure discharge planning included developing a discharge care plan for one sampled resident (#80). The deficient practice has the potential to result in an ineffective transition to post-discharge care, and increases the risk factors leading to preventable readmission. Findings include: Resident #80 was admitted on (MONTH) 8, (YEAR) with [DIAGNOSES REDACTED]. An initial social service assessment dated (MONTH) 8, (YEAR) revealed the resident's expectation at admission was to probably remain at the facility. The handwritten document included the Social Service Director (SSD/staff #132) would continue to assess for needs and significant changes. Review of the comprehensive care plan dated (MONTH) 9, (YEAR), revealed no discharge care plan had been developed. The admission Minimum Data Set (MDS) assessment dated (MONTH) 16, (YEAR) revealed a score of 13 on the Brief Interview for Mental Status (BIMS) which indicated the resident had no cognitive impairment. The assessment included the resident expected to remain in the facility, but wanted to be asked on all assessments about returning to the community. A psychosocial progress note dated (MONTH) 25, 2019 revealed staff #132 continued to be involved with providing primary services to the resident which included compiling and sending referral packets to other facilities and the resident's case manager as well as coordinating discharge date s and discharge plan of care paperwork with the facility's management team. However, review of the clinical record revealed no discharge care plan had been initiated. The quarterly MDS assessment dated (MONTH) 15, 2019 revealed a score of 15 on the BIMS which indicated the resident was cognitively intact. The assessment also included there was no active discharge plan in place for the resident to return to the community. A physician's orders [REDACTED]. A discharge MDS assessment dated (MONTH) 12, 2019 revealed the resident's discharge was a planned discharge. A discharge summary progress note dated (MONTH) 31, 2019, written by staff #132, revealed the resident was officially discharged from the facility on (MONTH) 12, 2019 around 11:50 AM. The note revealed the resident wanted to have a more independent living situation and that she was assessed to be capable and safe in an assisted living setting. The note included the resident and her family member had visited the assisted living facility prior to her move, and that her family member and a friend had come to the facility on (MONTH) 12 to help her move her belongings. The note also included the resident had become quite stable and pleasant during her stay at the facility, and that the resident was able to realize her goal of returning to the more independent setting. An interview was conducted on (MONTH) 5, 2019 at 8:56 AM with the Director of Nursing (DON/staff #84). He stated the resident's discharge processes may have been dropped due to the fact that it was a rapid discharge. Review of the facility's policy titled Discharging the Resident revealed the discharge care plan was not addressed.
F 0661 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policy review, the facility failed to develop a discharge summary for one sampled resident (#80) that included a recapitulation of the resident's stay and a final summary of the resident's status. The deficient practice could result in necessary information not being communicated at the time of discharge. Findings include: Resident #80 was admitted on (MONTH) 8, (YEAR) with [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. A nursing progress note dated (MONTH) 12, 2019 at 12:52 PM revealed the resident left the facility that morning at 11:50 AM. The note also revealed narcotic and prescription medications were given to the family member and that report was given to the coordinator at the assisted living facility. A discharge MDS assessment dated (MONTH) 12, 2019 revealed the resident's discharge was a planned discharge. A discharge summary progress note dated (MONTH) 31, 2019, written by the Social Service Director, revealed the resident was officially discharged from the facility on (MONTH) 12, 2019 around 11:50 AM. The note revealed the resident wanted to have a more independent living situation and that she was assessed to be capable and safe in an assisted living setting. The note included the resident and her family member had visited the assisted living facility prior to her move, and that her family member and a friend had come to the facility on (MONTH) 12 to help her move her belongings. The note also included the resident had become quite stable and pleasant during her stay at the facility, and that the resident was able to realize her goal of returning to the more independent setting. However, further review of the clinical record did not reveal a discharge summary that included a recapitulation of the resident's stay and a final summary of the resident's status at the time of discharge. An interview was conducted on (MONTH) 5, 2019 at 8:56 AM with the Director of Nursing (DON/staff #84). He stated the resident's discharge processes may have been dropped due to the fact that it was a rapid discharge. Review of the facility's policy titled Discharging the Resident revealed that if the resident is being discharged to another facility, ensure that a transfer summary is completed and telephone report is called to the receiving facility. The policy included assessing and documenting the resident's condition at discharge, including a skin assessment and documenting the assessment data.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide appropriate treatment and care according to orders, resident's preferences and**

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F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) **goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interviews, and policy review, the facility failed to ensure one of eighteen sampled residents (#3) received treatment and care in accordance with professional standards of practice, by failing to conduct weekly skin assessments. The deficient practice could result in delayed identification and treatment of [REDACTED]. Findings include: Resident #3 was admitted to the facility on (MONTH) 5, 2019, with [DIAGNOSES REDACTED]. Review of the care plan dated (MONTH) 5, 2019, revealed the resident had a pressure ulcer to the coccyx related to decreased mobility. Interventions included completing weekly skin checks. A physician's orders [REDACTED]. The admission Minimum Data Set assessment dated (MONTH) 15, 2019, revealed the resident was severely cognitively impaired regarding cognitive skills for daily decision making, The assessment included the resident had a stage 3 pressure ulcer. Review of the Treatment Administration Record (TAR) for (MONTH) 2019, revealed initials that a skin assessment was conducted weekly except on (MONTH) 13. However, review of the Skin Observation Tool form only revealed skin assessments for (MONTH) 21 and 28, 2019. Review of the TAR for (MONTH) 2019, revealed initials that skin assessments were conducted weekly. However, review of the Skin Observation Tool form only revealed skin assessments for (MONTH) 14 and 21, 2019. Review of the TAR for (MONTH) and (MONTH) 2019, revealed initials that skin assessments were conducted weekly. However, review of the clinical record revealed no Skin Observation Tool forms for (MONTH) or (MONTH) 2019. An interview was conducted on (MONTH) 3, 2019 at 10:15 a.m., with a Licensed Practical Nurse (LPN/staff #39). The LPN stated that he attempts to conduct skin assessments on resident #3 on shower days because he knows the resident is at risk for skin breakdown. The LPN stated that although he regularly checks the resident's skin during shower time, he does not document the skin assessments because the scheduled weekly skin assessment is not on his shift. An interview was conducted on (MONTH) 3, 2019 at 12:44 p.m., with the Director of Nursing (DON/staff #84). The DON stated that nurses are responsible for conducting and documenting the weekly skin assessments according to the schedule on the TAR. He stated the results of the skin assessments are documented in the electronic record, and that if the results were not documented it meant the assessments were not conducted. The facility's policy regarding Resident Skin Assessments revealed the policy of the facility is to assess all residents weekly to identify risk for skin breakdown and assess current skin issues. The policy included all residents will be assessed for skin risk using the assessment available in the electronic medical record.
F 0727 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.** Based on facility documents, staff interviews, and policy review, the facility failed to use the services of a Registered Nurse (RN) for at least 8 consecutive hours a day, 7 days a week. Findings include: Review of the facility's daily staff posting records and the staff sign-in sheets for (MONTH) 2019 revealed there was no RN on (MONTH) 10, 2019 who provided services for at least 8 hours. Review of the daily staff posting records and the staff sign-in sheets for (MONTH) 2019 revealed that on (MONTH) 7, 21, and 28, there was no RN who provided services for at least 8 hours. Review of the daily staff posting records and the staff sign-in sheets for (MONTH) 2019 revealed that on (MONTH) 18, 25, and 26, there was no RN who provided services for at least 8 hours. An interview was conducted with the staffing coordinator (staff #119) on (MONTH) 4, 2019 at 1:23 PM. Staff #119 stated that on weekdays they have an RN on duty for at least 8 hours daily. She stated that on the weekends, they do not always have a RN who provides services for at least 8 hours. Staff #119 stated the lack of RN coverage was not due to call offs but that it is the regular schedule. An interview was conducted with the Director of Nursing (DON/staff #80) on (MONTH) 4, 2019 at 3:02 PM. The DON stated that they do not have a RN on the schedule for the weekends right now. He said RNs are hard to find. The facility's policy titled Staffing revealed the facility maintains adequate staffing on each shift to ensure that residents' needs and services are met. The policy also revealed licensed registered nursing and licensed nursing staff are available to provide and monitor the delivery of resident care services. The policy did not include the facility must use the services of a Registered Nurse for at least 8 consecutive hours a day, 7 days a week.
F 0757 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, clinical record review, and facility documentation and policy review, the facility failed to ensure that 3 of 5 sampled residents (#13, #3, and #18) were free from unnecessary medications, by failing to administer pain medications within the ordered parameters. This deficient practice could result in residents receiving medications which may not be necessary. Findings include: -Resident #13 was admitted (MONTH) 12, 2019 with [DIAGNOSES REDACTED]. Review of the physician orders [REDACTED]. Review of the admission Minimum Data Set (MDS) assessment dated (MONTH) 22, 2019, revealed the resident had severely impaired cognitive skills for daily decision making. The MDS assessment also revealed the resident was receiving scheduled and as needed (PRN) pain medication and had frequent pain at a pain level of 7 on a scale of 0 to 10. The current care plan revealed the resident had pain related to chronic back and generalized pain. The goal was that the resident would be free of pain as evidenced by her subjective statement. Interventions included administering medications as ordered. Review of the Medication Administration Record (MAR) for (MONTH) 2019 revealed the resident was administered [MEDICATION NAME] 5 mg on (MONTH) 28 for a pain level of 0 and on (MONTH) 16 for a pain level of 4 and on (MONTH) 17, 18, 19, 22, 26, and 28 for a pain level of 5. Review of the MAR for (MONTH) 2019 revealed the resident was administered [MEDICATION NAME] 5 mg on (MONTH) 1 for a pain level of 0. Review of the MAR for (MONTH) 2019 revealed the resident was administered [MEDICATION NAME] 5 mg on (MONTH) 5, 7, and 20 for a pain level of 5 and on (MONTH) 27 for a pain level of 0. Review of the Consultant Pharmacist Medication Regimen Review for (MONTH) 2019 included [MEDICATION NAME] had been administered for pain rated at a 5. The review also included educating nursing on administering pain medications within the ordered parameters. However, review of the MAR for (MONTH) 2019 again revealed the resident was administered [MEDICATION NAME] 5 mg on (MONTH) 25 and 26 for a pain level of 5. Review of the clinical record revealed no documentation regarding administering [MEDICATION NAME] outside of the ordered parameters. During an interview conducted with a Registered Nurse (RN/staff #127) on (MONTH) 4, 2019 at 9:15 AM, the RN stated that the resident has Tylenol ordered for mild pain and [MEDICATION NAME] for severe pain. The RN further stated that she administers the [MEDICATION NAME] within the ordered parameters. -Resident #3 was admitted to the facility on (MONTH) 5, 2019, with [DIAGNOSES REDACTED]. Review of the care plan dated (MONTH) 5, 2019, revealed the resident had pain that appeared to be caused by musculoskeletal impairment. Interventions included utilizing a pain management flow sheet and administering pain strategies according to

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F 0757 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 3) the MAR and Treatment Administration Record (TAR). The admission MDS assessment dated (MONTH) 15, 2019, revealed the resident had severe cognitive impairment for daily decision making. The assessment included the resident had daily non-verbal indicators of pain and received scheduled and PRN pain medication. Review of the physician orders [REDACTED]. Review of the MAR for (MONTH) 2019, revealed the resident was administered [MEDICATION NAME] 50 mg for a pain level of 0 on (MONTH) 10 and 14 and for a pain level of 4 on (MONTH) 22. A physician order [REDACTED]. Review of the MAR for (MONTH) 2019, revealed the resident was administered [MEDICATION NAME] 50 mg 2 tablets for a pain level of 6 on (MONTH) 8 and for a pain of 7 on (MONTH) 14. Review of the MAR for (MONTH) 2019, revealed the resident was administered [MEDICATION NAME] 50 mg 2 tablets for a pain level of 7 on (MONTH) 4 and 27, and for a pain level of 0 on (MONTH) 11. Review of the MAR for (MONTH) 2019, revealed the resident was administered [MEDICATION NAME] 50 mg 2 tablets for a pain level of 6 on (MONTH) 11 and 27. Review of a pharmacy consultant report dated (MONTH) 21, 2019, revealed that the resident's medications had been reviewed with the following recommendation: [MEDICATION NAME] has been given outside of parameters - please educate nursing staff that if medication is given outside of parameters, a progress note must indicate rationale for this. A handwritten note on the pharmacy review stated in-service/meeting 5/20/19. An interview was conducted on (MONTH) 3, 2019 at 12:29 p.m. with a Licensed Practical Nurse (LPN/staff #39). He stated that the resident had orders to administer [MEDICATION NAME] 50 mg 1 or 2 tablets depending on the resident's level of pain. The LPN stated that he has administered the [MEDICATION NAME] within the ordered parameters. The LPN also stated that he had never encountered a situation where he felt it was necessary to administer pain medications outside of the ordered parameters. An interview was conducted on (MONTH) 3, 2019 at 12:44 p.m. with the Director of Nursing (DON/staff #84). He stated that the expectation is that PRN pain medications be administered according to the pain parameters and the time frame ordered by the provider. The DON stated that all PRN pain medication orders should have pain parameters, and the administration of the medication should match the ordered parameters. -Resident #18 was admitted on (MONTH) 27, (YEAR) with [DIAGNOSES REDACTED]. A quarterly MDS assessment dated (MONTH) 26, (YEAR) revealed a Brief Interview for Mental Status (BIMS) score of 9 which indicated the resident had moderate impaired cognition. The assessment also included the resident received PRN pain medications. Review of the current care plan revealed the resident was on opioid medication therapy related to chronic pain. Interventions included administering [MEDICATION NAME] medications as ordered by the physician. Review of the active physician orders [REDACTED]. Review of the MAR for (MONTH) (YEAR) revealed [MEDICATION NAME] was administered for a pain level of 5 on (MONTH) 12, (YEAR). A Consultant Pharmacist's Medication Regimen Review dated (MONTH) 30, (YEAR) revealed the resident was administered PRN [MEDICATION NAME] (ordered for pain 6-10) for a pain level of 5 per the MAR for (MONTH) (YEAR). The pharmacist's recommendation was Please ensure that nursing staff is educated on importance of adhering to PRN pain scale parameters. Review of the MARs for (MONTH) (YEAR), and (MONTH) and (MONTH) 2019 revealed the PRN [MEDICATION NAME] was administered according to the ordered pain parameters. However, review of the MAR for (MONTH) 2019 revealed the resident was administered [MEDICATION NAME] on (MONTH) 4 and 9 for pain levels of 5. An interview was conducted on (MONTH) 3, 2019 at 1:32 PM with a LPN (staff #97). The LPN stated that before administering a PRN opioid pain medication, she would ask the resident to rate the pain on a scale of 1-10. She stated that if the resident's pain is below the ordered pain parameters, she would offer the resident a non-opioid [MEDICATION NAME]. An interview was conducted on (MONTH) 3, 2019 at 1:37 PM with the DON (staff #84). He stated that his expectation is for nurses to follow the physician's orders [REDACTED]. The facility's policy titled Medication Administration revealed medications must be administered in accordance with the orders. The policy also included PRN medications shall be administered per a physician's orders [REDACTED].
F 0758 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policy review, the facility failed to ensure one of eight sampled residents (#39) received adequate monitoring for effectiveness of an antipsychotic medication, by failing to consistently monitor and accurately document target behaviors. The deficient practice could result in information that is not accurate regarding progress and/or decline towards the therapeutic goal. Findings include: Resident #39 was admitted on (MONTH) 26, (YEAR), with [DIAGNOSES REDACTED]. A quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had moderately impaired skills for daily cognitive decision making. The MDS assessment also included the resident had physical behaviors directed toward others such as hitting, kicking, scratching, etc. Review of the current care plan revealed the resident required [MEDICATION NAME] (antipsychotic medication) to help manage and alleviate agitation, physically aggressive, and exit seeking behavior. The goal was that the resident would be maintained on the lowest therapeutic medication dosage. Interventions included documenting any observed behavioral symptoms on the Behavior Tracking Form and reporting any untoward effects and abnormalities to the physician. The care plan also included the resident had behaviors related to dementia that included pacing or wandering the hallways into other residents' rooms and exit seeking. The goal was that the resident will have fewer episodes of exit seeking. Interventions included intervening as necessary to protect the rights and safety of other, approaching and speaking to the resident in a calm manner, diverting the resident's attention, and removing the resident from the situation. Review of the physician orders [REDACTED]. The orders included monitoring for combativeness, exit seeking, refusing care, agitation, physical aggression, wandering, and impulsivity and documenting the number of episodes observed. A review of the behavior monitoring on the Medication Administration Record [REDACTED]. Further review of the behavior monitoring on the MAR indicated [REDACTED]. However, review of the Certified Nursing Assistant (CNA) behavior note dated (MONTH) 23, 2019 at 5:45 AM, revealed the resident was very aggressive and refused to be directed when she wandered into other residents' rooms. The note included the nurse was notified and assisted the CN[NAME] Review of the CNA behavior note dated (MONTH) 26, 2019 at 7:24 PM, revealed the resident was wandering into resident rooms taking personal items and was unable to be redirected. Review of the CNA behavior note dated (MONTH) 27, 2019 at 9:48 PM revealed the resident was physically combative and rejected care. The note included the resident was punching, kicking, hitting, and grabbing staff. An interview was conducted with a Licensed Practical Nurse (staff #127) on 06/03/19 at 11:57 AM. Staff #127 stated that if behavior monitoring on the MAR indicated [REDACTED]. During an interview conducted with the Director Of Nursing (staff #84) on 06/03/19 at 1:47 PM, staff #127 stated that failure to properly monitor and document behaviors is not acceptable. The facility's policy regarding Antipsychotic Medication Use revealed nursing staff will document in detail a resident's

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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 0758 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 4) target symptom(s). The policy also included the staff will observe, document, and report to the attending physician information regarding the effectiveness of any interventions, including antipsychotic medications. The policy further included that based on the assessing of the resident's symptoms and overall situation, the physician will determine whether to continue, adjust, or stop existing antipsychotic medication.
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 review, observations, staff interviews, and policy review, the facility failed to ensure one of ten sampled employees (#24) had evidence of freedom from infectious [MEDICAL CONDITION] (TB) on or before the date the employee began providing services and failed to ensure containers of beverage thickener powder and protein powder were stored in a sanitary manner in four of five sampled medication carts. The deficient practice could result in the potential exposure of infectious TB and contamination of beverage thickener powder and protein powder. Findings include: -Review of the personnel file for employee #24, a Licensed Practical Nurse (LPN), revealed a hire date of (MONTH) 11, (YEAR).Review of the Employee Vaccine Record for annual TB testing revealed the LPN was administered a PPD (purified protein derivative) for TB on (MONTH) 7, (YEAR). However, the record did not reveal documentation whether the results of the test was positive or negative. An interview was conducted with the Director of Nursing (DON/staff #84) on (MONTH) 4, 2019 at 3:02 PM. After reviewing the vaccine record, the DON stated that staff #24 will have to be retested and that the LPN will be removed from the schedule until they have the results. The facility's policy regarding Employee Screening for [MEDICAL CONDITION] revealed each newly hired employee will be screened for TB infection and disease after an employment offer has been made but prior to the employee's duty assignment. The policy also included that if the skin test is negative, the employee may begin duty assignments. -During an observation conducted on (MONTH) 4, 2019 at 1:33 PM with a Licensed Practical Nurse (LPN/staff #39) of medication cart 1 on the Pine hall, a container of beverage thickener powder and a protein powder container were observed with a scoop inside with the scoop handle in contact with the powders. During an observation conducted on (MONTH) 4, 2019 at 1:42 PM with a Registered Nurse (RN/staff #127) of medication cart 1 on the Magnolia hall, a container of beverage thickener powder and a container of protein powder were observed with a scoop inside with the scoop handle in contact with the powders. During an observation conducted on (MONTH) 4, 2019 at 1:50 PM with a LPN (staff #141) of medication cart 1 on the Oak hall, a container of beverage thickener powder and a container of protein powder were observed with a scoop inside with the scoop handle in contact with the powders. During an observation conducted on (MONTH) 4, 2019 at 2:00 PM with a LPN (staff #141) of medication cart 2 on the Oak hall, a container of beverage thickener powder was observed with a scoop inside with the scoop handle in contact with the powder.An interview was conducted on (MONTH) 4, 2019 at 2:33 PM with staff #141. He stated that he keeps the scoops inside the containers because the scoops are not going to be in the container long. An interview was conducted with the Director of Nursing (DON/staff # 89) on (MONTH) 4, 2019 at 2:45 PM. He stated his expectation is that the scoops be stored separate from the containers of powders for infection control. The facility's policy titled Administering Medications revealed staff shall follow established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications, as applicable.