STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **035260**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **07/25/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FOUNTAIN VIEW VILLAGE	**16455 EAST AVENUE OF THE FOUNTAINS FOUNTAIN HILLS, AZ 85268**

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 0602 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Protect each resident from the wrongful use of the resident's belongings or money.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation and a staff interview, the facility failed to ensure one resident's (#79) credit cards were not misappropriated. Findings include: Resident #79 was admitted to the facility on (MONTH) 20, (YEAR), with [DIAGNOSES REDACTED]. Review of an admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident had intact cognition. Review of a facility's investigative report revealed that on 1/28/19 at 1:40 p.m., resident #79 reported that two credit cards and $40 in cash were missing from her purse. The police were notified and the credit cards were canceled. The police came out to the facility and started an investigation. On 2/19/19, the administrator (staff #36) and the Director of Nursing (staff #25) met with police, who showed them video footage of two females at a register using the resident's credit card at a local grocery store. The two people were identified as housekeepers that worked at the facility. The report further included the police determined that one of the housekeepers was innocent, and the other housekeeper (staff #84) was the one who used the credit card. Staff #84 was terminated. The report also included that the police had additional evidence that staff #84 had used the resident's credit card at other locations. An interview was conducted on 7/23/19 at 1:00 p.m. with staff #36, who stated that she did identify staff #84 in the video.
F 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interviews, and policy review, the facility failed to ensure that physician orders [REDACTED].#9). The deficient practice could result in residents not receiving optimal outcomes related to antibiotics. Findings include: Resident #9 was readmitted to the facility on (MONTH) 10, 2019, with [DIAGNOSES REDACTED]. Review of the admission physician's orders [REDACTED]. The order was discontinued on (MONTH) 10, 2019. Review of the Pharmacy Dosing Recommendation dated (MONTH) 10, 2019, revealed a recommendation to change [MEDICATION NAME] to 1000 mg IV every 12 hours and draw a trough prior to the fourth dose. Additional review of the clinical record revealed a physician order [REDACTED]. A physician order [REDACTED]. Review of the MAR for (MONTH) 2019 revealed [MEDICATION NAME] was administered as ordered on (MONTH) 11 and 12, 2019, and a trough was obtained on (MONTH) 12, 2019. Review of the lab results dated (MONTH) 13, 2019, revealed the resident's [MEDICATION NAME] trough was 14.8. A Pharmacy Dosing Recommendation dated (MONTH) 13, 2019, included the trough result was received and to continue the current dose of 1000 mg every 12 hours and to draw a trough prior to the first dose of [MEDICATION NAME] on (MONTH) 15, 2019. Continued review of the clinical record revealed a physician's orders [REDACTED]. Review of the MAR for (MONTH) 2019 revealed the [MEDICATION NAME] scheduled at 9:00 a.m. on (MONTH) 15 was not administered and to see the nursing note. The nursing note dated (MONTH) 15, 2019 at 12:22 p.m. revealed the trough was not done. Further review of the (MONTH) 2019 MAR revealed the trough was obtained on (MONTH) 15, 2019 at 3:14 p.m. Review of the lab results revealed the trough of 14.6 was reported to the facility on (MONTH) 16, 2019. However, review of the clinical record revealed the trough result was not reported to the pharmacy until (MONTH) 18, 2019. A Pharmacy Dosing Recommendation dated (MONTH) 18, 2019, included continuing the 1000 mg of [MEDICATION NAME] every 12 hours, drawing a trough 30 minutes prior to the first dose on (MONTH) 22, drawing an updated CMP for accuracy of dosing, and verifying that pharmacy is to dose and monitor this medication. The CMP was obtained and the result of the blood work was received by the facility on (MONTH) 19, 2019. However, review of the clinical record revealed no evidence the pharmacy was notified of the CMP results or the verification that the pharmacy was to dose and monitor the [MEDICATION NAME]. Review of the physician's orders [REDACTED]. However, review of the MAR for (MONTH) 2019 revealed the trough was not obtained until (MONTH) 23, 2019 at 8:39 a.m. Continued review of the clinical record revealed the trough was 20.2 and that the Pharmacy Dosing Recommendation dated (MONTH) 23, 2019 instructed continuing the current dose of [MEDICATION NAME] and repeating a trough 30 minutes before the next dose. The recommendation also included obtaining a Basic Metabolic Panel and faxing the results to the pharmacy and clarifying the dosing time. Review of the Pharmacy Dosing Recommendation dated (MONTH) 25, 2019 revealed the trough and blood work results were received by the pharmacy. An interview was conducted with a Licensed Practical Nurse on (MONTH) 24, 2019 at 1:53 p.m. with a Licensed Practical Nurse (LPN/staff #85). The LPN stated the reason for the (MONTH) 22, 2019 trough delay was because the nurse was unable to draw blood from the IV access and that a lab technician had to come and obtain the trough. The LPN further stated that the physician was notified of the delay and ordered the trough be drawn on (MONTH) 23, but that the pharmacy was not notified of the delay. An interview was conducted with the Director of Nursing (DON/staff #25) on (MONTH) 24, 2019 at 3:08 p.m. The DON stated that pharmacy was dosing and monitoring the [MEDICATION NAME] and that if a trough was unable to be drawn, the expectation is that the physician and the pharmacy would be notified. She also stated that the delay and the notifications should be documented on the MAR or in a progress note. The DON stated the delay for the pharmacy recommendation dated (MONTH) 23 was because it was filed in the clinical record before being acted upon. An interview was conducted with the Pharmacist Supervisor (staff #88) on (MONTH) 25, 2019 at 1:08 p.m. Staff #88 stated that no information was provided to the pharmacy regarding the delays on the pharmacy recommendations. He also stated that the pharmacy was not provided any information regarding why blood work was not obtained or why the request to clarify the dosing times was not provided. The pharmacist also stated that based on the troughs, the [MEDICATION NAME] dose remained within the therapeutic window. The facility's policy regarding Drug Regimen Review revealed the pharmacist reviews the resident's clinical record to monitor the medication regimen, including administration of medications which require close monitoring through lab work. The policy also included the pharmacist's review considers factors such as whether the physician and staff have identified and acted upon or should be notified about potential side effects.

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 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1)
F 0676 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation, resident and staff interviews, and policy review, the facility failed to ensure one sampled resident (#9) received an adequate number of showers. The census was 25. The deficient practice could result in hygiene needs not being met. Findings include: Resident #9 was initially admitted to the facility on (MONTH) 26, (YEAR), discharged on (MONTH) 3, 2019, and readmitted on (MONTH) 10, 2019 with [DIAGNOSES REDACTED]. Review of the care plan initiated (MONTH) 27, 2019, revealed the resident needed assistance with Activities of Daily Living related to a right [MEDICAL CONDITION] (BKA), Left BKA, impaired balance, and limited mobility. Interventions included the providing minimal assistance for showering. Review of the shower schedule posted on the bulletin board at the nurses' station and the Certified Nursing Assistant (CNA) tasks in Point of Care (P[NAME]) revealed the resident was scheduled for showers/baths on Tuesdays and Fridays on the a.m. shift per the resident's request. The admission Minimum Data Set assessment dated (MONTH) 17, 2019, revealed a Brief Interview for Mental Status score of 15, which indicated the resident had intact cognition. The assessment also included the resident required assistance of one person for showers/bath. Review of the P[NAME] documentation for showers revealed the resident was only provided a shower on (MONTH) 16 and did not reveal any refusal of showers/baths. During an interview conducted with the resident on (MONTH) 22, 2019 at 8:46 a.m., the resident stated that she had not received any showers or bed baths since being admitted to the facility. An interview was conducted with a CNA (staff #13) on (MONTH) 23, 2019 at 8:40 a.m. The CNA stated that they receive the information for residents that are to receive a shower on their shift from the P[NAME] system and from the shower posting on the bulletin board. She stated that providing a resident a shower or bed bath, how much assistance was required, and if a resident refused a shower or bed bath should be documented. The CNA stated that if a resident refuses, they will approach the resident 3 times before notifying the nurse of the refusal. The CNA also stated that if they are short staffed, any shower they were unable to provide will be passed on to the next shift. During an interview conducted with a Registered Nurse (RN/staff #50) on (MONTH) 13, 2019 at 8:55 a.m., the RN stated that if a resident refuses a shower, it should be documented in the P[NAME] system. The RN also stated that they are short staffed at times and showers are missed. She stated that the CNAs report the missed showers to the nurses and it is reported to the next shift. An interview was conducted with the Director of Nursing (DON/ staff #25) on (MONTH) 25, 2019 at 9:12 a.m. The DON stated that a resident is scheduled for at least 2 showers a week. She stated that for a resident who is refusing a shower, the expectation is that staff offers the resident the shower at least a couple of times. She stated that if the resident still refuses, the expectation is that the nurse will talk to the resident and if the resident still refuses, the refusal will be reported to the next shift. The DON stated that the expectation is that the next shift will provide the shower. The DON also stated that it should be documented in the P[NAME] system when a shower is given and when a shower is refused. The DON further stated that it is their policy that a resident receive showers twice weekly per the shower schedule. Review of the facility's policy regarding Bath and Shower/Tub revealed the purpose of showers is to promote cleanliness, provide comfort to the residents and to observe the condition of the skin. The policy included the date and time the shower/tub bath was performed is to be documented. The policy also included that if a resident refused a shower/tub bath the refusal and the reason(s) are to be documented and to notify the supervisor of the refusal.
F 0757 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **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 five sampled residents (#130) was free from unnecessary drugs by failing to administer drugs according to the physician ordered parameters. The deficient practice could result in low blood pressures and residents receiving drugs which may not be necessary. Findings include: Resident #130 was admitted to the facility on (MONTH) 19, 2019, with [DIAGNOSES REDACTED]. Review of the clinical record revealed a physician order [REDACTED]. A Pharmacy Medication Regimen Review dated (MONTH) 19, 2019, revealed the pharmacist made a recommendation to the prescriber to consider blood pressure (BP) hold parameters for [MEDICATION NAME] due to the risk of [MEDICAL CONDITION]. The review also revealed the prescriber accepted the recommendation and wrote give for systolic BP greater than 160. The prescriber's response and signature were not dated. The Medication Administration Record [REDACTED]. However, review of the blood pressure for (MONTH) 19, 2019 through (MONTH) 24, 2019, revealed the resident's systolic BP was not greater than 160. The systolic blood pressures ranged between 98 and 143. Continued review of the clinical record revealed a physician order [REDACTED]. Review of the MAR indicated [REDACTED]. An interview was conducted on (MONTH) 24, 2019 at 1:53 p.m. with a Licensed Practical Nurse (LPN/staff #85). The LPN stated that new orders are placed in the resident's chart with the top portion of the order flagged to alert the nurse to enter the order into the electronic orders. He stated the electronic orders were not updated by the nurse before the written order for [MEDICATION NAME] BP parameters was filed. An interview was conducted with the Director of Nursing (DON/staff #25) on (MONTH) 24, 2019 at 3:08 p.m. The DON stated her expectation is that staff follow physician orders [REDACTED]. The DON stated that since the physician did not date the order, it made it difficult to tell when the order should have been implemented. A follow-up interview was conducted with the DON on (MONTH) 25, 2019 at 11:31 a.m. The DON stated the reason the resident was administer [MEDICATION NAME] on (MONTH) 24, 2019 at 11:00 p.m. for a systolic BP less than 160 was because the wording was not clear on the physician order, which created confusion. She said the order was updated to direct the nurse to hold [MEDICATION NAME] for a systolic BP less than 160. Review of the facility's policy for Medication and Treatment Orders revealed that all drug orders shall be written, dated and signed. Only authorized, licensed practitioners, or individuals authorized to take verbal orders from practitioners, shall be allowed to write orders in the medical record. The policy also included medications shall be administered only upon the written order.
F 0761 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** Based on observation, staff interview, and policy review, the facility failed to ensure that expired medical supplies in the medication storage room were not available for resident use. The census was 25. The deficient practice could result in inaccurate laboratory and culture results. Findings include: An observation of the medication storage room was conducted on (MONTH) 24, 2019 at 1:02 p.m. with a Registered Nurse (RN/staff #50). One culture swab was observed with an expiration date of (MONTH) 2019 and three yellow cap BD vacutainers

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F 0761 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) were observed with an expiration date of (MONTH) 6, 2019. An interview was conducted on (MONTH) 25, 2019 at 9:12 p.m. with the Director of Nursing (DON/staff #25). She stated that the pharmacy conducts a full audit of the medication room and medication carts checking for expired medications, over-the-counter medications, and supplies once every 3 months. She said medication rooms and carts should also be checked by the night shift nurses every shift for expired medications and supplies. She stated that she expects the night shift nurses to discard any expired supplies and to notify her so she can reorder them. The DON stated that the expired culture swabs and vacutainers should have been removed from the inventory in the medication room. Review of the facility's policy Storage of Medication revealed the facility shall not use discontinued, outdated or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed.