STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035014	A. BUILDING _____ B. WING _____	03/08/2019

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DESERT TERRACE HEALTHCARE CENTER	2509 NORTH 24TH STREET PHOENIX, AZ 85008

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

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F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews and policy review, the facility failed to notify one resident's (#281) physician of a low blood sugar value. The total sample size was 17. The deficient practice has the potential for adverse effects on residents with sliding scale insulin orders. Findings include: Resident #281 was admitted (MONTH) 23, (YEAR), with [DIAGNOSES REDACTED]. The physician's admission orders [REDACTED]= 0 units and call MD (physician); 71-150 = 0 units; 151-200 = 3 units; 201-250 = 5 units; 251-300 = 7 units; 201-350 = 10 units; 351-400 = 12 units; greater than 401 = 14 units and notify MD. Review of the Medication Administration Record [REDACTED]. Further review of the clinical record did not reveal any documentation that the physician was notified of the low blood sugar. An interview was conducted with the Director of Nursing (DON/staff #56) on (MONTH) 6, 2019 at 7:48 a.m. Staff #56 stated staff should follow the physician's orders [REDACTED]. The DON further stated that no documentation was found the physician was notified when the resident blood sugar level dropped to 63. The facility's policy regarding change of condition revealed all changes in a resident's condition will be communicated to the physician.
F 0637 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Assess the resident when there is a significant change in condition** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews and the Resident Assessment Instrument (RAI) manual, the facility failed to ensure a Significant Change in Status (SCSA) Minimum Data Set (MDS) assessment was completed for one resident (#36), who was discharged from hospice services. The sample size was 17. This deficient practice could affect the resident's continuity of care. Findings include: Resident #36 was admitted on (MONTH) 13, 2012, with [DIAGNOSES REDACTED]. Review of the clinical record revealed a physician's orders [REDACTED]. The SCSA MDS assessment dated (MONTH) 13, (YEAR), revealed the resident was receiving hospice services. Additional review of the clinical record revealed a physician's orders [REDACTED]. However, continued review of the clinical record did not reveal a SCSA MDS assessment was completed. On (MONTH) 7, 2019 at 10:25 AM, an interview was conducted with the MDS coordinator (staff #22). She stated that when a resident is discharged from hospice services, a SCSA MDS assessment needs to be completed. She also stated that she did not know this resident had been discharged from hospice services because she was not notified. Later that morning at 11:38 AM, staff #22 stated that a SCSA MDS assessment should have been completed for resident #36 in (MONTH) 2019. She said she missed it. The RAI manual instructs a SCSA MDS assessment is required when hospice services are discontinued and that the Assessment Reference Date must be within 14 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 that Minimum Data Set (MDS) assessments were accurate for two residents (#382 and #81). The sample size was 31. This deficient practice could affect residents' continuity of care. Findings include: -Resident #382 was admitted on (MONTH) 21, 2019, with [DIAGNOSES REDACTED]. The physician's orders [REDACTED]. The orders also included blood sugar accuchecks before meals and at bedtime. Review of the Medication Administration Record [REDACTED]. A Nursing Progress Note dated (MONTH) 22, 2019, revealed the resident threw her medications when the medications were placed in her hand per her request. Review of the MAR indicated [REDACTED]. The admission MDS assessment dated (MONTH) 28, 2019 revealed a Brief Interview for Mental Status score of 15 which indicated the resident was cognitively intact. The assessment also included the resident had no behaviors during the seven day look-back period which included no verbal or other behaviors directed towards others, and no rejection of care. An interview conducted on (MONTH) 7, 2019 at 12:55 p.m. with the Certified Nursing Assistant (CNA/staff #57) who had completed the section of the MDS assessment for behavior. She stated that she was aware the resident had refused medications and treatments and had slapped and scratched the nurse. The CNA stated that she did not include the behaviors on the MDS assessment because she understood why the resident had those behaviors. She stated that it was a communication problem. An interview was conducted on (MONTH) 8, 2019 at 9:43 a.m. with the Licensed Practical Nurse (LPN/staff #22) MDS Coordinator and the MDS resource Registered Nurse (RN/staff #128). Staff #22 stated that she did not review the behavior section of the MDS assessment. Staff #22 further stated that if she was completing the behavior section for this resident, she would ask the resource nurse how to code this resident's behaviors. The RN stated that her instructions would be to include the resident's behaviors in the behavior section of the assessment and develop a care plan for the behaviors. They both agreed that they use the RAI Manual as the policy and procedure guide for coding the MDS assessment. The RAI manual revealed the behavior section of the MDS assessment focuses on the resident's actions, not the intent of the resident's behavior. The RAI Manual also included that once the frequency and impact of behavioral symptoms are accurately determined, follow-up evaluation and care plan interventions can be developed to improve the symptoms or reduce their impact. -Resident #81 was admitted on (MONTH) 15, 2019, with a [DIAGNOSES REDACTED]. Review of the closed record revealed a discharge summary progress note dated (MONTH) 24, 2019 that the resident was discharged home on (MONTH) 24, 2019. However, review of the discharge MDS assessment dated (MONTH) 25, 2019, revealed the resident was discharged to an acute

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F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) care hospital on (MONTH) 24, 2019. An interview was conducted on (MONTH) 7, 2019 at 1:23 p.m. with the MDS coordinator (staff #22). The MDS coordinator stated the resident was discharged home and not to the hospital. Staff #22 also stated that the discharge MDS assessment regarding the resident's discharge location was an error. An interview conducted on (MONTH) 8, 2019 at 8:20 a.m. with the Director of Nursing (DON/staff #56). She stated the resident was discharged home and that the MDS assessment was coded incorrectly. The DON stated that they follow the RAI manual for coding the MDS assessments. The RAI manual instructs to review the medical record including the discharge plan and discharge orders for documentation of discharge location and select the code that corresponds to the resident's discharge status. The RAI manual also included that it is required that the assessment accurately reflects the resident's status and that the importance of accurately completing and submitting the MDS assessments cannot be over-emphasized.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview, and policy review, the facility failed to ensure that a care plan for [MEDICAL CONDITION] risk was developed for one resident (#32). This deficient practice has the potential to cause delays in assessments and care. The sample size was 2. The universe was 17. Findings include: Resident #32 was admitted to the facility on (MONTH) 5, (YEAR), with [DIAGNOSES REDACTED]. Review of the clinical record revealed a care plan dated (MONTH) 17, (YEAR), which included goals and interventions related to a [DIAGNOSES REDACTED]. The resident was discharged from the facility with a return anticipated on (MONTH) 13, (YEAR). The resident was readmitted on (MONTH) 25, (YEAR). A new care plan was initiated for the resident on (MONTH) 25, (YEAR). However, the care plan did not include the resident's [DIAGNOSES REDACTED]. Review of the PPS (Prospective Payment System) 5 day MDS assessment dated (MONTH) 2, (YEAR), revealed the resident continued to have a [DIAGNOSES REDACTED]. An interview was conducted on (MONTH) 6, 2019 at 8:36 a.m. with the Director of Nursing (DON/staff #56). She stated that facility's protocol directs staff to discontinue a resident's orders and care plan if the resident is discharged from the facility for more than 24 hours. The DON stated that new orders and a new care plan would be initiated upon the resident's re-admission to the facility. A follow-up interview was conducted with the DON on (MONTH) 6, 2019 at 9:28 a.m. She stated that her expectation is that the comprehensive care plan include the resident's risk for [MEDICAL CONDITION]. The DON also stated there was a lapse in communication, and that the resident's risk for [MEDICAL CONDITION] was not included in the care plan when the resident was readmitted . Review of the facility's policy for care planning revealed the following: -The interdisciplinary team shall develop a comprehensive care plan for each resident. -The resident's care plan will be developed and implemented within 48 hours of admission.
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **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 three sampled resident's (#36) comprehensive care plan was revised to reflect the change in hospice services. This deficient practice could result in a delay of care. Findings include: Resident #36 was admitted on (MONTH) 13, 2012, with [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. Review of the care plan dated (MONTH) 8, (YEAR) regarding hospice services revealed interventions to consult with the resident's physician and social services to have hospice care for the resident in the facility and working with nursing staff to provide maximum comfort for the resident. A physician's orders [REDACTED]. A social service progress note dated (MONTH) 23, 2019, revealed the IDT (interdisciplinary team) had met for a care conference. The note included a discussion of the resident's change in Hospice services. The note did not include a discussion about revising the care plan. However, review of the resident's current care plan did not reveal the care plan had been revised to reflect the resident's discharge from hospice. An interview was conducted on (MONTH) 6, 2019 at 10:39 AM with the Director of Nursing (DON/staff #56). She said that facility's protocol and her expectation would include revising the resident's care plan to reflect the change in hospice services. The DON also said their policy states any member of the IDT could make that revision. On (MONTH) 7, 2019 at 09:40 AM, an interview was conducted with a licensed practical nurse (LPN/staff #62). The LPN stated that if a resident is admitted or discharged from hospice services, it would trigger a change of condition due to a change of services. She stated that the MDS (minimum data set) coordinator would revise the care plan. Review of the facility's policy for care planning revealed the resident's plan of care is reviewed and revised on an ongoing basis, quarterly at a minimum and/or as needed with changes in condition.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review and staff interview, the facility failed to ensure one resident (#281) had blood glucose monitoring done as ordered by the physician. The deficient practice could result in treatment not being provided, as a result of high/low blood sugars. The total sample size was 17. Findings include: Resident #281 was admitted on (MONTH) 23, (YEAR) at approximately 3:00 p.m. [DIAGNOSES REDACTED]. A review of the clinical record revealed admission orders [REDACTED] blood sugar 0-70 = 0 units and call MD (physician); 71-150 = 0 units; 151-200 = 3 units; 201-250 = 5 units; 251-300 = 7 units; 201-350 = 10 units; 351-400 = 12 units; greater than 401 = 14 units and notify MD. A review of the MAR (Medication Administration Record) for (MONTH) (YEAR), revealed the resident's blood sugar monitoring was to be done at 7:30 a.m., 11:30 a.m., 4:30 p.m. and 8:00 p.m. Further review of the MAR indicated [REDACTED] During an interview with the Director of Nursing (DON/staff #56) on (MONTH) 6, 2019 at 8:58 a.m., staff #56 stated that the nurse should have documented the resident's glucose levels. Staff #56 stated the facility did not have a policy regarding blood glucose monitoring and documentation and that the nurses are to follow the order on the MAR.
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, clinical record review and staff interviews, the facility failed to ensure one of five sampled

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F 0757 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) residents (#36) was free of unnecessary drugs, by failing to administer a narcotic pain medication as ordered by the physician. The potential outcome includes receiving a medication which may be unnecessary. Findings include: Resident #36 was admitted on (MONTH) 13, 2012, with [DIAGNOSES REDACTED]. Review of a physician's orders [REDACTED]. A pain care plan area dated (MONTH) 16, (YEAR) included that opioids were prescribed for chronic pain. Interventions included administering medication as ordered, monitoring for side-effects, monitoring for medication efficacy and educating the resident on alternatives. The Medication Administration Record [REDACTED]. Per the MAR, [MEDICATION NAME] 5 mg was administered six times outside of the physician ordered parameters as follows: twice on (MONTH) 17 for pain levels of 3 and 4; on (MONTH) 21 for a pain level of 3; on (MONTH) 23 for a pain level of 4; and on (MONTH) 25 and 28, for a pain level of 4. A physician's orders [REDACTED]. The quarterly Minimum Data Set (MDS) assessment dated (MONTH) 13, 2019, revealed the resident had severe cognitive impairment. Review of the MAR for (MONTH) 2019 revealed [MEDICATION NAME] 5 mg was administered 6 times outside of the physician ordered parameters as follows: on (MONTH) 4 for a pain level of 4; on (MONTH) 5 for a pain level of 3; on (MONTH) 6 for a pain level of 3; twice on (MONTH) 9 for pain levels of 4; and on (MONTH) 24 for a pain level of 4. Review of the MAR for (MONTH) 2019 revealed that [MEDICATION NAME] 5 mg was administered once outside of the physician ordered parameters on (MONTH) 20, for a pain level of 4. An observation of resident #36 was conducted on (MONTH) 6, 2019 at 12:05 p.m., in the dining room. The resident was asleep at the table and was not eating her lunch. A Certified Nursing Assistant (CNA) woke the resident up and asked her if she was going to eat her lunch. The resident said she wanted her yogurt, but took only one bite. The resident appeared to be sleepy. Another observation was conducted on (MONTH) 6, 2019 at 1:37 p.m., in the dining room. Resident #36 was still sitting at the table, asleep. An interview was conducted on (MONTH) 8, 2019 at 8:18 a.m., with a Licensed Practical Nurse (LPN/staff #62). She said she administers medications according to the physician's orders [REDACTED]. An interview was conducted on (MONTH) 8, 2019 at 10:20 a.m., with a LPN (staff #123). She said that she would not go outside of the ordered parameters when administering medication. An interview was conducted on (MONTH) 8, 2019 at 10:32 a.m., with the Director of Nursing (DON/staff #56). She stated that her expectation is for the nurses to administer medications according to the proper timeframe and pain scales. She said she expects the nurses to administer medications according to the order and within the parameters.