STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035244	A. BUILDING _____ B. WING _____	**02/21/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOOD SAMARITAN SOCIETY-PRESCOTT VALLEY	**3380 NORTH WINDSONG DRIVE PRESCOTT VALLEY, AZ 86314**

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 clinical record review, staff interviews, facility documentation and policy review, the facility failed to ensure one resident (#44) was treated in a respectful and dignified manner. Findings include: Resident #44 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. An admission Minimum Data Set assessment dated [DATE] revealed the resident had a Brief Interview for Mental status score of 15, indicating intact cognition. According to the facility's investigative report, on 3/16/18 resident #44 observed a registered nurse (RN/staff #99) give another resident some medications and then returned to the medication cart in the dining room. Resident #44 observed the resident drop one of the medications on her shirt, so resident #44 called for the nurse. Staff #99 came over and resident #44 asked the nurse why he didn't stand right next to the resident when she took her medications. Resident #44 reported that staff #99 said to her Do you think you're running this place? The report also included a statement from a RN case Manager, who is now the current Assistant Director of Nursing (staff #21). Per the statement, she heard staff #99 say to one of the residents that they need to quit acting like they run the place. Staff #21 did not see who staff #99 was talking to because she was in her office. A statement from staff #99 included that he told resident #44 please don't tell me how to do my job. An interview was conducted with staff #99 on 2/20/19 at 10:13 AM. Staff #99 stated resident #44 was being rude to him and attempted to tell him how to do his job. He stated he told the resident that it was not her concern. Staff #99 stated that he did not tell her that she needed to stop pretending to run the place. He also stated that he was not agitated and intended no disrespect. An interview was conducted with staff #21 on 2/20/19 at 10:43 AM. Staff #21 stated she did overhear the incident and that staff #99 sounded slightly agitated with the resident and said something to the effect that it was not her concern and that it was not her job to tell him how to do it. She stated the statement was disrespectful and was a dignity issue. She added that the nurse was counseled and given professionalism and conflict resolution training before returning to work. An interview was conducted with the Administrator (staff #14) on 2/20/19 at 11:09 AM. Staff #14 stated that he felt staff #99 may have been unprofessional. He stated that staff #99 had no previous complaints or incidents. The Administrator added that he does not tolerate being disrespectful towards residents. Review of the facility's policy and procedure on Resident Dignity revealed the purpose was to maintain the dignity of all residents, to promote, encourage, support and enhance the resident's self-esteem, to promote a sense of self-worth and to assist with respecting and abiding by resident rights. The policy included to promote care for residents in a manner and in an environment that maintains each residents dignity and respect in full recognition of his or her individuality.
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 clinical record review, staff interviews, facility documentation, review of the State Survey Agency data base and policies and procedures, the facility failed to implement their Abuse policy, by failing to ensure that an allegation of sexual abuse for one resident (#7) was reported immediately to the Administrator and to the State Survey Agency and to APS (Adult Protective Services) within two hours after the allegation was made, and by failing to protect residents from the potential for further abuse, as the staff member was not removed from providing direct care to residents at the time of the allegation. Findings include: Resident #7 was admitted on (MONTH) 18, 2014 and readmitted on (MONTH) 8, (YEAR), with [DIAGNOSES REDACTED]. Review of an annual MDS (Minimum Data Set) assessment dated (MONTH) 5, (YEAR) revealed that resident #7 had a BIMS (Brief Interview for Mental Status) score of 15, which indicated the resident was cognitively intact. Per the MDS, the resident had depressed mood and trouble concentrating and required extensive assistance with bed mobility and hygiene. An investigation report dated (MONTH) 26, 2019 included the following: On (MONTH) 23, (YEAR) resident #7 alleged that on (MONTH) 18, (YEAR) in the evening that two CNA's (staff #4 and #40) were changing his brief in bed and that one of the CNA's (staff #4) rolled him towards herself and rubbed the front of herself on his torso before rolling him to his back. Resident #7 stated that he felt that staff #4 had groped him. Resident #7 did not report the incident at the time to anyone, however, on (MONTH) 23, (YEAR) (on the night shift) the resident reported the allegation to staff #40. The report included that two nursing staff members did not report the allegation timely on 11/23/18, when the allegation was made. The report further included that staff #40 reported that staff #4 and she were getting the resident changed and that nothing happened. The allegation of sexual abuse was not substantiated. Continued review of the investigation report revealed the following: -The Administrator was informed of the allegation of abuse on (MONTH) 24, (YEAR), however, the State Survey Agency was not notified until (MONTH) 25, (YEAR) at 4:00 p.m., which was over the two hour time frame for reporting. -There was no documentation that APS had been notified of the allegation of sexual abuse. -There was no documentation that staff #4 had been removed from providing care to residents at the time that resident #7 voiced the allegation of sexual abuse to staff #40 on (MONTH) 23, (YEAR). Review of the State Agency data base revealed that although resident #7 had notified staff on (MONTH) 23, (YEAR) regarding an allegation of sexual abuse, it was not reported to the State Survey Agency until (MONTH) 25, (YEAR) at 4:00 p.m. An interview was conducted on (MONTH) 20, 2019 at 9:47 a.m. with staff #4. She stated that on the night shift on (MONTH) 23, (YEAR) (which started at 10:00 p.m. and ended on (MONTH) 24 at 6:00 a.m.) at approximately 11:00 p.m., staff #40 informed her that resident #7 had accused her of abuse. Staff #4 stated that she told staff #40 to report the accusation of abuse to the nurse on duty, who was a LPN (licensed Practical Nurse/staff #52). Staff #4 stated she did not report the allegation of abuse to the nurse. Staff #4 said that later in the shift between 4:00 and 6:00 a.m., staff #52 told her that an allegation of abuse had been made by resident #7 and that she had been accused of abuse. Staff #4 stated that she was not removed from duty, and that she completed her shift. She said that after she had completed her shift and gone home, she then texted the Administrator (staff #14) and informed him of the allegation of abuse. Staff #4 stated she was told by the Administrator not to report for work until notified. An interview was conducted on (MONTH) 20, 2019 at 10:45 a.m. with staff #52. During the interview, staff #52 stated that on

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) (MONTH) 24, (YEAR) staff #40 informed her of the allegation voiced by resident #7. She said that she did not remember the exact time that she was informed, only that she was informed early in the morning. The LPN stated that staff #40 told her that the alleged abuse had occurred two weeks earlier. The LPN stated that she reported the allegation to the Administrator later in the morning, but did not remember what time. She said that by the time she reported the allegation of abuse to the Administrator, another staff had already reported the allegation to him. An interview was conducted on (MONTH) 20, 2019 at 12:50 p.m. with a CNA (staff #40). Staff #40 stated that resident #7 had reported the allegation of abuse to her on (MONTH) 23, (YEAR) between 10:00 p.m. and 12:00 a.m. Staff #40 stated she did not remember if she had notified staff #4 that the resident had accused her of abuse. Staff #40 stated she immediately reported the allegation to the nurse (staff #52), and reported the allegation to the Administrator on (MONTH) 24, (YEAR) after her shift was completed and after she had arrived home sometime in the middle of the day. Staff #40 stated that staff are to report allegations of abuse within two hours, or immediately to the nurse, the supervisor or to the Administrator. On (MONTH) 20, (YEAR) at 1:18 p.m., an interview was conducted with the Administrator (staff #14). The Administrator stated that staff #4 reported the allegation of abuse to him on (MONTH) 24, (YEAR) between 9:00 a.m. and 10:00 a.m. via text message. The Administrator stated that staff #4 was suspended from duty when she reported the allegation of abuse to him. Staff #14 said that staff #40 and staff #52 did not report the allegation to him. The Administrator also stated that the State Survey Agency was not notified until (MONTH) 24, (YEAR) at 4:00 p.m. because he thought the facility had 24 hours to report an allegation of abuse. He said that APS was not notified because they had been told by APS not to notify them unless an allegation of abuse was substantiated. A policy and procedure titled Abuse and Neglect revealed that the purpose of the policy included the following: to ensure that residents are not subjected to abuse by anyone, including employees, other residents, family members and friends; to ensure that employees are knowledgeable regarding reporting and the investigative process of abuse and neglect allegations; to ensure that all incidents of alleged or suspected abuse are promptly investigated and reported. The policy included that alleged violations involving abuse will be reported immediately to the administrator and to other officials in accordance with State law including the State Survey Agency. The procedure also included that if an employee receives an allegation of abuse, the employee will then report the allegation to a supervisor or charge nurse immediately. If the allegation of abuse is an allegation of employee to resident abuse, the employee will be removed from providing direct care to all residents, and will be placed on suspension pending the results of the internal investigation. The facility will have evidence that all alleged or suspected violations are thoroughly investigated and will prevent further potential abuse, while the investigation is in progress. If there is an allegation of abuse, neglect or mistreatment, it will be reported not later than two hours after the allegation is made to the State Survey Agency and APS.
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 clinical record review, staff interviews, facility documentation, review of the State Survey Agency data base and policies and procedures, the facility failed to ensure that an allegation of sexual abuse for one resident (#7) was reported immediately to the Administrator and to the State Survey Agency and to APS (Adult Protective Services), within two hours after the allegation was made. Findings include: Resident #7 was admitted on (MONTH) 18, 2014 and readmitted on (MONTH) 8, (YEAR), with [DIAGNOSES REDACTED]. An investigation report dated (MONTH) 26, 2019 included the following: On (MONTH) 23, (YEAR) resident #7 alleged that on (MONTH) 18, (YEAR) in the evening that two CNA's (staff #4 and #40) were changing his brief in bed and that one of the CNA's (staff #4) rolled him towards herself and rubbed the front of herself on his torso before rolling him to his back. Resident #7 stated that he felt that staff #4 had groped him. Resident #7 did not report the incident at the time to anyone, however, on (MONTH) 23, (YEAR) (on the night shift) the resident reported the allegation to staff #40. The report included that two nursing staff members did not report the allegation timely on 11/23/18, when the allegation was made. The report further included that staff #40 reported that staff #4 and she were getting the resident changed and that nothing happened. The allegation of sexual abuse was not substantiated. Continued review of the investigation report revealed the following: -The Administrator was informed of the allegation of abuse on (MONTH) 24, (YEAR), however, the State Survey Agency was not notified until (MONTH) 25, (YEAR) at 4:00 p.m., which was over the two hour time frame for reporting. -There was no documentation that APS had been notified of the allegation of sexual abuse. Review of the State Agency data base revealed that although resident #7 had notified staff on (MONTH) 23, (YEAR) regarding an allegation of sexual abuse, it was not reported to the State Survey Agency until (MONTH) 25, (YEAR) at 4:00 p.m. An interview was conducted on (MONTH) 20, 2019 at 9:47 a.m. with staff #4. She stated that on the night shift on (MONTH) 23, (YEAR) (which started at 10:00 p.m. and ended on (MONTH) 24 at 6:00 a.m.) at approximately 11:00 p.m., staff #40 informed her that resident #7 had accused her of abuse. Staff #4 stated that she told staff #40 to report the accusation of abuse to the nurse on duty, who was a LPN (licensed Practical Nurse/staff #52). Staff #4 stated she did not report the allegation of abuse to the nurse. Staff #4 said that later in the shift between 4:00 and 6:00 a.m., staff #52 told her that an allegation of abuse had been made by resident #7 and that she had been accused of abuse. Staff #4 stated that she was not removed from duty, and that she completed her shift. She said that after she had completed her shift and gone home, she then texted the Administrator (staff #14) and informed him of the allegation of abuse. An interview was conducted on (MONTH) 20, 2019 at 10:45 a.m. with staff #52. During the interview, staff #52 stated that on (MONTH) 24, (YEAR) staff #40 informed her of the allegation voiced by resident #7. She said that she did not remember the exact time when she was informed, only that she was informed early in the morning. The LPN stated that staff #40 told her that the alleged abuse had occurred two weeks earlier. The LPN stated that she reported the allegation to the Administrator later in the morning, but did not remember what time. She said that by the time she reported the allegation of abuse to the Administrator, another staff had already reported the allegation to him. An interview was conducted on (MONTH) 20, 2019 at 12:50 p.m. with a CNA (staff #40). Staff #40 stated that resident #7 had reported the allegation of abuse to her on (MONTH) 23, (YEAR), between 10:00 p.m. and 12:00 a.m. Staff #40 stated that she did not remember if she had notified staff #4 that the resident had accused her of abuse. Staff #40 stated she immediately reported the allegation to the nurse (staff #52), and reported the allegation to the Administrator on (MONTH) 24, (YEAR) after her shift was completed and after she had arrived home sometime in the middle of the day. Staff #40 stated that staff are to report allegations of abuse within two hours or immediately to the nurse, the supervisor or to the Administrator. On (MONTH) 20, (YEAR) at 1:18 p.m., an interview was conducted with the Administrator (staff #14). The Administrator stated that staff #4 reported the allegation of abuse to him on (MONTH) 24, (YEAR) between 9:00 a.m. and 10:00 a.m. via text message. Staff #14 said that staff #40 and staff #52 did not report the allegation to him. The Administrator also stated that the State Survey Agency was not notified until (MONTH) 24, (YEAR) at 4:00 p.m., because he thought the facility had 24 hours to report an allegation of abuse. He said that APS was not notified because they had been told by APS not to notify them unless an allegation of abuse was substantiated. A policy and procedure titled, Abuse and Neglect revealed the purpose of the policy included the following: to ensure that employees are knowledgeable regarding reporting and the investigative process of abuse and neglect allegations; to ensure that all incidents of alleged or suspected abuse are promptly investigated and reported. The policy included that alleged violations involving abuse will be reported immediately to the administrator and to other officials in accordance with State law, including the State Survey Agency. The procedure included that if an employee receives an allegation of abuse, the employee will then report the allegation to a supervisor or charge nurse immediately. If there is an allegation of abuse, neglect or mistreatment, it will be reported not later than two hours after the allegation is made to the State Survey Agency and APS.
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**

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F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) Based on clinical record review, staff interviews, facility documentation and policies and procedures, the facility failed to prevent the potential for further abuse, by failing to remove a staff member (#4) from providing direct care to residents at the time of the allegation involving one resident (#7). Findings include: Resident #7 was admitted on (MONTH) 18, 2014 and readmitted on (MONTH) 8, (YEAR), with [DIAGNOSES REDACTED]. Review of an annual MDS (Minimum Data Set) assessment dated (MONTH) 5, (YEAR) revealed the resident had a BIMS (Brief Interview for Mental Status) score of 15, which indicated that the resident was cognitively intact. Per the MDS, the resident had depressed mood and trouble concentrating and required extensive assistance with bed mobility and hygiene. An investigation report dated (MONTH) 26, 2019 included the following: On (MONTH) 23, (YEAR) resident #7 alleged that on (MONTH) 18, (YEAR) in the evening that two CNA's (staff #4 and #40) were changing his brief in bed and that one of the CNA's (staff #4) rolled him towards herself and rubbed the front of herself on his torso before rolling him to his back. Resident #7 stated that he felt that staff #4 had groped him. Resident #7 did not report the incident at the time to anyone, however, on (MONTH) 23, (YEAR) (on the night shift) the resident reported the allegation to staff #40. The report included that two nursing staff members did not report the allegation timely on 11/23/18, when the allegation was made. The report further included that staff #40 reported that staff #4 and she were getting the resident changed and that nothing happened. The allegation of sexual abuse was not substantiated. Continued review of the investigation report revealed there was no documentation that staff #4 had been removed from providing care to residents at the time that resident #7 voiced the allegation of sexual abuse to staff #40 on (MONTH) 23, (YEAR). An interview was conducted on (MONTH) 20, 2019 at 9:47 a.m. with staff #4. She stated that on the night shift on (MONTH) 23, (YEAR) (which started at 10:00 p.m. and ended on (MONTH) 24 at 6:00 a.m.) at approximately 11:00 p.m., staff #40 informed her that resident #7 had accused her of abuse. Staff #4 stated that she told staff #40 to report the accusation of abuse to the nurse on duty, who was a LPN (licensed Practical Nurse/staff #52). Staff #4 stated she did not report the allegation of abuse to the nurse. Staff #4 said that later in the shift between 4:00 and 6:00 a.m., staff #52 told her that an allegation of abuse had been made by resident #7 and that she had been accused of abuse. Staff #4 stated that she was not removed from duty, and that she completed her shift. She said that after she had completed her shift and gone home, she then texted the Administrator (staff #14) and informed him of the allegation of abuse. Staff #4 stated she was told by the Administrator not to report for work until notified. An interview was conducted on (MONTH) 20, 2019 at 10:45 a.m. with staff #52. During the interview, staff #52 stated that on (MONTH) 24, (YEAR) staff #40 informed her of the allegation voiced by resident #7. She said that she did not remember the exact time that she was informed, only that she was informed early in the morning. The LPN stated that staff #40 told her that the alleged abuse had occurred two weeks earlier. The LPN stated that she reported the allegation to the Administrator later in the morning, but did not remember what time. She said that by the time she reported the allegation of abuse to the Administrator, another staff had already reported the allegation to him. When questioned if staff #4 was removed from providing care to residents during her shift, she replied no. An interview was conducted on (MONTH) 20, 2019 at 12:50 p.m. with a CNA (staff #40). Staff #40 stated that resident #7 had reported the allegation of abuse to her on (MONTH) 23, (YEAR) between 10:00 p.m. and 12:00 a.m. Staff #40 stated she did not remember if she had notified staff #4 that the resident had accused her of abuse. Staff #40 stated she immediately reported the allegation to the nurse (staff #52), but did not remember if staff #4 had completed her shift. On (MONTH) 20, (YEAR) at 1:18 p.m., an interview was conducted with the Administrator (staff #14). The Administrator stated that staff #4 reported the allegation of abuse to him on (MONTH) 24, (YEAR) between 9:00 a.m. and 10:00 a.m. via text message and staff #4 was then suspended. Staff #14 said that staff #40 and staff #52 did not report the allegation to him. A policy and procedure titled, Abuse and Neglect revealed the purpose of the policy was to ensure that employees are knowledgeable regarding reporting and the investigative process of abuse and neglect allegations, and to ensure that all incidents of alleged or suspected abuse are promptly investigated and reported. The policy stated that if an employee receives an allegation of abuse, the employee will then report the allegation to a supervisor or charge nurse immediately. If the allegation of abuse is an allegation of employee to resident abuse, the employee will be removed from providing direct care to all residents, and will be placed on suspension pending the results of the internal investigation. The facility will have evidence that all alleged or suspected violations are thoroughly investigated and will prevent further potential abuse, while the investigation is in progress.
F 0697 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide safe, appropriate pain management for a resident who requires such services.** **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 that pain medication was administered as ordered by the physician for one resident (#36). Findings include: Resident #36 was admitted to the facility on (MONTH) 28, (YEAR), with [DIAGNOSES REDACTED]. A 14 day Minimum Data Set (MDS) assessment dated (MONTH) 23, (YEAR) documented the resident had a brief interview for mental status score of 15, which indicated no cognitive impairment. The resident was also assessed to have pain on a daily basis. A care plan with a revision date of (MONTH) (YEAR) included a problem area of pain. An intervention was to administer pain medication as ordered. Review of the (MONTH) 2019 recapitulation of physician's orders [REDACTED]. Review of the (MONTH) 2019 Medication Administration Record [REDACTED] -January 3: for a pain level of 4 -January 14: for a pain level of 6 -January 16: for a pain level of 6 -January 17: for a pain level of 4 -January 18: for a pain level of 4 -January 19: for a pain level of 5 -January 24: for a pain level of 5 -January 30: for a pain level of 4 A review of the corresponding nursing progress notes for (MONTH) 2019 revealed no documentation as to why the physician ordered parameters for [MEDICATION NAME] were not followed. Review of the (MONTH) 2019 MAR indicated [REDACTED] -February 11: for a pain level of 4 -February 18: for a pain level of 5 -February 19: for a pain level of 5 A review of the corresponding nursing progress notes for (MONTH) 2019 revealed no documentation of why the [MEDICATION NAME] was administered instead of the [MEDICATION NAME]. An interview was conducted with a Licensed Practical Nurse (staff #51) on (MONTH) 21, 2019 at 10:38 a.m. She stated the procedure is for the nurses to assess the resident's pain level by using the pain scale, check the physician's PRN orders and then give the PRN pain mediations within the parameters. She stated if the parameters were not followed then it must be documented in the nursing note. An interview was conducted with the Director of Nursing (staff #67) on (MONTH) 21, 2019 at 10:41 a.m. She stated it was necessary for nurses to follow orders and to administer PRN pain medications within the parameters. She stated if for some reason the parameters were not followed the nurse must document it in the nursing notes. A facility policy regarding medication administration included the purpose was to administer medications correctly. An additional policy stated to follow the six rights of medication administration, which included the right medication and the right dose.
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 clinical record review, staff interviews and policy review, the facility failed to ensure that each resident's drug

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F 0757 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) regimen was free of unnecessary drugs, by administering a medication to one resident (#28) outside of the physician ordered parameters. Findings include: Resident #28 was admitted (MONTH) 16, (YEAR), with [DIAGNOSES REDACTED]. A physician's note dated (MONTH) 29, (YEAR) revealed the resident had a [DIAGNOSES REDACTED]. The physician orders [REDACTED]. The order included to hold and call for systolic blood pressure under 120 or heart rate below 60. Review of the Medication Administration Record [REDACTED] -December 10: systolic blood pressure was 118 and the medication was given -December 12: heart rate was 56 and the medication was given -December 24, systolic blood pressure was 119 and the medication was given -December 26, heart rate of 50 and the medication was given -December 28: systolic blood pressure was 119 and the heart rate was 56 and the medication was given -December 30: systolic blood pressure was 118 and the medication was given -December 31: systolic blood pressure was 117 and the heart rate was 50 and the medication was given Review of the progress notes for (MONTH) 10 through 31, (YEAR) revealed no documentation as to why the medication was given, despite being outside of the physician ordered parameters for blood pressure and heart rate. A Minimum Data Set assessment dated (MONTH) 25, 2019 revealed the resident had a Brief Interview for Mental Status score of 15, which indicated the resident had intact cognition. The assessment also included the resident had a [DIAGNOSES REDACTED].Review of the MAR for (MONTH) 2019 revealed that [MEDICATION NAME] XL was administered outside of the parameters as follows: -January 4: systolic blood pressure was 110 and the medication was given -January 6: systolic blood pressure was 115 and the heart rate was 53 and the medication was given -January 7: systolic blood pressure was 110 and the medication was given -January 11: heart rate of 47 and the medication was given -January 24: systolic blood pressure was 114 and the heart rate was 59 and the medication was given -January 31: there was no record of blood pressure or heart rate listed Review of the corresponding nursing notes for (MONTH) 4 through 31, 2019, revealed no documentation as to why the medication was given outside of the physician ordered parameters. Review of the MAR for (MONTH) 2019 revealed that [MEDICATION NAME] XL was administered outside of physician ordered parameters as follows: -February 3: systolic blood pressure was 116 and the medication was given -February 4: systolic blood pressure was 109 and the medication was given -February 6: systolic blood pressure was 117 and the medication was given -February 8: heart rate of 58 and the medication was given -February 11: systolic blood pressure was 114 and the medication was given -February 13: systolic blood pressure was 117 and the medication was given -February 15: systolic blood pressure was 110 and the medication was given -February 16: systolic blood pressure was 118 and the medication was given Review of the corresponding progress notes for (MONTH) 2019 revealed no documentation of why the medication was administered outside of the physician ordered parameters. An interview was conducted with a Registered Nurse (RN/staff #55) on (MONTH) 21, 2019 at 9:46 a.m. He stated the expectation is that the nurse would follow the physician's orders [REDACTED]. He stated that if the [MEDICATION NAME] was given to the resident when the resident's vital signs were below the specified parameters, it could cause the resident to become hypotensive. He also stated there should always be documentation that vitals were completed if the medication had ordered parameters. An interview was conducted with the Director of Nursing (DON/staff #67) on (MONTH) 21, 2019 at 10:16 a.m. She stated the expectation is for nurses to follow the physician's orders [REDACTED]. She stated the nurse is expected to follow parameters as ordered for a medication, or if the medication is given outside of the parameters there should be documentation of why the parameters were not followed. She said when the [MEDICATION NAME] was given outside of the ordered parameters, the resident had an increased risk of blood pressure and pulse dropping to critical levels. Review of a policy regarding Medication Administration revealed the purpose was to administer medications correctly.