STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035083	A. BUILDING ______ B. WING _____	**03/22/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HERITAGE COURT POST ACUTE OF SCOTTSDALE	**3339 NORTH DRINKWATER BOULEVARD SCOTTSDALE, AZ 85251**

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 and procedure, the facility failed to ensure one of five sampled residents (#2) was informed of the risks and benefits of a psychoactive medication, prior to administration. The deficient practice can result in the resident not being aware of the benefits and the potential adverse side effects of taking psychoactive medications. Findings include: Resident #2 was admitted to the facility on (MONTH) 30, (YEAR) and readmitted on (MONTH) 9, 2019, with [DIAGNOSES REDACTED]. The admission Minimum Data Set assessment dated (MONTH) 7, (YEAR) revealed a Brief Interview for Mental Status score of 13, which indicated the resident had intact cognition. Review of the clinical record revealed a physician order [REDACTED]. Review of the Medication Administration Record [REDACTED]. Continued reviewed of the physician's orders [REDACTED]. Review of the MAR for (MONTH) 2019 revealed the resident was administered [MEDICATION NAME] on (MONTH) 4, 5, and 15, 2019 Additional review of the clinical record revealed a physician order [REDACTED]. Review of the MAR for (MONTH) 2019 revealed the resident was administered [MEDICATION NAME] on (MONTH) 17, 2019. However, further review of the clinical record did not reveal evidence that the resident had been informed of the risks and benefits of [MEDICATION NAME]. An interview was conducted with a Registered Nurse (RN/staff #14) on (MONTH) 22, 2109 at 10:56 a.m. The RN stated that informed consent has to be obtained before a resident is administered a [MEDICAL CONDITION] medication. She stated that the informed consent form is completed which includes the medication name, the reason the medications is ordered, and the risk and benefits of the medication. She also stated that the resident would have to sign the form indicating that they agree or disagree to take the medication. During an interview conducted with the Director of Nursing (DON/staff #72) on (MONTH) 22, 2019 at 1:47 p.m., the DON stated that her expectation is that staff obtains informed consent prior to the administration of a [MEDICAL CONDITION] medication. Later that day at 1:56 p.m., the DON stated that she was unable to find documentation that informed consent had been obtain for [MEDICATION NAME]. Review of the facility's policy on psychoactive medication revealed the use of psychoactive medication must first be explained to the resident. The policy included the potential risk and benefits must be explained to the resident and consent has to be obtained from the resident. The policy also included the person obtaining the consent is to sign the consent once obtained.
F 0578 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interviews, the facility failed to ensure advanced directives were consistent in the clinical record for one of twelve sampled residents (#2). The census was 43. The deficient practice could result in residents receiving services which are not in accordance with their wishes. Findings include: Resident #2 was admitted on (MONTH) 30, (YEAR) and readmitted (MONTH) 9, 2019 with [DIAGNOSES REDACTED]. Review of the clinical record revealed an Advanced Directive/Medical Treatment Decisions form that the resident's choice was DNR (Do Not Resuscitate). The form revealed documentation that a verbal consent was obtained from the resident's Power of Attorney (POA) on (MONTH) 30, (YEAR) and that the POA signed the form on (MONTH) 1, (YEAR). An orange DNR form dated (MONTH) 2, (YEAR) was noted in the Health Records/Advanced Directive book at the nurses' station as well as the Advanced Directive form that the resident was a DNR. The admission Minimum Data Set assessment dated (MONTH) 7, (YEAR) revealed a Brief Interview for Mental Status score of 13, which indicated the resident had intact cognition. Review of a social service note dated (MONTH) 7, (YEAR) revealed the resident's advance directives choice was DNR. Continued review of the clinical record revealed a physician order [REDACTED]. A physician's orders [REDACTED]. Review of a social service note dated (MONTH) 16, 2019 revealed the resident's code status was CPR. A Nursing Home to Hospital Transfer form dated (MONTH) 24, 2019 revealed the resident code status was CPR/Full Code. However, further review of the clinical record did not reveal documentation that the resident or the resident's representative had changed the Advanced Directives to CPR/Full Code. On (MONTH) 22, 2019 at 10:47 a.m., the medical records supervisor (staff #) stated that the resident's advanced directives are kept in the resident's Health Records/Advanced Directives book at the nurses' station and that she updates the book daily. During an interview conducted with a Certified Nursing Assistant (CNA/staff #55) on (MONTH) 22, 2019 at 10:50 a.m., the CNA reviewed the Health Records/Advanced Directive book at the nurses' station and stated that the resident is a DNR and that she would not resuscitate the resident. An interview was conducted with a Registered Nurse (RN/staff #14) on (MONTH) 22, 2019 at 10:56 a.m. The RN stated that if a resident stopped breathing, she would have to ask someone to check to see if the resident was a DNR or a Full Code. She stated that she would know from the electronic record information bar at the top of the resident's page, but that they always double check the Health Records/Advanced Directives book at the nurses' station before proceeding. The RN reviewed the resident's status in the electronic record and stated the resident was a a full code. After reviewing the advanced directive form, she stated that the resident should be a DNR. The RN stated that there was a risk that if the nurse went off of what the electronic record stated, the nurse would do CPR which is not the resident's choice.

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

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F 0578 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) Another interview was conducted with medical records supervisor on (MONTH) 22, 2019 at 12:26 p.m. She stated that resident #2 is a full code per the electronic record. She stated that the nurse would look at the electronic record and the Health Records/Advanced Directives book at the nurse's station to find out the resident's code status. She stated that the order in the electronic record should match the decision on the advanced directive form. After reviewing the resident's Advanced Directive Form stating the resident was a DNR, she stated that there was a very bad risk of the resident's wishes not being followed if the order did not match the Advanced Directive form. An interview was conducted with the Director of Nursing (DON/staff #72) (MONTH) 22, 2019 at 12:29 p.m. The DON stated that advance directives information is obtained from residents upon admission. She stated that if a resident or their representative wished to changed their advance directives, another advanced directives form would be completed and a physician's orders [REDACTED].
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 review, staff interviews, the Resident Assessment Instrument (RAI) manual and policy review, the facility failed to ensure Minimum Data Set (MDS) assessments for 2 of 12 sampled residents (#4 and #6) were accurate. This deficient practice could result in care plans not accurately reflecting the residents' status and could affect residents' continuity of care. Findings include: -Resident #4 was admitted to the facility on (MONTH) 16, (YEAR), with [DIAGNOSES REDACTED]. Review of the clinical record revealed physician's orders [REDACTED]. sterile gauze to wound bed and to cover with dry dressing every shift for wound care; and to cleanse the left heel with wound cleanser, pat dry, apply [MEDICATION NAME], and cover with foam dressing on day shift every third day. The nursing progress notes dated (MONTH) 16, (YEAR), revealed the resident had a chronic indwelling urinary catheter in place. Review of the Treatment Administration Record (TAR) dated (MONTH) (YEAR) revealed treatments were provided to the resident's sacral pressure ulcer and left heel wound and that indwelling urinary catheter care was provided. A physician's admission progress note dated (MONTH) 17, (YEAR) revealed the resident was hard of hearing and that the resident had a chronic indwelling urinary catheter. A case manager progress note dated (MONTH) 18, (YEAR) revealed the resident required headphones with a hearing device in order to hear clearly. However, review of the admission MDS assessment dated (MONTH) 23, (YEAR) revealed the resident was occasionally incontinent, had an ostomy, was not provided pressure ulcer care, and did not use hearing appliances. Further review of the clinical record did not reveal documentation that the resident had an ostomy. Additionally, review of the 14 day Prospective Payment System (PPS) MDS assessment dated (MONTH) 30, (YEAR) revealed the resident was always incontinent and did not have a pressure ulcer. Review of the TAR for (MONTH) 2019 revealed the resident continued to have the indwelling urinary catheter and was receiving pressure ulcer care. However, review of the discharge MDS assessment dated (MONTH) 18, 2019 revealed the resident was occasionally incontinent and did not receive pressure ulcer care. An interview was conducted with a Certified Nursing Assistant (CNA/staff #21) on (MONTH) 21, 2019 at 9:33 a.m. He stated that the resident had an indwelling urinary catheter and that the CNA documentation of incontinent episodes was not accurate as the resident should have been documented as not rated for urinary incontinence. He stated that to his knowledge the resident has never had an ostomy. An interview was conducted with the MDS Licensed Practical Nurse (staff #10) on (MONTH) 21, 2019 at 9:51 a.m. He stated that the expectation is that the MDS assessments be 100% accurate. He stated that he uses the RAI manual to code the assessments. Staff #10 stated that at times resident #4 does not understand him but that he thought her hearing was adequate at the time of the admission assessment. He stated that the ostomy was coded in error on the admission MDS assessment. Staff #10 also stated that urinary incontinence should not have been coded on the MDS assessments and that the pressure ulcer care should have been coded on the MDS assessments. During an interview conducted with the Director of Nursing (DON/staff #72) on (MONTH) 21, 2019 at 12:45 p.m., she stated that her expectation is that the MDS assessments be accurate. The RAI manual instructs to review the clinical record, including skin care flow sheets or other skin tracking forms, speak with direct care staff and the treatment nurse, and to examine the resident to determine whether any pressure ulcers are present. The manual also instructs to review the clinical record, including treatment records and health care provider orders for documented skin treatments during the past 7 days. The RAI manual also included speaking with direct care staff and the treatment nurse to confirm conclusions from the clinical record review and to code the care provided. Further review of the RAI manual revealed the resident should be examined for the presence of any ostomies and to review the clinical record for documentation of ostomies. The manual also included that urinary continence should be coded not rated for residents that have an indwelling bladder catheter during the 7 day look-back period. The RAI manual instructs that prior to beginning the hearing assessment, determine if the resident uses a hearing aid or other hearing appliances by asking the resident, checking the clinical record, and asking staff and significant others. Ensure the resident is using his or her normal hearing appliance and that the hearing appliance is operational. The manual included some residents by choice may use hearing amplifiers or a microphone and headphones as an alternative to hearing aids. The manual also instructs to code yes if the resident did use a hearing aid or other hearing appliance for the hearing assessment. -Resident #6 was admitted to the facility on (MONTH) 26, (YEAR) with [DIAGNOSES REDACTED]. Review of a daily skilled nursing note dated (MONTH) 22, (YEAR), revealed the resident was alert and oriented to person, place, and time. Review of a social services assessment dated (MONTH) 1, 2019 revealed the resident was alert and oriented to person, place, time and is able to make needs known. However, review of the quarterly MDS assessment dated (MONTH) 3, 2019, revealed a Brief Interview for Mental Status (BIMS) was not conducted. An interview was conducted with social services (staff #38) on (MONTH) 21, 2019 at 9:53 a.m. She stated that she is responsible for completing the cognitive patterns which includes the BIMS of the MDS assessment. After reviewing the quarterly MDS assessment for resident #6, she stated the BIMS was not conducted. During an interview conducted with the MDS coordinator (staff #10) on (MONTH) 21, 2019 at 10:13 a.m., the MDS coordinator stated that social services completes the cognitive patterns portion of the MDS assessment which includes the BIMS. He stated that he will review the completed MDS assessment before it is transmitted. After reviewing the quarterly MDS assessment for resident #6, he stated that the BIMS portion of the assessment was not conducted and that it was an error. The facility's policy dated (MONTH) (YEAR) for Accuracy of Resident Assessment revealed it is the facility's policy to ensure that the assessment accurately reflects the resident's status. The policy included that the purpose is to assure that each resident receives an accurate assessment by staff that are qualified to assess relevant care areas and knowledgeable about the resident's status, needs, strengths, and areas of decline. The RAI manual revealed a structured cognitive test is more accurate and reliable than observation alone for observing cognitive performance. The manual included that without an attempted structured cognitive interview, a resident might be mislabeled based on his or her appearance or assumed diagnosis. The manual also included structured interviews will efficiently provide insight into the resident's current condition that will enhance good care and will assist in identifying needed supports. The manual instructs to attempt to conduct the interview with all residents. Additional review of the RAI manual for the MDS revealed the importance of accurately completing and submitting the MDS assessment cannot be over emphasized. The MDS assessment is the basis for the development of an individualized care plan.
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**

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F 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) Based on clinical record review, staff interviews, and policy review, the facility failed to meet professional standards of quality, by failing to ensure one of five sampled residents (#2) was administered a medication as ordered by the physician. The deficient practice could result in a decrease in blood pressure. Findings include: Resident #2 was readmitted on (MONTH) 9, 2019, with [DIAGNOSES REDACTED]. Review of the clinical record revealed a physician's orders [REDACTED]. Review of the MAR for (MONTH) 2019 revealed [MEDICATION NAME] was not administered 4 times for systolic blood pressures less than 120. An interview was conducted with the LPN (staff #59) on (MONTH) 22, 2019 at 1:45 p.m. The LPN stated that medications are to be administered according to the parameters ordered by the physician. During an interview conducted with the DON (staff #72) on (MONTH) 22, 2019 at 1:47 a.m., the DON stated that her expectation is that the nurses administer medications according to the parameters ordered by the physician. After reviewing resident #2's clinical record, the DON stated that [MEDICATION NAME] was not administered according to the physician's orders [REDACTED].>The facility's policy regarding administration of drugs revealed medications must be administered in accordance with the written orders of the attending physician.
F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record reviews, staff interviews, facility documentation and policy and procedures, the facility failed to ensure that care and treatments were provided to 1 of 3 sampled residents (#4) who developed an unstageable pressure ulcer, and by failing to provide care and treatments for two additional pressure ulcers which were present upon admission. There were five residents in the facility who were identified as having pressure ulcers. The deficient practice could result in delayed wound healing and/or deterioration of wounds. Findings include: Resident #4 admitted to the facility on (MONTH) 16, (YEAR) and readmitted to the facility on (MONTH) 29, 2019, with [DIAGNOSES REDACTED]. A nursing progress note dated (MONTH) 16, (YEAR) included the resident was admitted with a large stage 4 sacral ulcer and had a chronic indwelling urinary catheter in place. Regarding the right thigh pressure ulcers: Physician orders dated (MONTH) 16, (YEAR) included for an indwelling urinary catheter for a [DIAGNOSES REDACTED]. Review of the clinical record revealed no documentation that the resident was admitted with any pressure ulcers to the right thigh. An admission Minimum Data Set (MDS) assessment dated (MONTH) 23, (YEAR) revealed the resident had a Brief Interview for Mental Status (BIMS) score of 6, which indicated severe cognitive impairment. Per the MDS, the resident required extensive assistance with bed mobility, transfers and toileting, was always incontinent of bowel and had an indwelling urinary catheter. Review of the (MONTH) (YEAR) Treatment Administration Record (TAR) revealed that catheter care was not completed on the night shift on (MONTH) 17 and 25. Review of the clinical record revealed there was no weekly skin evaluation which was completed the week of (MONTH) 23-29, (YEAR). Another physician's order dated (MONTH) 6, 2019 included for an indwelling urinary catheter for [MEDICAL CONDITION]. The (MONTH) 2019 TAR revealed the order for catheter care, however, there was no documentation that catheter care was provided on (MONTH) 1, 8 or 13 (on the night shift) or (MONTH) 15 (on the day and night shift). Further review of the clinical record revealed no documentation that a weekly skin evaluation was completed from (MONTH) 13-18, 2019. The clinical record documentation showed that the resident was admitted to the hospital on (MONTH) 18, 2019 for altered mental status and readmitted on (MONTH) 29, 2019. Review of the re-admission physician's orders dated (MONTH) 29, 2019, revealed for an indwelling catheter for [MEDICAL CONDITION]/urine retention, a bariatric low air loss mattress for decubitus precautions and for weekly skin checks. Upon re-admission, there was no clinical record documentation that the resident had any pressure ulcers to the right thigh. A provider's progress note dated (MONTH) 5, 2019 included the resident had an indwelling urinary catheter for compromised skin condition. A weekly skin assessment dated (MONTH) 5, 2019 revealed there were no skin issues to the right thigh. A care plan initiated on (MONTH) 6, 2019 included the resident was at risk for further pressure ulcer development related to immobility, incontinence, diabetes mellitus and [MEDICAL CONDITION]. The care plan included for an indwelling catheter to promote wound healing with a goal that the resident will remain free from catheter related trauma. An intervention included to provide catheter care every shift and as needed. Further review of the pressure ulcer care plan revealed it was revised on (MONTH) 9, 2019 to include that the resident had a right inner thigh pressure ulcer, due to the indwelling urinary catheter. The care plan included the resident was at risk of her condition worsening due to non-adherence with plan of care, as the resident does not like pillows or other assistive devices separating her legs. The goal included there will be signs of improved healing through the next review date. Interventions included the following: administer treatments as ordered and monitor for effectiveness; assess/record/monitor wound healing; measure length, width and depth where possible; assess and document status of wound perimeter, wound bed and healing progress; report improvements and declines to the medical doctor; catheter tubing re-routed to avoid inner thigh area; continue to educate and encourage resident on keeping padding in place to inner thighs; needs monitoring/reminding/assistance to turn/reposition; padding applied between legs to decrease pressure to the area; and weekly head to toe skin at risk assessment. Although the care plan identified that the resident was non compliant with keeping pillows or other assistive devices to keep her legs separated, there was no clinical record documentation of the resident's non compliance prior to (MONTH) 9. In addition, there was no clinical record documentation that a treatment order was obtained on (MONTH) 9 or 10, or that a thorough assessment of the right inner thigh pressure ulcer was conducted on (MONTH) 9, 10 or 11, 2019, which included any measurements, description of the wound bed and surrounding skin, staging of the pressure ulcer and if any drainage was present. A physician's progress noted dated (MONTH) 11, 2019 included the resident had new groin wounds, however, there was no description of the wounds. A physician's order for wound treatment was obtained on (MONTH) 11, 2019, two days after the pressure ulcer to the right thigh was identified. The order included to cleanse the right medial thigh pressure ulcer with normal saline, apply xeroform and cover with a dry sterile dressing every 24 hours. Review of the physician's progress note (MONTH) 12, 2019, revealed the resident had an ulceration on the right medial inner thigh (upper lid caused by the Foley catheter). There is mild thinning slough with scant serous drainage. No peri-wound inflammation. The note further included that the resident has a medical device associated ulceration to the right medial inner thigh. This note did not include any measurements. Review of a weekly pressure ulcer assessment dated (MONTH) 13, 2019 revealed the resident had a lower right inner thigh wound, with an onset date of (MONTH) 9. The wound was described as an unstageable pressure ulcer that measured 15.5 cm length by 1 cm, and the wound bed had slough with undefined wound edges with a small amount of serous exudate. This was the first documentation of any measurements to the right thigh pressure ulcer, since it was identified on (MONTH) 9. This same weekly pressure ulcer assessment dated (MONTH) 13, 2019 also included documentation that the resident now had a second pressure ulcer to the upper right inner thigh, which was a stage 2. The wound measured 18.5 cm length by 1 cm width with a pink wound bed and undefined edges and had a small amount of serous exudate. There was no physician ordered treatment for [REDACTED]. A wound care nurse practitioner progress note dated (MONTH) 21, 2019 revealed the resident had two ulcerations on the right medial inner thighs. The superior ulceration had minimal slough and the inferior ulceration had mild slough, with minimal granulation. No measurements were documented. The note indicated the wounds were medical device associated ulcerations. The

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F 0686

Level of harm - Actual harm

Residents Affected - Few

(continued... from page 3)
note also included that a curette was used to remove slough from the right thigh.
Review of the weekly pressure ulcer assessment dated (MONTH) 24, 2019 revealed the resident had an unstageable pressure ulcer to the right medial inner thigh, which measured 13.5 cm length by 1 cm width. The wound had a small amount of serous exudate and slough in the wound bed, with undefined wound edges. The note further included that the stage 2 pressure ulcer had healed.
A nurse practitioner wound care note dated (MONTH) 26, 2019 revealed the medical device ulceration on the right medial inner thigh was improving and the superior ulceration has 100% re-[MEDICATION NAME] and the inferior ulceration has mild thin slough and mild granulation.
A physician's order dated (MONTH) 27, 2019 included to cleanse the right medial thigh with wound cleanser, pat dry, apply [MEDICATION NAME], then apply a thin strip of xeroform and cover with a dry dressing for moisture associated skin damage.
Review of the CNA documentation regarding assistance provided to the resident with bed mobility and turning and repositioning revealed no documentation of any assistance that was provided on (MONTH) 2, 6, 9, 18, 20, 23, 26, and 28, 2019 on the night shift. Regarding toileting assistance revealed no documentation that assistance was provided on (MONTH) 2, 9, 18, 20, 23, and 26, 2019 on the night shift. Regarding pressure ulcer devices in place revealed no documentation of any devices on (MONTH) 2, 6, 9, 18, 20, 23, 26 and 28, 2019 on the night shift.
A physician's wound care progress note dated (MONTH) 5, 2019 revealed the right medial thigh ulceration was improving, with [MEDICATION NAME] of the edges and thin slough on the wound bed.
Review of the weekly pressure ulcer assessment dated (MONTH) 6, 2019 revealed the resident had an unstageable pressure ulcer to the right medial thigh with an onset date of (MONTH) 9, 2019 which measured 13.2 length and width and 1 cm depth. The wound had a small amount of serosanguinous exudate with slough in the wound bed and defined edges. Only one thigh wound was documented.
Review of the weekly pressure ulcer assessment dated (MONTH) 13, 2019 revealed the resident had an unstageable pressure ulcer to the right medial thigh, with an onset date of (MONTH) 9, 2019. The wound measured 9.5 cm length by 0.5 cm width by 0.2 cm depth with slough in the wound bed and undefined edges, and had a scant amount of serous exudate.
Another physician's order dated (MONTH) 15, 2019 included for an indwelling catheter for wound management.
Review of the CNA documentation regarding assistance provided to the resident with bed mobility revealed no documentation of any assistance that was provided on (MONTH) 2, 4, 9, 10, 13, 17, 19, 2019 on the night shift. Regarding assistance provided with turning and repositioning revealed no assistance was provided on (MONTH) 2, 4, 9, 10, 13, 17, 20, 2019 on the night shift. Regarding assistance with toilet use revealed no documentation of assistance provided on (MONTH) 2, 4, 9, 10, 13, 17, 19, 2019 on the night shift. Regarding documentation of pressure ulcer devices in place revealed no documentation on (MONTH) 2, 9, 10, 13, 17, 20, 2019 on the night shift.
A Nurse Practitioner wound progress note dated (MONTH) 19, 2019 revealed the right thigh ulceration had resolved.
A wound care observation of the resident was performed on (MONTH) 20, 2019 at 9:21 a.m., with the wound care certified Licensed Practical Nurse (LPN/staff #19). The resident was observed to be lying on her back in bed. There was a long thin strip of lightened skin noted to the inner right medial thigh, which was identified by the wound nurse as the newly healed pressure area that had been caused by the catheter tubing. The resident was not observed to have any open wounds to the right thigh.
An interview was conducted with staff #19 on (MONTH) 20, 2019 at 10:06 a.m. He stated that the catheter caused the thigh wounds. He stated they assess residents for any items that could cause pressure injury, and that the catheter related wounds to the thigh could have been prevented by staff.
Regarding the stage 4 sacral pressure ulcer:
A nursing progress note dated (MONTH) 16, (YEAR) documented the resident was admitted with a large stage 4 sacral ulcer.
Review of the Braden Scale for Predicting Pressure Sore Risk dated (MONTH) 16, (YEAR), revealed the resident was at low risk, despite having a stage 4 pressure ulcer.
A physician's order dated (MONTH) 16, (YEAR) included to cleanse the sacral pressure ulcer with wound cleanser, pat dry, apply 1/4 strength Dakin's soaked sterile gauze to the wound bed and cover with a dry dressing.
Further review of the clinical record revealed no documentation that the stage 4 pressure ulcer was thoroughly assessed on (MONTH) 16 or 17, (YEAR), which included any measurements, a description of the wound bed and surrounding skin and if any drainage was present.
Review of the (MONTH) (YEAR) TAR revealed no documentation that the physician ordered treatment was provided to the sacral wound on (MONTH) 17 (night shift).
A physician's progress note dated (MONTH) 17, (YEAR) included the resident had a chronic indwelling urinary catheter for a stage 4 sacral wound.
A weekly pressure ulcer assessment was completed on (MONTH) 18, (YEAR) and revealed that the resident had a very large stage 4 sacral pressure ulceration, which was present on admit. The wound was described as having exposed necrotic bone and heavy necrotic soft eschar to the wound bed, with slough and no significant granulation. The wound had heavy serous to brownish drainage with moderate odor on dressing removal and no peri-wound inflammation was present. The was the first assessment of the stage 4 sacral pressure ulcer, which was done two days after admission. The assessment also did not include any wound measurements.
A physician's wound progress note dated (MONTH) 18, (YEAR) included the resident has a very large sacral ulceration, with exposed necrotic bone on the wound bed. There is heavy necrotic soft eschar on the wound bed with slough. No significant granulation. Heavy serous to brownish drainage with moderate odor on dressing removal. No periwound inflammation. The plan included to turn the resident per facility protocol, continue dressing the sacral ulceration and a nutrition consultation. No measurements were included.
A care plan dated (MONTH) 18, (YEAR) identified a problem of actual impairment to skin integrity related to pressure injury to the sacrum. A goal was that the resident would be free of injury though the next review date. Approaches included to educate resident/family/caregivers on causative factors and measures to prevent skin injury; follow facility protocols for treatment of [REDACTED].
Review of the admission Minimum Data Set (MDS) assessment dated (MONTH) 23, (YEAR), revealed the resident was always incontinent of bowel and had an indwelling catheter. The MDS also included that the resident had a stage 4 pressure ulcer, which was present on admission.
Review of the (MONTH) (YEAR) TAR revealed no documentation that the physician ordered treatment was provided to the sacral wound on (MONTH) 24 and 25 (day and night shifts) and on (MONTH) 29 (day shift).
Review of the Braden Scale for Predicting Pressure Sore Risk dated (MONTH) 31, (YEAR) revealed the resident was at moderate risk.
Review of the CNA documentation regarding assistance provided to the resident with bed mobility and toileting revealed no documentation of assistance provided on (MONTH) 20, 28, 29 or 31, (YEAR) on the night shift or on (MONTH) 30 on the day shift. Regarding assistance provided with turning and repositioning revealed no documentation of assistance provided on (MONTH) 16, 20, 28, 29 or 31, (YEAR) on the night shift or on (MONTH) 30 on the day shift. Regarding pressure ulcer devices in place revealed no documentation on (MONTH) 20, 28, 29 or 31, (YEAR) on the night shift and (MONTH) 30 on the day shift.
Review of the (MONTH) 2019 TAR revealed no documentation that the physician ordered treatment to the sacral pressure ulcer was provided on the night shift on (MONTH) 1, 6 and 8.
The next assessment of the sacral pressure ulcer was conducted nineteen days after the last assessment (which was done on (MONTH) 18). Per the weekly pressure ulcer assessment dated (MONTH) 7, 2019, the resident had a stage 4 pressure ulcer to the sacrum. The measurements were unclear as they were written as follows: 5.3.5 length and width, with a depth of 2.5 cm. The wound bed was described as beefy red, with attached wound edges and no exudate. This was the first documentation of any measurements of the stage 4 sacral pressure ulcer.
A physician's order dated (MONTH) 9, 2019 included to cleanse the sacrum every day shift with wound cleanser, pat dry, apply Santyl ointment 250 units per gram to wound bed, apply [MEDICATION NAME] and cover with an island dressing.
Physician orders dated (MONTH) 11, 2019 revealed to cleanse the sacrum with wound cleanser, pat dry, use skin prep to peri-wound, drape with tape, apply black foam to wound bed, apply wound vac at 125 millimeters of mercury (mmHg) continuous.
Physician orders dated (MONTH) 12, 2019 included to discontinue the Santyl dressing once the wound vac was available.

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NAME OF PROVIDER OF SUPPLIER **HERITAGE COURT POST ACUTE OF SCOTTSDALE**		STREET ADDRESS, CITY, STATE, ZIP **3339 NORTH DRINKWATER BOULEVARD SCOTTSDALE, AZ 85251**	

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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 0686 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 4) A weekly pressure ulcer assessment dated (MONTH) 14, 2019 revealed the resident had a very large sacral pressure ulcer stage 4, with exposed necrotic bone and heavy necrotic soft eschar on the wound bed with slough and no significant granulation. The assessment further noted heavy serous to brownish drainage with moderate odor on dressing removal and no peri-wound inflammation. The assessment did not include any wound measurements. A physician's order dated (MONTH) 15, 2019 revealed to cleanse the sacrum with wound cleanser, gently pack Dakin's 0.25% soaked Kerlix into wound bed and cover with an island dressing. Another treatment order dated (MONTH) 15, 2019 regarding the wound vac included to cleanse the sacrum with wound cleanser, pat dry, use skin prep to peri-wound, drape with tape, apply black foam to wound bed and apply wound vac at 125 millimeters of mercury (mmHg) continuous. Review of the (MONTH) 2019 TAR revealed no documentation that the sacral wound care was provided on (MONTH) 15. Review of the CNA documentation regarding assistance provided to the resident with bed mobility, toilet use and turning and repositioning revealed no documentation of assistance provided on (MONTH) 4, 5, 9, 12, 14, 2019 on the night shift and (MONTH) 17 on the day shift. Regarding pressure ulcer devices in place revealed no documentation on (MONTH) 4, 5, 9,12,14, 2019 on the night shift and (MONTH) 17 on the day shift. The clinical record documentation showed that the resident was admitted to the hospital on (MONTH) 18, and readmitted to the facility on (MONTH) 29, 2019. Review of the weekly pressure ulcer assessment dated (MONTH) 29, 2019 revealed the resident had a stage 4 pressure ulcer to the sacrum that was a deep beefy red full thickness wound and measured 9.5 cm in length by 11 cm in width by 5 cm in depth. The wound was described as now having 3 cm of undermining, moderate serosanguinous exudate with no odor and defined edges. This is the first documentation of clear measurements of the stage 4 sacral pressure ulcer. The physician orders dated (MONTH) 29, 2019 included to cleanse the sacral wound with wound cleanser or normal saline, apply wet to moist dressing with Dakin's and secure with tape every 12 hours until wound vac can be placed. A physician's order dated (MONTH) 29, 2019 included to cleanse the sacrum with wound cleanser, pat dry, apply no sting barrier skin prep to peri-wound skin, window frame wound with drape, apply black foam to sacral wounds, secure with additional drape, suction at continuous 125 mmHg. The order also included to change wound vac on Tuesday, Thursday, and Saturday, and as needed for malfunction or dislodgement and to monitor wound vac every shift for functioning and placement.Review of the provider's progress note dated (MONTH) 30, 2019 included the resident was admitted to the facility for rehabilitation and for wound care for a stage 4 decubitus ulcer of the sacral region and sacral osteo[DIAGNOSES REDACTED]. The note included that the sacral ulcer measured 7 cm by 6 cm by 5 cm and contained eschar/necrosis through to the muscle, tendon or bone. The note indicated to continue current dressing orders for wound care. Physician orders dated (MONTH) 2, 2019 included to cleanse the sacral wound with wound cleanser or normal saline, apply wet to moist dressing with Dakin's and secure with tape every 12 hours until wound vac can be placed started which was discontinued (MONTH) 6, 2019. A weekly pressure ulcer assessment dated (MONTH) 4, 2019 revealed the stage 4 pressure ulcer to the sacrum measured 9.5 cm length by 11 cm width, by 5 cm depth and 3 cm undermining. The wound bed was described as beefy red with no slough or eschar and has a moderate amount of serosanguinous exudate that now has a foul odor. A provider progress note dated (MONTH) 5, 2019 included the sacral ulcer measured 6 cm by 12.5 cm by 2.7 cm and contained eschar/necrosis through to the muscle, tendon or bone, and to continue current dressing orders. A care plan was initiated on (MONTH) 6, 2019 to reflect that the resident has a pressure ulcer to the sacrum and is at risk for further pressure ulcer development related to immobility, incontinence, diabetes mellitus and [MEDICAL CONDITION]. A goal included that the pressure ulcer will show signs of healing and remain free from infection. Interventions were as follows: administer treatments as ordered and monitor for effectiveness; assess/record/monitor wound healing, measure length, width and depth where possible; assess and document status of wound perimeter, wound bed and healing progress; report improvements and declines to the medical doctor; weekly head to toe skin at risk assessments and needs monitoring/reminding/assistance to turn and reposition. Review of the (MONTH) 2019 TAR revealed no documentation that wound vac monitoring was provided on (MONTH) 10. A physician's order dated (MONTH) 11, 2019 included to cleanse the sacrum wound with wound cleanser or normal saline, apply Dakin's 0.25% wet to moist dressing, cover with dressing and secure with tape every 12 hours. The next weekly pressure assessment was dated (MONTH) 13, 2019, which was nine day after the previous assessment (done on (MONTH) 4). The documentation revealed the stage 4 sacral pressure ulcer measured 7 cm length by 12 cm width by 4.5 cm depth, with 2.8 cm undermining. The wound bed was described as beefy red with a moderate amount of serosanguinous drainage, with no odor. The weekly pressure ulcer assessment dated (MONTH) 24, 2019 revealed the stage 4 sacral pressure ulcer measured 10 cm length by 7 cm width by 3.5 cm depth, with no undermining. The wound bed was described as beefy red with a moderate amount of serosanguinous drainage, with no odor. The next weekly pressure ulcer assessment was dated (MONTH) 6, 2019, which was 10 days after the previous assessment. The stage 4 sacral pressure ulcer measured 10 cm length by 6.8 cm width by 3.4 cm depth, with tunneling of 2.8 cm. The wound bed was described as having slough with a small amount of serosanguinous drainage, with no odor. Review of the weekly pressure ulcer assessment dated (MONTH) 13, 2019 revealed the stage 4 sacral pressure ulcer measured 9.2 cm length by 5.3 cm width by 3 cm depth and tunneling of 2.8 cm. The wound bed was described as beefy red with a moderate amount of serosanguinous drainage, with no odor and the wound edges are now rolling under. A wound observation of the resident was performed on (MONTH) 20, 2019 at 9:21 a.m. with a LPN/staff #19. The resident was observed lying on her back in bed. There was an intact dressing to the sacral area,with yellow, pinkish drainage to the dressing. Upon removal of the old dressing and packing, an odor was identified. The resident was observed to have a large deep oval pressure ulcer to the sacrum. The wound bed had a deep pink base with rolled edges and undermining was present. Staff #19 measured the wound and was 8.5 cm length 5.3 cm width by 2.5 cm deep, with tunneling of 2.3 cm between 10 to 1. The wound was identified by staff #19, as a stage 4 pressure wound which was present on admit. The weekly pressure ulcer assessment dated (MONTH) 20, 2019 revealed the stage 4 sacral pressure ulcer measured 8.5 cm length by 5.3 cm width by 2.5 cm depth and tunneling of 2.3 cm. The wound bed was described as normal for skin and had a moderate amount of serosanguinous drainage, with no odor and the wound edges are now undefined. Review of the CNA documentation regarding assistance provided to the resident with bed mobility revealed no documentation of assist provided on (MONTH) 2, 4, 9, 10, 13, 17, 19, 2019 on the night shift. Regarding assistance with turning and repositioning revealed no documentation of assistance provided on (MONTH) 2, 4, 9, 10, 13, 17, 20, 2019 on the night shift. Regarding assistance with toilet use revealed no documentation of assistance provided on (MONTH) 2, 4, 9, 10, 13, 17, 19, 2019 on the night shift. Regarding pressure ulcer devices in place revealed no documentation on (MONTH) 2, 9, 10, 13, 17, 20, 2019 on the night shift. Regarding the left heel deep tissue injury: According to the initial admission record dated (MONTH) 16, (YEAR), the resident was identified to have a superficial deep tissue injury (DTI) to the left heel. A physician's order dated (MONTH) 16, (YEAR) included to float heels as tolerated. Review of the (MONTH) (YEAR) TAR revealed no documentation that the heels were floated on (MONTH) 17, on the night shift. A physician's order was obtained on (MONTH) 17, (YEAR) to cleanse the left heel with wound cleanser, pat dry, apply [MEDICATION NAME], and cover with foam dressing. A care plan dated (MONTH) 18, (YEAR) identified a problem of actual impairment to skin integrity related to pressure injuries to the left and right heel. A goal included the resident would be free of injury though the review date. Approaches included to educate resident/family/caregivers on causative factors and measures to prevent skin injury; follow facility protocols for treatment of [REDACTED]. Review of the (MONTH) (YEAR) TAR revealed no documentation that the heel wound treatment was provided on (MONTH) 29. Review of the clinical record revealed no documentation that a weekly skin assessment was completed during the week of (MONTH) 23-29, (YEAR). A weekly skin evaluation dated (MONTH) 31, (YEAR) revealed the resident's bilateral heels were non blanchable. According to the (MONTH) 2019 TAR, there was no documentation that the resident's heels were floated on (MONTH) 1, 8 and 13 on the night shift and on (MONTH) 15 (day and night shift).

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F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 5) A weekly skin evaluation dated (MONTH) 7, 2019 included the bilateral heels had healed. A wound care observation was performed on (MONTH) 20, 2019 at 9:21 a.m. The resident was not observed to have any wounds to the heels. An interview was conducted with a Certified Nursing Assistant (staff #42) on (MONTH) 20, 2019 at 1:59 p.m. She stated that residents would be at risk for pressure ulcers if staff were not cleansing residents well after incontinence, if left in a wet brief, and if a resident stayed in the same position too long. She stated that residents are repositioned every two hours and receive indwelling catheter care at least one time each eight hour shift by the CNA's. She stated that catheter tubing could cause pressure and staff could place a towel between the skin and catheter tubing and to make sure there is slack in the tubing between the stat Lock (indwelling urinary catheter stabilization device) and the insertion site. She stated that during catheter care, staff should lift the tubing when cleaning and visualize the skin beneath the tubing, and if she noticed any skin changes she would tell the nurse right away to come and assess the area. She stated that a resident should not develop a pressure ulcer under the indwelling urinary catheter tubing. Staff #42 said that she received in-services regarding residents with indwelling catheters and that staff were told to ensure that the skin was intact beneath the indwelling catheter tubing. She stated that during the training the wounds on resident #4's thighs were presented to the CNA's as pressure ulcers and were avoidable. An interview was conducted with a CNA (staff #3) on (MONTH) 20, 2019 at 2:23 p.m. She stated that pressure injuries could result from not positioning a resident often enough and improper placement of the catheter tubing. She stated the catheter tubing should be placed under the stat lock unless the resident refuses. She said that she would immediately report any changes to the skin to the nurse. She stated that resident #4 developed wounds from the indwelling catheter tubing, because the tubing was between her legs and her legs were pressing together which created pressure. She stated the CNA does catheter care every time the brief is changed. She stated that for staff to complete good catheter/peri-care, the resident would need to spread her legs, so staff can lift the catheter tubing to clean it and to look at the skin. She stated that she was told the wounds were pressure ulcers and were caused by the catheter tubing and the wounds should not have occurred. She also stated that residents receive repositioning every two hours. An interview was conducted with a CNA (staff #21) on (MONTH) 21, 2019 at 9:33 a.m. He stated that staff are expected to have 100% of their documentation completed by the end of the shift, and are to document after the care has been completed. He stated that there should not be any blanks in the documentation and if the care is not documented, then there is no proof that they did the care. He stated this resident is pretty compliant with her care. An interview was conducted with a LPN (staff #59) on (MONTH) 21, 2019 at 10:21 a.m. She stated that a resident is at risk for skin breakdown, if they are not repositioned often enough, if anything is sitting on the skin too long, if the resident does not have what they need for pressure relief and outside devices. She stated that an indwelling urinary catheter could cause a pressure injury, if the tubing is improperly placed (example: between areas of skin that are touching) or if a stat lock is improperly located. She stated that staff were told to be careful of the placement of the catheter tubing, and to be sure the stat lock position was being alternated. She stated that pressure wounds from medical devices/indwelling catheters would not be unavoidable. She stated that indwelling catheter care is completed each shift and that good care would include separating the resident's legs, lifting the tube and visualizing the peri area and under the tubing, as well as around the stat lock. She stated that any changes should be reported to the nurse as soon as the care is completed. She stated that she was aware of the pressure ulcer formation from the indwelling catheter tubing on resident #4 and that it was included in the shift to shift report. She stated the CNA's were made aware that the wounds were caused by pressure and were avoidable, and that the wounds could have been prevented with appropriate care and moving of the indwelling catheter tubing. She also stated there should not be blanks in the MARs/TARs and that a blank spot would mean the care was not given. She stated the risk of not doing wound care would be the wound could get worse or not show improvement. Staff #59 said if a resident's heels were not floated, the resident could get pressure ulcers in that area. At this time, she reviewed the holes in the TARs for resident #4 and stated that staff did not follow the expectation of the facility. Another interview was conducted with staff #19 on (MONTH) 21, 2019 at 12:05 p.m. He stated that the procedure followed by the facility for a new resident included assessing the resident's skin integrity. He stated the nurse does a skin assessment during the admission process to identify any skin integrity issues, including wounds. He
F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, resident and staff interviews, facility documentation and policy review, the facility failed to ensure that safety measures and adequate supervision were provided to one resident (#2) who sustained a fall with injuries. The number of residents with falls was 6. The deficient practice could result in further falls with injuries. Findings include: Resident #2 was admitted to the facility on (MONTH) 30, (YEAR) and readmitted (MONTH) 9, 2019, with [DIAGNOSES REDACTED]. Review of a fall risk evaluation dated (MONTH) 30, (YEAR) revealed a fall risk score of 8, which indicated the resident was at medium risk for falls. The initial care plan with an effective date of (MONTH) 30, (YEAR) revealed the resident was at risk for falls. Interventions included keeping the bed in the lowest position and having a floor mat at the bedside. Review of the admission Minimum Data Set (MDS) assessment dated (MONTH) 7, (YEAR) revealed a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident had intact cognition. The assessment included the resident had [MEDICAL CONDITION] and required extensive assistance of two, with bed mobility and toilet use. The MDS also included the resident had no falls within the last 6 months or since admission. The comprehensive care plan dated (MONTH) 11, (YEAR) revealed the resident was at risk for falls with a goal to decrease the likelihood of falls. Interventions included keeping the bed in the lowest position and a floor mat at the bedside. The care plan also included the resident had ADL (activities of daily living) self care deficits related to [MEDICAL CONDITION]. Interventions included keeping the air activated call light within reach and that the resident required total assistance with transfers. Review of a fall risk evaluation dated (MONTH) 9, (YEAR) revealed a fall risk score of 9, which indicated the resident was at medium risk for falls. Review of a nursing progress note dated (MONTH) 24, 2019 at 7:17 a.m., revealed Heard a loud sound at the nursing station minutes after leaving resident's room/after repositioning lower legs back onto the resident lowered bed and medicating him. Resident found lying face down on the floor of his room in a pool of blood at his head . The note included the resident was assessed and observed to have a one and a half inch laceration under the left zygomatic arch, a half inch laceration to the left upper forehead and a slight amount of fresh blood from the left side of his mouth. Neurological assessments were initiated per their protocol. The note also included meticulous perineal care was given to the resident due to having a large formed bowel movement. The note did not include if a floor mat was in place at the time of the fall. The fall risk evaluation dated (MONTH) 24, (YEAR) revealed a fall risk score of 8. A nursing progress note dated (MONTH) 24, 2019 at 8:18 a.m. revealed 4 steri-strips were applied to the left zygomatic arch laceration and was reinforced with a heavy tight compression bandage, due to active bleeding. The note included the resident was transported to the hospital via ambulance. Review of the Nursing Home to Hospital Transfer form dated (MONTH) 24, 2019 revealed the resident was transported to the hospital, due to a fall and that the resident was having facial pain. Review of the hospital After Visit Summary dated (MONTH) 24, 2019, revealed the resident had a closed head injury and facial lacerations. The summary included a CT scan of the head/brain which revealed no evidence of an acute intracranial abnormality. The summary also included sutures were applied to the lacerations. A nursing progress note dated (MONTH) 24, 2019 at 11:45 a.m. revealed the resident returned to the facility via stretcher by medical transport. The note included the resident was observed to have an abrasion to the right shoulder and sutures to the left cheek bone. Review of the fall investigation report dated (MONTH) 24, 2019 revealed the fall occurred in the resident's room and that

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F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 6) the resident stated that he moved his legs off the edge of the bed and fell . The report included the physician was notified and that orders were received to apply steri-strips to the left zygomatic arch and transfer the resident to the hospital. The report did not include documentation if the floor mat was in place at the time of the fall. Review of the Certified Nursing Assistant task documentation for fall prevention devices dated (MONTH) 2019 revealed documentation of a low bed, but did not include documentation that mats were to be on the floor, until after the resident fell . An interdisciplinary team fall committee progress note dated (MONTH) 25, 2019 revealed the fall was reviewed. The note included implementing a low bed with a floor mat to prevent further fall related injuries and that the resident agreed. During an interview conducted with residents on (MONTH) 20, 2019 at 10:13 a.m., they stated that the facility is understaffed and that residents are constantly crying out for help. One of the residents stated that they heard resident #2 calling for help and that he fell out of bed, and the next time they saw him he had stitches all over his face. An observation was conducted of the resident on (MONTH) 22, 2019 at 10:37 a.m. The resident was observed sleeping in the bed with a mat on the floor by the bed. An interview was conducted with resident #2 on (MONTH) 22, 2019 at 12:00 p.m. He stated that he woke up on the edge of the bed and that his call tube (air activated call light) was not next to him so he yelled for about 20 minutes and ended up falling off the edge of the bed. The resident stated that he hit a rolling table as he fell . He also stated that he received two wounds from the fall that required sutures. He stated that only two people were working the floor that day. The resident stated that there was never a mat on the floor beside his bed before he fell . During an interview conducted with a Certified Nursing Assistant (CNA/staff #55) on (MONTH) 22, 2019 at 10:40 a.m., the CNA stated that residents who are fall risks have their beds in the lowest position with the call light in reach, and with mats on the floor. She stated that resident #2 is a fall risk and now has a larger bed, with mats on the floor. An interview was conducted with a Registered Nurse (RN/staff #14) on (MONTH) 22, 2019 at 10:56 a.m. The RN stated that all residents are assessed for fall risk when they are admitted . She stated that for residents who are a fall risk, staff will ensure there is no clutter in the room, the call light is within reach, the bed is in the lowest position, and/or a floor mat is beside the bed. She stated that if the resident is care planned for a floor mat beside the bed, an order should be obtained and it should be on the Treatment Administration Record. The RN stated that resident #2 is at risk for falls and has had a fall. She stated if a floor mat is on his care plan, then there should have been a floor mat beside his bed. The RN also stated a resident's risk for injury is increased when fall interventions are not implemented, and if a floor mat was not in place the resident could hit their head on the floor. An interview was conducted with the Director of Nursing (DON/staff #72) on (MONTH) 22, 2019 at 12:29 p.m. The DON stated residents are assessed for fall risk on admission, quarterly, and as needed after a fall. She stated a fall care plan is initiated with interventions for residents that are assessed at risk for falls. The DON stated if the interventions included a low bed and a floor mat, her expectation is that staff implement the interventions. She also stated that if a floor mat is on the care plan, a physician's order should be obtained. Review of the facility policy titled, Fall Management System revealed each resident is provided with appropriate assessment and interventions to prevent falls and to minimize complications if a fall occurs. The policy included care plan interventions will be developed to prevent falls and will consider the particular elements of the assessment that put the resident at risk. The policy also included each resident is assisted in maintaining their highest practicable level of function, by providing the resident adequate supervision to prevent accidents.
F 0692 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide enough food/fluids to maintain a resident's health.** **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 obtain weights for 1 of 3 sampled residents (#29) who was identified to have severe malnutrition, and failed to modify the plan of care to include additional interventions to address the resident's non compliance. The deficient practice places residents at risk for the potential for nutritional decline. Findings include: Resident #29 was admitted on (MONTH) 20, (YEAR), with [DIAGNOSES REDACTED]. The nursing admission note dated (MONTH) 20, (YEAR) included the resident was admitted at the facility following an 83 day hospitalization stay for a septic open wound. The note included the resident was alert and oriented x 4 and was able to make needs known. A Braden Scale dated (MONTH) 20, (YEAR) included the resident's nutrition was very poor. Clinical record documentation included the resident had a PEG (percutaneous endoscopic gastrostomy) tube in place. Admission physician's orders [REDACTED]. -Regular diet, regular texture and thin liquids -Weekly weights x 4 every day shift for 4 weeks. -Vitamin A (supplement) 1000 units 1 capsule by mouth daily -Vitamin C (supplement) 500 mg (milligrams) 1 tablet by mouth daily -[MEDICATION NAME] (supplement) 325 mg 1 tablet daily -Flush tube feeding with 30 ml water before and after medication administration and after disconnecting tube feeding. A daily skilled note dated (MONTH) 21, (YEAR) included the resident was receiving and tolerating enteral feedings and was receiving pleasure feedings for oral gratification. Review of the clinical record revealed there was no documentation that the resident's weight was obtained on (MONTH) 20 or 21, (YEAR). There was no documentation that the resident refused to be weighed at this time. Review of the dietary admission evaluation dated (MONTH) 21, (YEAR) revealed the resident was on a regular diet, thin liquid consistency and enteral nutrition. The resident's height was 65 inches. Under weight history, it was documented that the resident's weight was 166.54 lbs per a History and Physical (from (MONTH) 8, (YEAR)). This weight was approximately six weeks prior to admission, when the resident was in the hospital. Per the evaluation, the resident had increased protein needs related to nutrient loss as evidenced by wound healing, and that the tube feeding was likely indicated for supplemental nutrition to promote wound healing. Recommendations included for [MEDICATION NAME] (enteral feeding/nutritional supplement) and to continue to monitor oral intake and weight change. A nutritional care plan dated (MONTH) 21, (YEAR) included the resident had a nutritional problem related to increased nutrient needs, due to nutrient loss. Interventions included for medications, supplements, tube feeding, weights as ordered, and to monitor and document intake and report to the physician any signs and symptoms of decreased appetite and unexpected weight loss. According to the meal intake percentages, the resident refused lunch and dinner on (MONTH) 21, (YEAR). A physician's admission note dated (MONTH) 21, (YEAR) included the resident was alert and oriented to person, place and time. Physical examination included the resident was alert and weak appearing and had an extensive sacral open wound with graft. Under assessments, the note included the following Diagnoses: [REDACTED]. Physician orders [REDACTED]. -[MEDICATION NAME] 1.5 (enteral feeding) at 75 ml (milliliters)/hour or until 1500 ml is infused with 30 ml/hour for 20 hours per PEG tube. -Prostat (liquid protein supplement) 30 ml mixed with 60 ml water via tube feeding twice daily or 30 ml by mouth twice daily and may mix with 4 ounces fluid of choice. These orders were transcribed onto the (MONTH) (YEAR) MAR (Medication Administration Record) and revealed the resident refused the [MEDICATION NAME] on (MONTH) 22 for the morning feeding and on (MONTH) 23 for the morning and afternoon feeding.A daily skilled note dated (MONTH) 22, (YEAR) included the resident refused the feeding and the physician was notified. The meal intake percentages included documentation that the resident refused breakfast, lunch and dinner on (MONTH) 22. A physician's note dated (MONTH) 23, (YEAR) included the resident was feeling nauseous on tube feeds. Physical examination included the resident was alert and weak appearing and had protein energy malnutrition, severe malnutrition and was on tube feeding, with oral intake as tolerated. The daily skilled note dated (MONTH) 24, (YEAR) included the resident was alert and oriented x 2, was anorexic and had refused enteral feeding or any food. Per the note, the resident drank a lot of soda.

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F 0692 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 7) Another nursing note dated (MONTH) 24, (YEAR) revealed the resident refused to take any vitamins/minerals. The meal intake percentages also included the resident refused breakfast and lunch on (MONTH) 24, (YEAR). There was no clinical record documentation that the physician was notified that the resident had refused feedings/meals on (MONTH) 24. A daily skilled note dated (MONTH) 25, (YEAR) included the resident refused to eat anything/tube feeding and the physician was notified. Review of the (MONTH) (YEAR) MAR indicated [REDACTED]. The documentation included that a weight was due on (MONTH) 25, however, the area to document the weight was blank. Further review of the (MONTH) (YEAR) MAR indicated [REDACTED]. A physician's progress note dated (MONTH) 26, (YEAR) included the resident had low oral intake. Physical examination included the resident was alert and weak appearing and had [MEDICAL CONDITION] of chronic disease, chronic non healing abdominal wound, protein energy malnutrition and severe malnutrition. The note included the resident was refusing tube feeding, with oral intake as tolerated. Continued review of the clinical record revealed there was no documentation that the resident was weighed from admission through (MONTH) 26, (YEAR), despite the resident frequently refusing tube feedings/meals, Prostat and vitamins/minerals. There was also no documentation that the resident refused to be weighed during this time frame. In addition, there was no evidence that the resident was informed of the risks associated with refusing tube feedings/meals, Prostat and vitamins/minerals, nor was there documentation that the resident was offered any alternatives or that additional interventions were implemented to address the resident's non compliance. An admission MDS (Minimum Data Set) assessment dated (MONTH) 27, (YEAR) included a Brief Interview for Mental Status score of 15, indicating the resident was cognitively intact. The MDS also identified that the resident was on tube feeding, had no swallowing problems and received 51% or more total calories via tube feeding. There was no weight entered in the MDS assessment. A nursing note dated (MONTH) 27, (YEAR) included the tube feeding resumed per the resident's request. A physician's progress note dated (MONTH) 28, (YEAR) revealed the resident was restarted on tube feeding after prolonged discussion with the resident. Physical examination included the resident was alert and weak appearing and had [MEDICAL CONDITION] of chronic disease, chronic non healing abdominal wound, protein energy malnutrition and severe malnutrition. The meal intake percentages included the resident refused lunch on (MONTH) 28. A daily skilled note dated (MONTH) 29, (YEAR) included the resident refused feedings. A physician's orders [REDACTED]. This order was transcribed onto the MAR. Per the MAR, the entry was coded as 1 indicating the resident refused. Further review of the (MONTH) (YEAR) MAR indicated [REDACTED]. Continued review of the meal intake percentage records for (MONTH) (YEAR) revealed the resident was mostly coded as 0 indicating the resident consumed 2-25% of his meal and 0% of meal alternates. Review of the resident's care plans revealed that none of the care plans addressed the resident's refusal of tube feedings/meals, supplements and weight. A daily skilled note dated (MONTH) 2, (YEAR) included the resident continued to refuse all vitamins and minerals. physician progress notes [REDACTED]. A nursing note dated (MONTH) 9, (YEAR) included the resident refused to get weighed after 3 unsuccessful attempts and the nurse was informed. However, the documentation did not include that the physician was notified. A physician's note dated (MONTH) 10, (YEAR) included the resident's wound was positive for Pseudomonas. The note also documented the resident refused tube feedings. A physician's note dated (MONTH) 12, (YEAR) included the resident refused tube feedings, but was tolerating oral intake and tube feeding. Daily skilled notes dated (MONTH) 12 and 13, (YEAR) included the resident was tolerating enteral feedings and was receiving pleasure feedings for oral gratification. A change in condition note dated (MONTH) 14, (YEAR) included the resident declined his feeding. A physician's progress note dated (MONTH) 14, (YEAR) revealed the resident was refusing tube feedings, but was tolerating oral intake and tube feeding. A physician's orders [REDACTED]. On (MONTH) 24, (YEAR), a physician's progress note documented the resident was scheduled for 1 unit of PRBC (packed red blood cell) transfusion for [DIAGNOSES REDACTED]. The CNA (certified nursing assistant) documentation for (MONTH) (YEAR) included the resident refused to be weighed on (MONTH) 3, 9, 16, 23 and 30, (YEAR). However, there was no evidence found in the clinical record that the physician was notified of the resident's refusal to be weighed as ordered. In addition, there was no clinical record documentation that the resident's dietary needs were re-assessed since the last dietary assessment on 11/21/18 through 12/25/18, despite the resident's ongoing refusal of tube feedings/meals, supplements and weight. There was also no documentation that additional interventions were attempted or implemented to address the resident's refusals; such as offering other types of protein supplements, fortified foods and food choices based on the resident's preferences. A Nutrition Interdisciplinary Team Update note dated (MONTH) 26, (YEAR) revealed to continue the plan of care, which included tube feedings and supplements. Per the note, laboratory results were reviewed and the resident's current body weight was requested. The resident continued with varied oral intake with average meal percent intake of 50%. The note did not address the resident's refusals of meals, tube feedings, the Prostat and vitamins/minerals. There were also no new interventions which were recommended at this time. A physician's note dated (MONTH) 28, (YEAR) included the resident was refusing tube feeding and was tolerating oral intake well, and that it was okay to wean off of tube feeding. However, the meal intake percentages for (MONTH) (YEAR) revealed the resident refused meals on multiple dates. The meal percentages were coded with a 0 indicating 0-25% intake and 1 indicating 26%-50% majority of the time. A nursing note dated (MONTH) 5, 2019 included the resident was transferred to the hospital because of increased drainage from the wound site. A Change in Condition note dated (MONTH) 6, 2019 included the resident returned from the hospital. Review of the CNA documentation from (MONTH) 1 through 6, 2019 revealed the resident refused to be weighed on (MONTH) 6. According to the (MONTH) 2019 MAR, the resident refused tube feedings, Prostat, vitamin C, vitamin A and [MEDICATION NAME] sulfate multiple times from (MONTH) 1-16. A physician's note dated (MONTH) 14, 2019 included the resident had an episode of emesis with nausea and a low grade fever. It included to monitor hemoglobin and if trending down, transfusion will be arranged. Review of the Nutrition Interdisciplinary Team Update note dated (MONTH) 16, 2019, revealed the resident continued with varied oral intake and was likely not meeting needs to promote healing. The note included that per nursing, the resident self-directs weights. It also included the resident received Prostat, vitamin A, vitamin C and [MEDICATION NAME] sulfate. The plan was to continue the plan of care. There was no current body weight listed. There was also no documentation that addressed the resident's frequent refusal of tube feedings, meals, Prostat, vitamin A, vitamin C and [MEDICATION NAME] sulfate. and there were no new interventions which were recommended. A physician's note dated (MONTH) 21, 2019 included the resident had a low grade fever and wounds were improving slowly. The note also included for increased free water via tube for dehydration. The physician note dated (MONTH) 23, 2019 included the resident had a fever related to UTI (urinary tract infection), had received 2 liters of IVF (intravenous fluid) and was started on antibiotic for 7 days. A physician's note dated (MONTH) 28, 2019 included the resident continued to be on antibiotic for UTI. It also included slow improvement to the wound and the resident had a low hemoglobin and that a transfusion will be arranged. The CNA documentation from (MONTH) 7 through 31, 2019 revealed the resident refused to be weighed on (MONTH) 27. The MAR from (MONTH) 17 through 31, 2019 included the resident continued to refuse tube feeding, meals, Prostat, vitamin A, vitamin C and [MEDICATION NAME] sulfate.

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HERITAGE COURT POST ACUTE OF SCOTTSDALE	**3339 NORTH DRINKWATER BOULEVARD SCOTTSDALE, AZ 85251**

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F 0692 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 8) The meal intake percentages for (MONTH) 2019 revealed the resident refused meals on multiple dates and the intake amount was coded as 0 indicating 0-25% and 1 indicating 26%-50% majority of the time. Despite documentation of the resident's ongoing refusals of tube feedings, meals, supplements and weights in (MONTH) 2019, there was no evidence in the clinical record that additional interventions were attempted or implemented to address the resident's refusals; such as offering foods in accordance with the resident's likes and preferences, offering fortified foods (ingredients added to food which adds calories) or other types of oral protein supplements. There was also no documentation that the risks associated with continued refusals of feedings, supplements and weights were explained to the resident. A dietary note dated (MONTH) 1, 2019 included the resident was refusing tube feedings, so the dietician recommended to discontinue the tube feedings and add 100 ml free water twice daily for tube patency. Per the note, the resident self directs food and fluid intake, has outside food available and had refused all attempts to obtain a weight. The plan was to continue to monitor and proceed with the plan of care. Other than discontinuing the tube feedings, there were no additional interventions recommended. The physician note dated (MONTH) 1, 2019 included the resident had a low grade fever and to wean the resident off tube feedings per dietary and that the resident was tolerating oral intake. The nutritional care plan was revised on (MONTH) 1, 2019 to include that the tube feedings were discontinued related to the resident's refusal. A physician's orders [REDACTED]. A care plan was initiated on (MONTH) 3, 2019, which identified that the resident was resistive to care, as evidenced by refusal of tube feeding and refusal to be weighed. The care plan also included the resident self-directs care. An intervention included educating the resident of the possible outcome of not complying with treatment or care. This care plan was developed more than two months after the resident was identified to frequently refuse tube feedings, meals, supplements and weights. Review of the CNA documentation revealed the resident refused breakfast on 2/4/19 and lunch on 2/6/19. The physician note dated (MONTH) 8, 2019 included the resident's hemoglobin was low and will direct admit to the hospital for 2 units of PRBC (packed red blood cells) transfusion for chronic blood loss. A physician's note dated (MONTH) 11, 2019 included the resident was off tube feeds. The quarterly dietary evaluation dated (MONTH) 15, 2019 included the resident consumed 85% of Prostat and had oral meal intakes of 70% and that the resident's oral intake has improved. The resident continues to self direct weights, food and fluid intakes. According to the CNA documentation for (MONTH) 2019, the resident refused breakfast on 2/16, lunch on/2/17 and breakfast on 2/18. Review of the CNA documentation for (MONTH) 2019 revealed the resident refused to be weighed on (MONTH) 3, 9 and 17. A physician's note dated (MONTH) 18, 2019 included the resident had the transfusion and had complex medical issues. The nutrition IDT note dated (MONTH) 19, 2019 included the resident continued with varied oral intakes mostly 75% of meals and 100% of 30 ml Prostat. Per the note, the resident receives vitamin A, vitamin C and [MEDICATION NAME] sulfate. The resident continues to self direct weights and nutrition as evidenced by refusing tube feeding. Tube feeding was previously changed to 100 ml water twice daily related to refusing feeds. The IDT recommendation was to continue plan of care. The CNA documentation showed that on 2/20, the resident refused breakfast and dinner, and on 2/21 2/22, 2/25 and 2/26 refused breakfast and lunch. A nutrition IDT note dated (MONTH) 26, 2019 included the dietician was notified that if resident has poor meal intake, the physician requested to re-initiate tube feeding orders. Per the note, the resident declined to speak with the dietician. The documentation included the resident had a history of [REDACTED]. A physician's orders [REDACTED]. A physician's note dated (MONTH) 27, 2019 included the resident had an upper respiratory infection likely due to flu and had a positive urinalysis and was started on Bactrim (antibiotic). Review of the MAR for (MONTH) 2019 revealed the resident continued to refuse the Prostat, vitamin A, vitamin C and [MEDICATION NAME] sulfate on numerous occasions. An interview with a CNA (certified nursing assistant/staff #55) was conducted on (MONTH) 19, 2019 at 12:58 p.m. She stated the CNA's complete daily weights and weekly weights. She said if weight loss is identified, it is reported immediately to the DON (Director of Nursing) and/or the nurse. She stated if a resident is not eating, the resident is encouraged to eat and offered alternate foods. An interview with the dietary manager (staff #7) was conducted on (MONTH) 21, 2019 at 11:30 a.m. She stated weights are done weekly and that any issues related to weight will be addressed by the registered dietician (staff #75) and the dietary technician (staff #77). She stated that residents with weight issues are discussed during the NAR (Nutrition at Risk) weekly meetings and if there are any interventions related to food modifications, she will ensure they are implemented. She stated the nursing department ensures that supplements are administered as ordered. An interview with the dietary technician (staff #77) was conducted on (MONTH) 21, 2019 at 12:45 p.m. She stated that she is responsible for conducting the initial assessment of a resident upon admission, and the quarterly assessments. Staff #77 said if there is no height and/or weight available for the initial assessment, she will use the information from the History and Physical (from the hospital). She said the succeeding assessments such as the quarterly assessments, will be based on information and weights recorded in the electronic record. During an interview with the registered dietician (staff #75) conducted on (MONTH) 22, 2019 at 10:14 a.m., she stated the dietary technician writes weekly weight notes if there is a 2% weight gain or loss, and this will be discussed in the weekly weight meetings, and that recommendations are made to address the identified concerns. She stated that she does not review recommendations because she is not involved with the weekly weight meetings, unless they have asked her to assess and evaluate a specific resident whom the facility identified as having difficulty in weight management. She stated that she is responsible for assessing the nutritional needs of high risk residents, which included residents with wounds, on tube feedings or on [MEDICAL TREATMENT]. She stated for these high risk residents, she will write monthly notes. Regarding resident #29, staff #75 stated the resident refused to have his weight taken, because for the most part he self-directs a lot of his care. She stated that she attempted to talk with the resident, but he refused to talk to her. She said she informed the provider regarding the resident's refusal to measure his weight. She said when she completed her assessment of resident #29, she used the data from the laboratories, her knowledge that the resident orders outside food, and that the resident was receiving Prostat. She stated Prostat is a protein supplement which provides the resident 100 calories and 15 grams of protein per ounce. She stated the facility does have another way to measure a resident's weight by using the chair scale, but the resident also refused this. She said that she has not tried any other means to measure the resident's weight. During an interview with a registered nurse (RN/staff #14) conducted on (MONTH) 22, 2019 at 11:43 a.m., she stated the resident is alert and oriented, can verbalize his wants and needs, refuses a lot of care, and has a huge wound on his bottom which is bad. Staff #14 stated the resident once had his tube feeding removed because he refused, but the resident started to not eat so it was put back in. She also stated the resident refused to be weighed and she does not know why, but figured it was because of his wounds, tube feeding and a lot of things going on. Another interview with staff #77 was conducted on (MONTH) 22, 2019 at 12:04 p.m. She stated that when she conducts her assessment of a resident's nutritional needs, she uses the following data from the clinical record: diagnoses, height, weight, skin condition, appetite, BMI (body mass index), medications and laboratory results. She said if and when any of this data is missing such as height and weight, she will send a tiger text message (a message in the resident's computerized electronic record) to the DON and MDS coordinator. She stated that depending on when the assessment is due, if the DON and the MDS coordinator do not respond to her right away, she will use the data from the History and Physical and will document it in her assessment where the data came from. She said that residents with weight loss, pressure ulcers, wounds and residents who refuse weights are discussed during the weekly dietary meetings. She stated she does not know why resident #29 refused to be weighed. She stated the resident has snacks inside his room and has outside food delivered. Staff #77 stated that if resident #29 would allow her, she could measure arm circumference, but it is not a reliable way in determining weight loss or weight gain, but it is an alternate method. When asked how she ensures that resident #29 is

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F 0692 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 9) meeting his nutritional needs, staff #77 stated I know what you mean but did not elaborate further. Review of the Weight policy revealed, It is the policy of this facility to obtain an accurate weight as part of the resident's assessment upon admission and at least monthly thereafter. A policy titled, Nutrition included to ensure that all residents maintain acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible. The policy further stated to provide care and services including .defining and implementing interventions for maintaining or improving nutritional status that are consistent with resident needs, goals, and recognized standards of practice, or explaining adequately in the medical record why the facility could not or should not do so; and monitoring and evaluating the resident's response or lack of response to the interventions; and revising or discontinuing the approaches as appropriate, or justifying the continuation of current approaches.
F 0755 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, staff interviews, and policy review, the facility failed to ensure the account of narcotics for two sampled residents (#240 and #33) were accurate. This deficient practice could result in misappropriation of residents' narcotic medications. Findings include: -Resident #240 was admitted to the facility on (MONTH) 4, 2019 with [DIAGNOSES REDACTED]. Review of the clinical record revealed a physician order [REDACTED]. Review of the Medication Administration Record [REDACTED]. An observation was conducted on (MONTH) 20, 2019 at 7:15 a.m. of staff #15 and a Licensed Practical Nurse (LPN/staff #9) reconciling narcotics at shift change. Review of the narcotic sheet for resident #240 dated (MONTH) 2019 revealed there were 22 [MEDICATION NAME] pills available. However, review of the blister package containing the [MEDICATION NAME] pills revealed there were 23 pills available. -Resident #33 was admitted to the facility on (MONTH) 1, 2019 with [DIAGNOSES REDACTED]. Review of the physician orders [REDACTED]. Review of the MAR indicated [REDACTED]. During the same observation conducted of the RN and LPN reconciling narcotics on (MONTH) 20, 2019, review of resident #33 narcotic sheet for [MEDICATION NAME] revealed there should be 26 [MEDICATION NAME] pills available. However, review of the blister package containing the [MEDICATION NAME] pills revealed there were 25 [MEDICATION NAME] pills available. An interview was conducted with staff #15 immediately following the observation. Staff #15 stated that during the early morning hours of (MONTH) 20, 2019 she mistakenly removed a [MEDICATION NAME] 5-325 mg from the blister package for resident #33 and administered it to resident #240. Staff #15 stated that one resident's medication cannot be administered to another resident. The RN stated that this discrepancy needed to be reported immediately to the Director of Nursing and the physician. An interview was conducted with the corporate RN (staff #68) on (MONTH) 20, 2019 at 7:25 a.m. Staff #68 stated that the administration of medication designated for one resident being administered to a different resident is a medication error. Staff #68 further stated the expectation is that there are no discrepancies in the reconciliation of narcotic medications. The facility's policy regarding pharmacy services and narcotic count included the following: It is the policy of this facility to justify amount of narcotics remaining when control of supply is released to the nurse coming on duty. Procedures: One RN going off duty and one LPN coming on duty must count and justify narcotics supply for each individual resident at the exchange of each shift. If the count is not correct the nurse going off duty is not to leave until the count is correct. Every effort is made to reconcile the count and notify the DON of any discrepancy immediately.
F 0756 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.** **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 the pharmacist identified irregularities during the medication regimen review (MRR) for 1 of 5 sampled residents (#7) receiving [MEDICAL CONDITION] medications. This deficient practice could result in the administration of unnecessary medications. Findings include: Resident #7 was admitted on (MONTH) 5, (YEAR) with [DIAGNOSES REDACTED]. Review of the clinical record revealed physician's orders [REDACTED]. The Medication Administration Records (MAR) for (MONTH) through (MONTH) (YEAR) and (MONTH) through (MONTH) 2019 revealed [MEDICATION NAME] and [MEDICATION NAME] were administered as ordered. Review of the behavior monitoring on the MARs for (MONTH) through (MONTH) 2019 revealed the resident displayed no anxiety or depression behaviors except for (MONTH) 1, 2019. On (MONTH) 1, 2019 on the night shift there was documentation that the resident had 2 episodes of anxiety. Review of the MRR for (MONTH) through (MONTH) 2019 did not reveal a recommendation or a contraindication for a gradual dose reduction of [MEDICATION NAME] and [MEDICATION NAME]. The MRRs revealed documentation that the resident's medication regimen contained no new irregularities. An interview was conducted on (MONTH) 22, 2019 at 10:33 a.m. with the Director of Nursing (DON/staff #72) and the Administrator (staff #71). The DON stated that she and the pharmacist review all [MEDICAL CONDITION] medications monthly and discuss gradual dose reductions. She stated the pharmacist is responsible for tracking and scheduling the required gradual dose reductions. The DON stated that if the required dose reduction is contraindicated, the pharmacist will document the recommendation and the contraindication will be added to the physician's orders [REDACTED]. During an interview conducted with the consulting pharmacist (staff #80) on (MONTH) 22, 2019, the pharmacist stated that the [MEDICATION NAME] and [MEDICATION NAME] were not appropriate for gradual dose reductions. The pharmacist stated that they do not do GDRs on antianxiety medications and that they only recommend annual GDRs for antidepressants. The facility's policy titled Medication Regimen Review (MRR), Revised 8/2017, revealed the pharmacist reviews each resident's medication regimen at least once a month in order to identify irregularities. The policy also included that in performing the drug regimen review, the Pharmacist utilizes federally mandated standards of care. Review of the facility's policy titled Psychoactive Medication, Revised 5/2007, reviewed 11/17, revealed the facility should attempt to taper psychoactive medications per recommended guidelines. The policy included that tapering may be indicated when the resident's clinical condition has improved or stabilized, the underlying causes of the original target symptoms have resolved, or other interventions have been effective in reducing the symptoms. The policy also included the physician will document in the clinical record any contraindications to gradual dose reduction or rationale for why subsequent dose reductions should not be attempted.
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 reviews, staff interviews and policy review, the facility failed to ensure 2 of 5 sampled residents (#6 and #2) were free from unnecessary drugs. The potential outcome includes receiving medications which may not be necessary. Findings include: -Resident #6 was admitted to the facility on (MONTH) 26, (YEAR) with [DIAGNOSES REDACTED]. Review of physician's orders [REDACTED].

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F 0757 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 10) -Tylenol 325 milligrams (mg) two tablets by mouth every 4 hours as needed for pain levels of 1-3 out of 10 dated (MONTH) 26, (YEAR). -[MEDICATION NAME] (narcotic) 10 mg by mouth every 4 hours as needed for pain levels of 4-10 dated (MONTH) 30, (YEAR). The quarterly Minimum Data Set (MDS) assessment dated (MONTH) 3, (YEAR) revealed a score of 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident had intact cognition. The MDS assessment also included the resident experienced pain at a level of 6 on a daily basis. Review of the Medication Administration Record [REDACTED]. The physician's orders [REDACTED]. The order also included [MEDICATION NAME] 5 mg by mouth every 24 hours as needed for pain levels of 4-6. Review of the MAR indicated [REDACTED]. The MAR indicated [REDACTED]. Review of the MAR for (MONTH) (YEAR) revealed the resident was administered [MEDICATION NAME] 10 mg more than 45 times for pain levels less than 7. The MAR indicated [REDACTED]. The order for [MEDICATION NAME] 10 mg was changed on (MONTH) 1, 2019 to [MEDICATION NAME] 10 mg by mouth every 4 hours as needed for pain levels of 4-10. Review of the MAR indicated [REDACTED]. Further review of the MARs for October, November, and (MONTH) (YEAR) and (MONTH) 2019 revealed the resident was not administered Tylenol for pain. During an interview conducted with a Certified Nursing Assistant on (MONTH) 19, 2019 at 10:43 AM, the CNA stated that if a resident states they have unrelieved pain, he would notify the nurse. On (MONTH) 21, 2019 at 11:59 AM, an interview was conducted with a Licensed Practical Nurse (LPN/staff #59). The LPN stated that she would ask a resident that was having pain to rate their pain on a scale of 1-10. She stated that she would then administer pain medications according to the ordered parameters. The LPN stated that if the resident's pain was not relieved, she would notify the physician. She also stated that she would obtain a physician's orders [REDACTED]. An interview was conducted with the Director of Nursing (DON/staff # 72) on (MONTH) 21, 2019 at 12:13 PM. The DON stated that her expectation is that nurses administer pain medications to residents according to the physician's orders [REDACTED].- Resident #2 was readmitted on (MONTH) 9, 2019, with [DIAGNOSES REDACTED]. Review of the clinical record revealed a physician's orders [REDACTED]. Review of the MAR for (MONTH) 2019 revealed [MEDICATION NAME] was administered 7 times for systolic blood pressures more than 120. Review of the MAR indicated [REDACTED]. An interview was conducted with the LPN (staff #59) on (MONTH) 22, 2019 at 1:45 p.m. The LPN stated that medications are to be administered according to the parameters ordered by the physician. She stated that the physician should be notified before administering a medication outside the ordered parameters. The LPN also stated that administering medications outside of the ordered parameters could result in unwanted side effects or harm to the resident. During an interview conducted with the DON (staff #72) on (MONTH) 22, 2019 at 1:47 a.m., the DON stated that her expectation is that the nurses administer medications according to the parameters ordered by the physician. After reviewing resident #2's clinical record, the DON stated that [MEDICATION NAME] was not administered according to the physician's orders [REDACTED].>The facility's policy regarding administration of drugs revealed medications must be administered in accordance with the written orders of the attending physician.
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 that GDR (Gradual Dose Reductions) were attempted within the required timeframe or that there was clinical rationale documentation by the physician why GDRs were contraindicated for 1 of 5 sampled residents (#7) receiving [MEDICAL CONDITION] medications. This deficient practice could result in residents receiving unnecessary [MEDICAL CONDITION] medications. Findings include: Resident #7 was admitted on (MONTH) 5, (YEAR) with [DIAGNOSES REDACTED]. Review of the clinical record revealed physician's orders [REDACTED]. The Medication Administration Records (MAR) for (MONTH) through (MONTH) (YEAR) and (MONTH) through (MONTH) 2019 revealed [MEDICATION NAME] and [MEDICATION NAME] were administered as ordered. Review of the behavior monitoring documented on the MARs for (MONTH) through (MONTH) 2019 revealed the resident displayed no anxiety or depression behaviors except for (MONTH) 1, 2019. On (MONTH) 1, 2019 on the night shift there was documentation that the resident had 2 episodes of anxiety. Review of the Medication Regimen Review (MRR) for (MONTH) through (MONTH) 2019 did not reveal a recommendation or a contraindication for a GDR of [MEDICATION NAME] and [MEDICATION NAME]. The MRRs revealed documentation that the resident's medication regimen contained no new irregularities. Further review of the clinical record did not reveal documentation by the physician regarding GDRs attempts or why GDRs were contraindicated. During an interview conducted with a Registered Nurse (RN/staff #14) on (MONTH) 22, 2019 at 10:25 a.m., the RN stated that per the resident's request, a GDR had been attempted with the resident's pain medication, but that she was unaware of any GDR for the resident's [MEDICAL CONDITION] medications. An interview was conducted with the Director of Nursing and the Administrator (staff #71) on (MONTH) 22, 2019 at 10:33 a.m. The DON stated that prior to admission, she makes sure there are appropriate [DIAGNOSES REDACTED]. The DON stated that the nurses monitor for target behaviors and side effects of [MEDICAL CONDITION] medications. She stated that she and the pharmacist review all [MEDICAL CONDITION] medications monthly and discuss gradual dose reductions. The DON stated gradual dose reductions of [MEDICAL CONDITION] medications would be considered for reduced episodes of target behaviors and inappropriate diagnoses. She stated the pharmacist is responsible for tracking and scheduling the required gradual dose reductions. The DON stated that if the required dose reduction is contraindicated, the pharmacist will document the recommendation and the contraindication will be added to the physician's orders [REDACTED]. During an interview conducted with the consulting pharmacist (staff #80) on (MONTH) 22, 2019, the pharmacist stated that [MEDICATION NAME] is in a class unique to itself and is not technically a [MEDICAL CONDITION] medication. He stated that because [MEDICATION NAME] has much lower side effects than other antianxiety medications, residents are likely to experience rebound anxiety if the medication is discontinued. The pharmacist stated that he does not recommend gradual dose reductions for antianxiety medications. The pharmacist further stated that he does not recommend gradual dose reductions for antidepressants until a resident has been receiving the medication for a year because the resident may suffer rebound depression. He stated that a gradual dose reduction will be attempted in (MONTH) 2019 for [MEDICATION NAME]. Review of the facility's policy titled Psychoactive Medication, Revised 5/2007, reviewed 11/17, revealed the facility should attempt to taper psychoactive medications per recommended guidelines. The policy included that tapering may be indicated when the resident's clinical condition has improved or stabilized, the underlying causes of the original target symptoms have resolved, or other interventions have been effective in reducing the symptoms. The policy also included the physician will document in the clinical record any contraindications to gradual dose reduction or rationale for why subsequent dose reductions should not be attempted.
F 0770 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide timely, quality laboratory services/tests to meet the needs of residents.**

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	035083	A. BUILDING ______ B. WING _____	**03/22/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HERITAGE COURT POST ACUTE OF SCOTTSDALE	**3339 NORTH DRINKWATER BOULEVARD SCOTTSDALE, AZ 85251**

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F 0770 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 11) Based on facility documentation, staff interviews and policy review, the facility failed to ensure that quality control solution testing was consistently completed on the glucometers. The deficient practice could result in not being aware of glucometers that were not functioning properly and therefore; providing inaccurate glucose level results for residents with diabetes. Findings include: Review of the blood glucometer daily quality control record dated (MONTH) (YEAR) revealed sections for staff to complete the date, nursing station A or B, operator initials, test strip lot number, expiration date, low control result, high control result and any corrective action taken, due to out of range results. However, there were nine days in (MONTH) (YEAR) with no documentation that the daily glucometer control testing for accuracy was completed. Review of the blood glucometer daily quality control record dated (MONTH) (YEAR) revealed a total of 24 days that were blank, with no documentation to indicate that the glucometers had been tested for accuracy. Review of the blood glucometer daily quality control record dated (MONTH) (YEAR) revealed a total of 30 days which were blank, indicating the glucometers had not been tested for accuracy. An interview was conducted on (MONTH) 21, 2019 at 1:13 p.m. with a Licensed Practical Nurse (LPN/staff #59). Staff #59 stated the night shift are responsible for the daily glucometer control records. After staff #59 reviewed the glucometer testing logs for October, (MONTH) and (MONTH) (YEAR), she stated the night shift should have noticed all of the missing dates and taken the problem to the Director of Nursing (DON). An interview was conducted with the DON (staff #72) on (MONTH) 21, 2019 at 2:00 p.m. She stated the glucometer daily testing logs are to be completed every night shift to make sure all glucose tests are accurate. Staff #72 stated the importance is to ensure residents with diabetes and on insulin have accurate glucose monitoring machines to regulate the amount of insulin to be administered. Staff #72 further stated any nurse on the night shift could have noticed the gaps in the testing and reported it to the DON. A request for the facility policy for glucometers was identified to be the same as the manufacturer's insert instructions, which included the purpose is to validate the glucose monitoring system. A control test that falls within the acceptable range indicates the user's techniques are appropriate and the test strip and monitor are functioning properly.
F 0926 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Have policies on smoking.** Based on observations, clinical record review, resident and staff interviews and policy review, the facility failed to implement their policy to ensure safety measures and adequate supervision were provided to residents who smoked, in order to ensure a safe environment. As the facility identified the smoking concerns and implemented correction action, this is cited at past non-compliance. Findings include: The State Agency received information on (MONTH) 29, (YEAR) that residents had been fighting on the smoking patio and flicking cigarettes at each other, smoking in the sitting area inside the building by the front door, and smoking in their rooms. The information also included cigarette butts were all over the parking garage and residents' clothing and bed linens had burn holes. An interview was conducted with a Certified Nursing Assistant (CNA) on (MONTH) 19, 2019 at 10:43 AM. The CNA stated that the facility had become a non-smoking facility at the beginning of the year because residents were not following the smoking rules. The CNA said residents were mad that they had to wait for designated smoking times, so they started smoking whenever they wanted to. The CNA stated that residents would hide their cigarettes and smoke in their rooms. The CNA stated that the residents would put a towel at the bottom of their doors, open their windows, and smoke cigarettes in their rooms to mask the smell of marijuana that they were smoking. The CNA also stated that one resident with oxygen snuck a cigarette outside and asked for light. The CNA stated the resident was not given a light. The CNA further stated that there was smoke smell in the facility which put everyone at risk. On (MONTH) 19, 2019 at 11:51 PM, an interview was conducted with one of the residents who currently smokes. He stated that administration changed the smoking policy about a month ago. He said the change in policy occurred because some smokers were not following the rules. The resident stated that residents were smoking all over the place including inside the facility, whenever they wanted, and no one was cleaning up their butts. He stated that he is currently one of two residents who still have smoking privileges. The resident stated that he is only allowed to smoke a few times per day, and that he must be supervised while he smokes. An interview was conducted with laundry (staff #74) on (MONTH) 19, 2019 at 12:33 PM. He stated that he saw burn holes in the blankets from the beds of the residents who smoked and also saw burn holes in their clothing. Staff #74 stated that he reported his observations to the head of the department (staff #18). On (MONTH) 20, 2019 at 8:57 AM, an interview was conducted with the Activities Coordinator (staff #38). She stated that smoking privileges were reinstated in the fall of (YEAR) which did not require residents to be supervised. She said the smoking rules changed again in (MONTH) and required residents to be supervised while smoking and to only smoke during scheduled smoking times. The Activities Coordinator stated that was when the problems started. She said all of the smokers refused to follow the rules and that there were at least 15 residents who smoked. She stated that staff would take their cigarettes away, but the families would bring them more. Staff #38 stated some of the residents were given a 30 day discharge notice. She said staff tried to educate the residents, but they would not listen. She stated that when it got bad, staff came together to address the problem and came to the conclusion that it was safer for everyone if they became a non-smoking facility. On (MONTH) 20, 2019 at 9:10 AM, an interview was conducted with the Director of Nursing (DON/staff #72). She stated that there were quite a few residents who smoked when she started working in (MONTH) 2019. The DON stated the residents were non-compliant, they smoked in non-smoking areas, and smoked during non-smoking hours. She said she may have heard that some had been caught smoking in their rooms. The DON stated staff would take their cigarettes away or offer to help them find placement in another facility. At 9:16 AM, the Clinical Resource Nurse (staff #68) and the Administrator (staff #71) joined the DON interview. The Clinical Resource Nurse stated that she knew there were going to be problems when they started allowing the residents to smoke again. She recalled the staff commenting that they thought it would help them get more residents into the facility. She said she knew with the population they had, there would be problems. The Administrator (staff #71) stated that approximately two weeks to a month ago the leadership team discussed the smoking issue and came up with a plan to convert to a non-smoking facility. The administrator also stated that two residents continue to smoke, but that they are compliant with the smoking rules. The Activities Coordinator (staff #38) stated on (MONTH) 20, 2019 at 2:04 PM that the policy implemented the summer of (YEAR) did not allow smoking in the facility, all residents had to be supervised while smoking, and that the smoking times were 8:45 AM, 1:15 PM, 4:00 PM, and 7:45 PM. Staff #38 stated that the times for smoking were no more than 15 minute increments or 2 cigarettes and that there was to be no smoking between the hours of 8:00 PM and 8:45 AM. The Administrator provided documentation of the following measures that were implemented regarding smoking: -The decision to become a non-smoking facility was set with a goal date of (MONTH) 1, 2019. -Appropriate placement would be offered to current smoking residents. -A few residents would continue with supervised smoking. -Documentation of the new policy would be included in the nursing and new admissions packets. -Information would be updated in brochures and on the website to reflect the new policy. -Hospitals/referring partners would be notified of upcoming change. Review of the facility's list of residents who currently smoke revealed there were two residents that currently smoked in the facility. Review of the two residents' clinical records revealed the residents were assessed and care planned for smoking. Observations were conducted of the two residents who smoked on (MONTH) 19, 2019 at 8:34 AM and (MONTH) 20, 2019 at 1:20 PM. The residents were supervised and no concerns were identified. During an interview conducted with a CNA (staff #3) on (MONTH) 19, 2019 at 10:26 AM, the CNA stated that they are now a

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