STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035250	A. BUILDING _____ B. WING _____	01/10/2019

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
IMMANUEL CAMPUS OF CARE	**11301 NORTH 99TH AVENUE PEORIA, AZ 85345**

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 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff and resident interviews, facility documentation, and a review of policy and procedures, the facility failed to ensure one resident (#148) was free from physical abuse by one resident (#97). Findings include: Resident #148 was admitted on (MONTH) 11, (YEAR) with [DIAGNOSES REDACTED]. The admission Minimum Data Set (MDS) assessment dated (MONTH) 18, (YEAR) revealed the resident scored a 15 on the Brief Interview for Mental Status (BIMS) indicating the resident was cognitively intact. Review of the clinical record revealed a physician's orders [REDACTED]. -Resident #97 was admitted to the facility on (MONTH) 6, (YEAR) with [DIAGNOSES REDACTED]. Review of the care plan initiated on (MONTH) 7, (YEAR) revealed the resident had behavior problems of physical and verbal aggression and swings his arms uncontrollably and may hit others related to [DIAGNOSES REDACTED]. Interventions included administering medications as ordered and to anticipate and meet needs. Review of the admission MDS assessment dated (MONTH) 13, (YEAR) revealed the resident scored an 11 on the BIMS indicating the resident had moderate cognitive impairment. The assessment also included the resident displayed behavioral symptoms and at times is verbally and physically aggressive towards staff and peers. Review of an incident note dated (MONTH) 13, (YEAR) revealed at 4:30 p.m. in the men's day room resident #148 was at the table playing a board game with a certified nursing assistant (CNA/staff #87) when resident #97 passed by and slapped the posterior side of resident's 148 upper arm with his left opened hand. Per the documentation, the CNA (#87) separated both residents and called the nurse for help. A physician's orders [REDACTED].#97 on 5 minute checks every shift due to initiating a physical non-injury aggression incident. Review of the facility's investigation dated (MONTH) 14, (YEAR) revealed that on (MONTH) 13, (YEAR) at 4:30 p.m. an incident of resident to resident abuse occurred. Resident #97 was walking out of the day room and hit resident #148 who was playing a board game with a Certified Nursing Assistant (CNA/staff #87) on his right upper arm. The investigation included the facility was unable to conclude whether it was intentional or accidental. Per the investigation, the residents were separated and placed on 5 minute checks. The investigation included a statement from the CNA that resident #97 hit resident #148 with his open hand as he passed by resident #148 who was playing a board game. The investigation also included a statement from resident #148 that he was playing a board game when resident #97 passed by and suddenly hit him with his left hand on the right upper arm. Per the investigation, resident #97 was unable to give a statement. A psychiatric physician progress notes [REDACTED]. The note also included the resident was very confused and required staff redirection with all care. An interview was conducted on (MONTH) 10, 2019 at 1:00 p.m. with resident #148. He stated a couple months ago he and a CNA (staff 87) were in the day room playing a game when resident #97 hit his arm with a closed fist. He stated he and resident #97 did not exchange words. He stated that he did not get hurt; however, he does not like being a punching bag. An interview was conducted on (MONTH) 10, 2019 at 1:10 p.m. with the CNA (staff #87). He stated that in (MONTH) (YEAR), he and resident #148 were in the day room and resident #97 was sitting in his wheelchair watching TV. He stated resident #97 reached over and hit resident #148 with an open hand. He further stated resident #97 was not provoked and that the action was intentional. He stated the residents were separated and the nurse was notified. He stated resident #97 is confused at time and that at other times he is able to hold a conversation. He further stated resident #97 had been physically aggressive toward staff but not with residents. During an interview conducted with resident #97 on (MONTH) 10, 2019 at 1:12 p.m., he stated that he hit resident #148 and that he meant to hit him and that he did not know why he hit him. He stated resident #148 did not do anything to provoke him. An interview was conducted on (MONTH) 10, 2019 at 3:54 p.m. with the Director of Nursing (DON/staff #184). She stated that once abuse is reported or witnessed, staff are to separate the resident and notify the DON. The DON stated that regarding the incident between resident #148 and resident #97, resident #148 reported resident #97 hit him but that no one saw resident #97 purposely hit resident #148. She stated resident #97 was trying to exit the day room and had spastic arm movement as he walked by resident #148 was sitting near the doorway. The DON stated no words were exchanged between the residents. She stated resident #97 stated that he did not hit resident #148 and that the allegation was not substantiated. Review of the facility's abuse program policy and procedure revealed residents has the right to be free from abuse and that the facility will not condone any form of resident abuse. The policy included residents must not be subjected to abuse by anyone, including but not limiting to staff and other residents. The policy also included that physical abuse includes hitting, slapping, pinching, and kicking.
F 0602 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Protect each resident from the wrongful use of the resident's belongings or money.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation, resident and staff interviews, and policy review, the facility failed to ensure one resident (#110) was free from misappropriation of the resident's property. Findings include: Resident #110 was admitted on (MONTH) 20, (YEAR) with [DIAGNOSES REDACTED]. The quarterly MDS (Minimum Data Set) assessment dated (MONTH) 27, (YEAR) revealed a BIMS (Brief Interview for Mental Status) score of 14 indicating the resident had intact cognition. The current comprehensive care plan revealed the resident was alert and oriented and independent with decision making. A review of the NP (nurse practitioner) note dated (MONTH) 26, (YEAR) revealed the resident was alert and oriented x 3. Review of the facility's investigative report revealed that on (MONTH) 29, (YEAR) at around 2:00 p.m., an allegation of misappropriation of resident property was reported. Per the report, resident #110 was missing $300.00 from his checkbook. The report included the resident took the money out of his safe the night before and placed it in his checkbook and that his family was going to take him to lunch on (MONTH) 29, (YEAR). The report revealed the resident stated the $300.00 was given to him by his family the previous weekend. The report also included the family confirmed the resident was given $200.00 (which was a different amount from what the resident reported). During an interview conducted with the resident on (MONTH) 31, (YEAR) at 2:54 p.m., the resident stated that the $300.00 he

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

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F 0602 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) had in his bedside stand drawer was stolen. He stated that he thinks a night CNA (certified nurse assistant) took the money and that he reported it to staff. Another interview was conducted with the resident on (MONTH) 3, 2019 at 11:12 a.m. The resident stated that he reported to the nurse that he lost his $300.00 which was in his wallet in the drawer by the side of his bed. He stated that he believed the morning CNA took the money after he had left the room to have a shower. An interview was conducted on (MONTH) 3, 2019 at 1:53 p.m. with one of the CNAs (staff #203) who worked the morning shift on (MONTH) 29, (YEAR). Staff #203 stated that the resident told him about the missing money after management had knowledge of the allegation. She stated that the resident did not tell her how much money was missing or who took the money. An interview was conducted with the unit manager (staff #204) on (MONTH) 3, 2019 at 2:22 p.m. He stated that during a care plan meeting on (MONTH) 29, (YEAR), the resident reported to the social worker that he was missing $300.00 which he took out of the safe the night before and placed in his checkbook. During an interview conducted with the director of social services (staff #235) on (MONTH) 4, 2019 at 8:37 a.m., he stated that the resident had several incidents of missing items in the past and that they had provided the resident a safe to keep personal property. Staff #235 stated that they were able to verify the resident had money in his possession but was unable to establish how much money was missing. An interview was conducted with the administrator (staff #254) on (MONTH) 8, 2019 at 12:16 p.m. He stated the investigation determined that the resident had money but was unable to determine how much money the resident had. He stated there was no alleged perpetrator because the resident was not able to identify who could have taken the money. He also stated the allegation was not substantiated because of the discrepancies related to the amount of money the resident had and where the resident had placed the money prior to it being identified as lost. Two CNAs (staffs #157 and #231) that worked the morning shift on (MONTH) 29, (YEAR) and the resident's family were unable to be reached for an interview. Review of the facility's policy titled Abuse Program Policy and Procedure revealed that residents have the right to be free from abuse, neglect, misappropriation of resident property, corporal punishment and involuntary seclusion.
F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, resident and staff interviews, facility documentation, and policy review, the facility failed to implement their abuse policy for an allegation of misappropriation of property for one resident (#110), an allegation of abuse regarding two residents (#97 and #148), and an allegation of abuse for one resident (#52). Findings include: -Resident #110 was admitted on (MONTH) 20, (YEAR) with [DIAGNOSES REDACTED]. The quarterly MDS (Minimum Data Set) assessment dated (MONTH) 27, (YEAR) revealed a BIMS (Brief Interview for Mental Status) score of 14 indicating the resident had intact cognition. Review of the facility's investigative report dated (MONTH) 30, (YEAR), revealed that on (MONTH) 29, (YEAR) at around 2:00 p.m., an allegation of misappropriation of resident property was reported. Per the report, resident #110 was missing $300.00 from his checkbook. The report revealed the resident stated the $300.00 was given to him by his family the previous weekend. The report further revealed the family confirmed the resident was given $200.00 (which was a different amount from what the resident reported). The report also included the Director of Social Services (staff #235) was unable to locate the missing money. The report also included a Concern/Grievance Report that revealed the following: -Resident filed the concern/grievance regarding missing $300.00 on (MONTH) 29, (YEAR) at 2:00 p.m. -Investigation was conducted and completed by the Director of Social Services (staff #235) on (MONTH) 30, (YEAR) -The resident, staff, nurse, Unit Manager, and housekeeping were interviewed. However, the names of staff interviewed and details or results of the interviews were not documented except for a witness statement from a clinical manager. During an interview conducted with the Director of Social Services (staff #235) on (MONTH) 4, 2019 at 8:37 a.m., he stated that for allegations of missing or stolen items including money, he will complete a grievance report, submit it to the administrator within the hour, and initiate an investigation. He stated that he will interview the resident first and will interview staff who might have worked or entered the resident's room within the timeframe of the allegation. Staff #235 stated that if the timeframe is not known, he will interview staff on the unit and check the clinical record for the resident's inventory list to verify whether the resident actually had the missing item or money. He stated that it was determined that the resident had possession of the money but because of discrepancies regarding the amount missing, what the resident did with the money after it was given to him and where the resident placed the money after it was given to him, the allegation was not substantiated. He said this incident was more of a missing property issue and not of abuse or misappropriation of property. He said that if the allegation is abuse, neglect and misappropriation, documentation of the report will be more detailed. An interview was conducted with the Director of Nursing (DON/staff #184) on (MONTH) 8, (YEAR) at 2:18 p.m. The DON stated that if an allegation is about missing money, social services and the administrator handles the investigation. An interview was conducted with the administrator on (MONTH) 8, 2019 at 3:34 p.m. He stated that the investigation of this allegation of misappropriation of resident property was conducted by social services. He also stated that the allegation was initially treated as a missing item. After reviewing the investigative report, the administrator stated that the investigative report was not complete. He stated the report did not include details of the staff interviews and did not include interviews with other resident. -Resident #52 was admitted to the facility on (MONTH) 12, 2011 with [DIAGNOSES REDACTED]. A quarterly Minimum Data Set assessment dated (MONTH) 18, (YEAR) revealed a BIMS score of 15 which indicated the resident had no cognitive impairment. Review of the investigative report dated (MONTH) 9, (YEAR) revealed the resident alleged a Certified Nursing Assistant (CNA/staff #136) had physically abused her while providing care on (MONTH) 2, (YEAR). The report included the resident reported this allegation to staff at approximately 5 p.m. on (MONTH) 2, (YEAR) and an investigation was initiated. However, the report revealed the State Agency was not notified of the allegation until (MONTH) 3, (YEAR) at 10:56 a.m. and APS was not notified until (MONTH) 3, (YEAR) at 10:50 a.m. An interview was conducted with the administrator (staff #254) on (MONTH) 8, 2019 at 3:34 p.m. He stated that he is ultimately responsible for the overall coordination and implementation of the abuse prevention policies and procedures. An interview was conducted with social services (staff #235) on (MONTH) 10, 2019 at 9:40 a.m. After reviewing the fax sheet that had been attached to the investigative report, staff #235 stated that the notification to the State Agency was not within the required time frame. -Resident #148 was admitted to the facility on (MONTH) 11, (YEAR) with [DIAGNOSES REDACTED]. Review of the admission Minimum Data Set (MDS) assessment dated (MONTH) 18, (YEAR) revealed the resident scored a 15 on the Brief Interview for Mental Status (BIMS) indicating the resident was cognitively intact. -Resident #97 was admitted to the facility on (MONTH) 6, (YEAR) with [DIAGNOSES REDACTED]. Review of the admission MDS assessment dated (MONTH) 13, (YEAR) revealed the resident scored an 11 on the BIMS indicating the resident had moderate cognitive impairment. Review of the facility's investigation report dated (MONTH) 14, (YEAR) revealed that on (MONTH) 13, (YEAR) at 4:30 p.m. an incident of resident to resident abuse occurred. Resident #97 was walking out of the day room and hit resident #148 who was playing a board game with a Certified Nursing Assistant (CNA/staff #87) on his right upper arm. The investigation included the facility was unable to conclude whether it was intentional or accidental. Per the investigation, the residents were separated and placed on 5 minute checks. The report included a statement from the CNA and resident #148 and that resident #97 was unable to give a statement. No additional resident or staff interviews were included in the report. Further review of the report revealed the facility's completed investigation report was not provided to the State Agency until (MONTH) 20, (YEAR). An interview was conducted on (MONTH) 10, 2019 at 3:54 p.m. with the Director of Nursing (DON/staff #184). She stated that once an allegation of abuse is reported or witnessed, staff should make sure the resident is safe and notify her. She

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F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) stated an investigation is initiated that includes interviews with staff, witnesses, and other residents and that the results of the investigation are submitted to the State Agency within 5 days. Review of the facility's policy titled Abuse Program Policy and Procedure revealed residents have the right to be free from abuse. The policy included all reports of resident abuse shall be promptly and thoroughly investigated by facility management. The policy also included the person conducting the investigation will interview persons reporting the incident, interview witnesses to the incident, interview the resident, interview the resident's attending physician as needed to determine the resident's cognitive function and medical condition, interview staff members on all shifts who have had contact with the resident during the period of the alleged incident, interview roommates, and review all events leading up to the alleged incident. The policy further included all alleged violations involving abuse are to be reported immediately, but no later than 2 hours after the allegation is made to the State Agency and APS. The policy revealed the results of the investigation will be recorded on approved documentation forms and a written report of the findings of the investigation will be provided to the State Agency within five working days of the occurrence of the incident.
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, staff interviews, facility documentation and policy review, the facility failed to ensure an allegation of abuse for one resident (#52) and an allegation of misappropriation of property for one resident (#110) were reported to the State Agency (SA) and Adult Protective Services (APS) within the required timeframe. Findings include: -Resident #110 was admitted on (MONTH) 20, (YEAR) with [DIAGNOSES REDACTED]. Review of the facility's investigative report revealed that on (MONTH) 29, (YEAR) at around 2:00 p.m., an allegation of misappropriation of resident property was reported. Per the report, resident #110 was missing $300.00 from his checkbook. The report also included the family confirmed the resident was given $200.00 (which was a different amount from what the resident reported). The report also included a Concern/Grievance Report that included the resident filed the concern/grievance regarding missing $300.00 on (MONTH) 29, (YEAR) at 2:00 p.m. However, further review of the facility's investigative report revealed documentation that the allegation of missing money was reported to the State Agency on (MONTH) 30, (YEAR) at 10:15 a.m. and to APS on (MONTH) 3, (YEAR) at 2:00 p.m. In an interview with a licensed practical nurse (LPN/staff #15) conducted on (MONTH) 2, 2019 at 1:26 p.m., she stated that if she received a report or allegation of missing or stolen money, she would report this immediately to the social worker who will be responsible for the investigation. An interview was conducted with another LPN (staff #3) on (MONTH) 2, 2019 at 1:29 p.m. Staff #3 stated that if she received reports or allegations of missing or stolen money, she together with another staff would attempt to locate the money and if it was not found, she would report the incident that same day to social services. She said social services will conduct an investigation and will be responsible for reporting the incident. During an interview conducted with the Director of Social Services (staff #235) on (MONTH) 4, 2019 at 8:37 a.m., he stated that if he receives a report or allegations of missing or stolen items including money, he will complete a grievance report, submit it to the administrator within the hour, and initiate an investigation. He said the administrator will be responsible for reporting the allegation or incident to the SA and APS. An interview was conducted with the Director of Nursing (DON/staff #184) on (MONTH) 8, (YEAR) at 2:18 p.m. She stated that when there is an allegation of missing/stolen money, staff is expected to report this to the DON or administrator who will then report the allegation to the SA and APS within 2 hours. In an interview with the administrator (staff #254) on (MONTH) 8, 2019 at 3:34 p.m., he stated that allegations of misappropriation are reported to the SA and APS within 2 hours. He also stated that resident #110 allegation of missing money was not reported to the SA and APS within 2 hours as required because the allegation was initially treated as a missing item. -Resident #52 was admitted to the facility on (MONTH) 12, 2011 with [DIAGNOSES REDACTED]. A quarterly Minimum Data Set assessment dated (MONTH) 18, (YEAR) revealed a BIMS score of 15 which indicated the resident had no cognitive impairment. Review of the investigative report dated (MONTH) 9, (YEAR) revealed the resident alleged a Certified Nursing Assistant (CNA/staff #136) had physically abused her while providing care on (MONTH) 2, (YEAR). The report included the resident reported this allegation to staff at approximately 5 p.m. on (MONTH) 2, (YEAR) and an investigation was initiated. However, the report revealed the State Agency was not notified of the allegation until (MONTH) 3, (YEAR) at 10:56 a.m. and APS was not notified until (MONTH) 3, (YEAR) at 10:50 a.m. An interview was conducted with the administrator (staff #254) on (MONTH) 8, 2019 at 3:34 p.m. He stated that he is ultimately responsible for the overall coordination and implementation of the abuse prevention policies and procedures. An interview was conducted with social services (staff #235) on (MONTH) 10, 2019 at 9:40 a.m. After reviewing the fax sheet that had been attached to the investigative report, staff #235 stated that the notification to the State Agency was not within the required time frame. The facility's policy titled Abuse Program Policy and Procedure stated that All alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and Adult Protective Services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, resident and staff interviews, facility documentation, and policy, the facility failed to have evidence that an allegation of abuse regarding two residents (#97 and #148) and an allegation of abuse regarding one resident (#52) and an allegation of misappropriation of property for one resident (#110) was thoroughly investigated and failed to ensure the results of the investigation regarding an allegation of abuse involving two residents (#52 and #148) was reported to the State Agency within 5 working days. Findings include: -Resident #110 was admitted on (MONTH) 20, (YEAR) with [DIAGNOSES REDACTED]. Review of the facility's investigative report dated (MONTH) 30, (YEAR), revealed that on (MONTH) 29, (YEAR) at around 2:00 p.m., an allegation of misappropriation of resident property was reported. Per the report, resident #110 was missing $300.00 from his checkbook. The report revealed the resident stated the $300.00 was given to him by his family the previous weekend. The report further revealed the family confirmed the resident was given $200.00 (which was a different amount from what the resident reported). The report also included the Director of Social Services (staff #235) was unable to locate the missing money. The report also included a Concern/Grievance Report that revealed the following: -Resident filed the concern/grievance regarding missing $300.00 on (MONTH) 29, (YEAR) at 2:00 p.m. -Investigation was conducted and completed by the Director of Social Services (staff #235) on (MONTH) 30, (YEAR) -The resident, staff, nurse, Unit Manager, and housekeeping were interviewed. However, the names of staff interviewed and details or results of the interviews were not documented except for a witness statement from a clinical manager. The investigative report did not include if staff from all shift who may have had contact with the resident were interviewed. The report also did not included if other residents were interviewed. In an interview with a licensed practical nurse (LPN/staff #15) conducted on (MONTH) 2, 2019 at 1:26 p.m., she stated that

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F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) if she received a report or allegation of missing or stolen money, she would report this immediately to the social worker who will be responsible for the investigation. An interview was conducted with another LPN (staff #3) on (MONTH) 2, 2019 at 1:29 p.m. Staff #3 stated that if she received reports or allegations of missing or stolen money she would report the incident to social services who will conduct an investigation. During an interview conducted with the Director of Social Services (staff #235) on (MONTH) 4, 2019 at 8:37 a.m., he stated that he initiates an investigation when reports or allegations of missing or stolen item including money is reported to him. Staff #235 stated that he will interview the resident first and will interview staff who may have worked with or entered the resident's room. He stated that it was verified that #110 had possession of money but because of discrepancies regarding the amount, what the resident did with the money after it was given to him, and where the resident placed the money after it was given to him, the allegation was not substantiated. He said the incident was more of a missing property issue and not of abuse or misappropriation of property. Staff #235 stated that if an allegation is abuse, neglect, or misappropriation of property, the documentation of the report will be more detailed. During an interview conducted with the Director of Nursing (DON/staff #184) on (MONTH) 8, (YEAR) at 2:18 p.m., she stated that social services and the administrator handles the investigation regarding allegations of missing money. An interview was conducted with the administrator on (MONTH) 8, 2019 at 3:34 p.m. He stated that the investigation of this allegation of misappropriation of resident property was conducted by social services. He also stated that the allegation was initially treated as a missing item. After reviewing the investigative report, the administrator stated that the investigative report was not complete. He stated the report did not include details of the staff interviews and did not include interviews with other resident. -Resident #52 was admitted to the facility on (MONTH) 12, 2011 with [DIAGNOSES REDACTED]. A quarterly Minimum Data Set assessment dated (MONTH) 18, (YEAR) revealed a BIMS score of 15 which indicated the resident had no cognitive impairment. Review of the investigative report dated (MONTH) 9, (YEAR) revealed the resident alleged a Certified Nursing Assistant (CNA/staff #136) had physically abused her while providing care on (MONTH) 2, (YEAR). The report included the resident reported this allegation to staff at approximately 5 p.m. on (MONTH) 2, (YEAR) and an investigation was initiated. A continued review of the investigative report revealed staff #136 and a witness were interviewed and provided statements. However, there was no evidence additional staff were interviews or residents who had been provided care and services by staff #136 were interviewed. An interview was conducted with the administrator (staff #254) on (MONTH) 8, 2019 at 3:34 p.m. He stated that he is ultimately responsible for the overall coordination and implementation of the abuse prevention policies and procedures. He further stated that additional staff and resident interviews have to be conducted as a part of the investigation process. An interview was conducted with social services (staff #235) on (MONTH) 10, 2019 at 9:40 a.m. He stated that he reviewed the investigative report and that there was a lack of additional staff and resident interviews. Staff #235 further stated additional interviews are necessary to provide opportunities for residents and staff to give statements regarding the care and services of the alleged perpetrator/staff. -Resident #148 was admitted at the facility (MONTH) 11, (YEAR) with [DIAGNOSES REDACTED]. Review of the admission Minimum Data Set (MDS) assessment dated (MONTH) 18, (YEAR) revealed the resident scored a 15 on the Brief Interview for Mental Status (BIMS) indicating the resident was cognitively intact. -Resident #97 was admitted to the facility on (MONTH) 6, (YEAR) with [DIAGNOSES REDACTED]. Review of the admission MDS assessment dated (MONTH) 13, (YEAR) revealed the resident scored an 11 on the BIMS indicating the resident had moderate cognitive impairment. Review of the facility's investigation dated (MONTH) 14, (YEAR) revealed that on (MONTH) 13, (YEAR) at 4:30 p.m. an incident of resident to resident abuse occurred. Resident #97 was walking out of the day room and hit resident #148 who was playing a board game with a Certified Nursing Assistant (CNA/staff #87) on his right upper arm. The investigation included the facility was unable to conclude whether it was intentional or accidental. Per the investigation, the residents were separated and placed on 5 minute checks. The investigation included a statement from the CNA that resident #97 hit resident #148 with his open hand as he passed by resident #148 who was playing a board game. The investigation also included a statement from resident #148 that he was playing a board game when resident #97 passed by and suddenly hit him with his left hand on the right upper arm. Per the investigation, resident #97 was unable to give a statement. Further review of the facility's investigation revealed no additional resident or staff statements or interviews. An interview was conducted on (MONTH) 10, 2019 at 3:54 p.m. with the Director of Nursing (DON/staff #184). She stated that once an allegation of abuse is reported or witnessed, staff should make sure the resident is safe and notify her. She stated an investigation is initiated that includes interviews with staff, witnesses, and other residents and that the results of the investigation are submitted to the State Agency within 5 days. The facility's policy titled Abuse Program Policy and Procedure revealed all reports of abuse and misappropriation of resident property shall be promptly and thoroughly investigated by the facility. The individual conducting the investigation will at a minimum: -Interview any witnesses to the incident; -Interview staff members on all shifts who have had contact with the resident during the period of the alleged incident; and,-Interview other residents, resident's roommate, and visitors. In addition, the results of the investigation will be recorded on approved documentation forms and a written report of the findings of the investigation will be provided to the State Agency within five working days of the occurrence of the incident.
F 0644 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policy review, the facility failed to incorporate PASRR (preadmission screening and resident review) level II recommendations into one resident (#139) assessment and care planning. Findings include: Resident #139 was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of the state PASRR level II screening psychiatric evaluation dated (MONTH) 16, (YEAR) revealed the resident had a qualifying serious mental illness [DIAGNOSES REDACTED]. The evaluation included the resident would benefit from psychiatric medication management and psychotherapy. However, review of the annual Minimum Data Set (MDS) assessment dated (MONTH) 21, (YEAR) revealed the resident was not considered by the state level II PASRR process to have serious mental illness. The MDS assessment also included the resident did not receive psychological therapy. Review of the care plan initiated on (MONTH) 15, (YEAR) revealed focus issues regarding [MEDICAL CONDITION] that included behaviors, self-isolation, and poor impulse control with interventions that included psychiatric provider as needed and psychiatric/psychogeriatric consult as needed but did not include psychotherapy was provided. Further review of the clinical record revealed no physician's order for psychotherapy and no documentation that the resident was provided psychotherapy. An interview was conducted on (MONTH) 10, 2019 at 10:32 AM with a Registered Nurse (RN/staff #122). He stated that he assumed social services or the physician made the referrals for special services and that he was not sure if anyone was referred out for services. The RN stated that he thought there was a psychologist that worked at the facility, but that he worked with residents on a different unit and not with resident #139. He stated We meet our residents' needs here. During an interview conducted on (MONTH) 10, 2019 at 10:43 AM with the Director of Nursing (DON/staff #184), she stated that she thought social services made referrals for psychotherapy services. The DON stated that resident #139 resides on the high acuity behavioral unit and has been seen by the facility's psychiatrist. She stated that she did not know if resident #122 had received psychotherapy. After reviewing the clinical record, she acknowledged there was a recommendation for

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F 0644 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) psychotherapy. An interview was conducted on (MONTH) 10, 2019 at 11:13 AM with social services (staff #178). He stated that a psychotherapy referral requires an order from the primary care physician. Staff #178 stated the psychiatrist provides psychiatric management for this resident. He also stated that he did not believe there was a reason for the resident not to receive psychotherapy. The facility's policy regarding PASRR states: the facility will care plan and provide the specialized services as indicated in the level II determination. The services will be provided under the direction of the qualified personnel indicated.
F 0655 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interviews, the facility failed to ensure a summary of the baseline care plan for one resident (#83) was provided to the resident and their representative. Findings include: Resident #83 was admitted on (MONTH) 26, (YEAR) with [DIAGNOSES REDACTED]. The admission nursing data assessment dated (MONTH) 26, (YEAR) revealed that the resident was alert, able to make needs known, and participated in the assessment. The admission summary note dated (MONTH) 26, (YEAR) revealed the resident was alert and oriented x 3 and able to make needs known and signed all her consent and document. The baseline care plan dated (MONTH) 26, (YEAR) revealed that the resident was alert and cognitively intact, able to verbally communicate, and vision and hearing were adequate. The baseline care plan also included the resident was independent with bed mobility, transfer, walking and toileting. However, further review of the baseline care plan revealed the section that the care plan was reviewed with the resident/representative and the date was blank. The admission social services evaluation dated (MONTH) 29, (YEAR) included the resident was her own responsible party. The admission MDS (Minimum Data Set) assessment dated (MONTH) 2, (YEAR) revealed a BIMS (Brief Interview for Mental Status) score of 12 which indicated the resident had moderately impaired cognition. A physician progress notes [REDACTED]. Further review of the clinical record revealed no evidence the baseline care plan was reviewed with the resident and/or the resident's responsible party. An interview was conducted with a registered nurse (RN/staff #17) on (MONTH) 8, 2019 at 10:00 a.m. The RN stated that the resident is alert and oriented and requires supervision but is independent with ADLs (activities of daily living). She stated the baseline care plan is initiated by the admitting nurse and is completed within 24-48 hours of admission. The RN stated that sometimes the baseline care plan is not reviewed with the resident or responsible party if the resident is cognitively impaired or the responsible party did not accompany the resident on admission. Later, after reviewing the clinical record, the RN stated that she did not know whether or not the baseline care plan was reviewed with the resident or responsible party. During an interview conducted with the Director of Nursing (DON/staff #184) on (MONTH) 8, 2019 at 2:18 p.m., she stated that the baseline care plan is initiated for all residents by the IDT (interdisciplinary team) and/or the resident upon admission. She also stated that the resident has to sign the baseline care plan to indicate it was reviewed with them.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policies, the facility failed to ensure that a comprehensive person-centered care plan was developed for one resident (#148) regarding the use of a supra-pubic catheter and an ostomy. Findings include: Resident #148 was admitted on (MONTH) 11, (YEAR) with [DIAGNOSES REDACTED]. Review of the current physician's orders [REDACTED]. Review of the Admission Nursing Data Collection dated (MONTH) 11, (YEAR) revealed that the resident had an indwelling catheter. Review of the nursing skin/wound note dated (MONTH) 12, (YEAR) revealed that the resident had a [MEDICAL CONDITION] to the left lower quadrant and a supra pubic catheter. The baseline care plan dated (MONTH) 12, (YEAR) revealed the resident had a [MEDICAL CONDITION] and a suprapubic catheter that required care each shift. The annual Minimum Data Set (MDS) assessment dated (MONTH) 18, (YEAR) revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact. The assessment included the resident had an indwelling catheter, a [MEDICAL CONDITION] bladder diagnosis, and an ostomy. The urinary incontinence and indwelling catheter Care Area Assessment (CAA) for the assessment included it would be addressed in the care plan with the overall objective of avoiding complications, maintaining current level of functioning, and minimizing risks. However, review of the comprehensive care plan did not reveal any care plan, goals, or approaches that addressed the care required for the supra pubic catheter or the ostomy. Review of the Treatment Administration Records (TAR) for (MONTH) and (MONTH) (YEAR) and (MONTH) 2019 revealed that the resident was receiving [MEDICAL CONDITION] care and routine supra pubic catheter care each shift. An interview was conducted with a Licensed Practical Nurse (LPN/staff #255) on (MONTH) 10, 2019 at 2:17 p.m. He stated that when a resident is admitted the nurse would include any tubes or appliances on the care plan. The LPN stated that the care plan would include flushing needs, need for intake and output, and special care. The LPN also stated that a supra pubic catheter and an ostomy should be care planned and that the care plan would include monitoring, cleaning, monthly changes, dressing needs, and tape allergies [REDACTED]. An interview was conducted with the Director of Nursing (DON/staff #184) on (MONTH) 10, 2019 at 3:55 p.m. She stated that the comprehensive care plan would include the any tubes and appliances. The DON stated that the supra pubic catheter and the ostomy should have been on the care plan so that staff knows what the resident has and how to take care of the resident. She stated that her expectations and the policy were not followed. The facility's policy regarding comprehensive care plans revealed that a comprehensive, person centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The policy further included that the care plan will describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. Review of the facility's policy regarding supra pubic catheter care revealed the purpose of this procedure is to prevent skin irritation around the stoma site and to prevent infection of the resident's urinary tract. The preparation for the catheter care included to review the resident's care plan to assess for any special needs of the resident. The facility's policy regarding [MEDICAL CONDITION]/[MEDICAL CONDITION] care revealed the purpose of this procedure is to provide guidelines that will aid in preventing exposure of the resident's skin to fecal matter. The preparation for the [MEDICAL CONDITION]/[MEDICAL CONDITION] care included to review the resident's care plan to assess for any special needs of the resident.
F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policy and procedures, the facility failed to ensure one resident (#148) received pain medications per the physician's orders [REDACTED].

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F 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 5) Findings include: Resident #148 was admitted to the facility on (MONTH) 11, (YEAR), with [DIAGNOSES REDACTED]. Review of the physician's orders [REDACTED]. 7-10. The admission Minimum Data Set (MDS) assessment dated (MONTH) 18, (YEAR) revealed a score of 15 on the Brief Interview for Mental Status (BIMS) indicating the resident was cognitively intact. The assessment also included the resident was on a pain medication regimen. Review of the current care plan regarding pain medication revealed a goal that the resident would be free of any discomfort or adverse side effects from pain medication. Interventions included administering [MEDICATION NAME] medications as ordered by the physician. Review of the Medication Administration Record [REDACTED]. The MAR indicated [REDACTED]. Review of the MAR indicated [REDACTED]. An interview was conducted on (MONTH) 10, 2019 at 1:15 p.m. with a registered nurse (RN/staff # 122). He stated pain medications with parameters have to be administered according to physician orders. He stated if the pain level is outside of the ordered pain medication parameters then the nurse would need to call the physician. An interview was conducted on (MONTH) 10, 2019 at 3:54 p.m. with the Director of Nursing (DON/staff #184). She stated the nursing staff are expected to follow the ordered pain medication parameters. She stated it is appropriate for the nurse to administer a low dose of medication if the resident is requesting the lower dose for their pain level. She stated if the resident insist on receiving a pain medication that is for a higher pain level than their current pain level, the nurse is to notify the physician and document on the clinical record. Review of the facility's policy titled Administering Medications revealed medications shall be administered in a safe, timely manner, and as prescribed. The policy also included medications shall be administered in accordance with the orders, including any required timeframe.
F 0744 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observations, staff interviews, and policy, the facility failed to ensure one resident (#83) diagnosed with [REDACTED]. Findings include: Resident #83 was admitted on (MONTH) 26, (YEAR) with [DIAGNOSES REDACTED]. The Level II PASRR (Pre-Admission Screening and Resident Review) Evaluation dated (MONTH) 6, (YEAR) revealed a principal [DIAGNOSES REDACTED]. It also included the resident was alert, oriented to self and can handle simple daily activities. The DSM-IV (Diagnostic and Statistical Manual of Mental Disorders) Axis I [DIAGNOSES REDACTED]. The behavioral hospital discharge/aftercare instructions dated (MONTH) 25, (YEAR) included the principal [DIAGNOSES REDACTED]. The instructions included dementia with behaviors was addressed during treatment and that things that scared the resident was a trigger for the unwanted behaviors (specific behaviors not listed). The following interventions were effective in reducing the behaviors: music, reading, pacing/walking and talking with peers. Per the documentation, the resident's behaviors had improved at discharge. The behavioral hospital discharge medication list dated (MONTH) 26, (YEAR) included [MEDICATION NAME] (antipsychotic) 0.25 mg (milligrams) by mouth at bedtime for [MEDICAL CONDITION]. A physician's orders [REDACTED]. The consent for Treatment with [MEDICAL CONDITION] Medication dated (MONTH) 26, (YEAR) revealed administration of the antipsychotic medication [MEDICATION NAME] was recommended for the [DIAGNOSES REDACTED]. The care plan dated (MONTH) 26, (YEAR) regarding the use of the [MEDICAL CONDITION] medication [MEDICATION NAME] (brand name for [MEDICATION NAME]) related to [MEDICAL CONDITION] as evidenced by yelling included a goal that the resident will be/remain free of [MEDICAL CONDITION] drug related complications. Interventions included administering the [MEDICAL CONDITION] medication as ordered by the physician, consulting with pharmacy for the physician to consider a dose reduction, discussing with the physician the ongoing need for use of the medication, monitoring for side effects and effectiveness every shift; and reviewing behaviors and interventions and alternate therapies attempted and their effectiveness. The care plan also included the following Black Box warning Elderly patients with dementia-related [MEDICAL CONDITION] treated with antipsychotic drugs are at an increased risk of death. [MEDICATION NAME] is not approved for the treatment of [REDACTED]. The physician's orders [REDACTED]. Review of the Consultant Pharmacist's Medication Regimen Review dated (MONTH) 27, (YEAR) revealed a note was written to the physician that CMS (Centers for Medicare & Medicaid Services) guidelines states a facility must re-evaluate the use of the antipsychotic medication at the time of admission and/or within 2 weeks of admission and consider whether or not the medication is appropriate and if the medication can be tapered or discontinued. The review included the pharmacist instructed the physician to please re-evaluate the need of [MEDICATION NAME] for possible taper of dose or discontinuation and document rationale in the clinical record. The review also included a handwritten note that a dose reduction evaluation was completed on (MONTH) 16, (YEAR) 0 dose reduction. The note was not signed or initialed. Review of the Psychoactive Gradual Dose Reduction Review dated (MONTH) 13, (YEAR) included the resident was on [MEDICATION NAME] 0.25 mg by mouth at bedtime. The review included the target behaviors could be auditory and visual hallucinations, delusional and paranoid statements, and continuous crying out, yelling, screaming or pacing if so continuous as to impair functionality (track # of hours of these continuous behaviors). However, no target behavior was circled. The review also included the facility assessment of the medication benefit included [MEDICAL CONDITION], depression, and social isolation. Additional review of the form revealed [MEDICATION NAME] cannot be used for wandering, impaired memory, unsociability or behaviors that do not represent a danger to the resident or others because the risks exceed the benefits. Further review of the form revealed the physician signed the review on (MONTH) 16, (YEAR). However, the section for the provider to check and document for determination was blank. Psychiatry notes dated (MONTH) 29, (YEAR), (MONTH) 19, (YEAR) and (MONTH) 16, (YEAR) did not reveal the resident exhibited hallucinations and/or delusions and social isolation as behaviors. The quarterly nursing evaluation dated (MONTH) 24, (YEAR) revealed the resident did not displayed delusions, hallucinations, or social isolation. Review of the Psychoactive Gradual Dose Reduction Review dated (MONTH) 8, (YEAR) included the resident was receiving [MEDICATION NAME] 0.25 mg by mouth at bedtime. The facility assessment regarding the medication benefit included [MEDICAL CONDITION] and depression as evidenced by social isolation. This form was signed by the physician on (MONTH) 8, (YEAR). However, the physician did not indicate whether the medication could be tapered or discontinued nor did the physician indicate the clinical rationale for the continued use of the medication. The CNA (Certified Nursing Assistant) behavioral documentation from (MONTH) 26, (YEAR) through (MONTH) 8, 2019, revealed the resident was coded as isolating herself during the evening shift on several occasions. However, the documentation did not include the number of times the resident self-isolated each shift, the interventions administered to address the behavior, and/or whether the interventions were effective. Review of the MAR and TAR (Treatment Administration Record) from (MONTH) 1, (YEAR) through (MONTH) 8, 2019 revealed the resident was administered [MEDICATION NAME] but did not reveal evidence that the resident was monitored for [MEDICAL CONDITION] as evidenced by yelling or social isolation. Further review of the clinical record revealed no evidence of a specific diagnosed condition for the administration of [MEDICATION NAME], that the resident had [MEDICAL CONDITION] as evidenced by yelling, that the side effects for the use of the antipsychotic were monitored and documented every shift as care planned, and that non-pharmacological interventions to address the resident's behavior were developed, implemented, and evaluated for effectiveness. An observation was conducted on (MONTH) 7, 2019 from 12:25 p.m. through 2:24 p.m. The resident was observed in the unit

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F 0744 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 6) dining area sitting in a chair with three other residents at the dining table. She was awake, alert, calm, pleasant and conversational when staff would talk to her. She was observed eating her meals independently conversing with the other residents at the table. When she finished her meal, she stood up and pushed her chair to the side of the wall and watched television. She was not observed to be anxious, upset, combative, or angry with staff or other residents. In an interview with a day shift CNA (staff #41) conducted on (MONTH) 7, 2019 at 1:12 p.m., she stated that she was very familiar with the residents on the unit. She stated resident #83 is alert with some confusion related to time, very kind, and quiet. The CNA stated that the resident is aware of her surroundings, requires very little help, can talk and tell staff needs, and is very capable of doing things while supervised. She stated the resident comprehends and responds to staff with appropriate answers and attends and actively participates in activities. The CNA stated that she had not observed the resident yell and that as far as she knows; the resident does not yell and does not have any behaviors, hallucinations and/or delusions. An interview was conducted with a licensed practical nurse (LPN/staff #273) on (MONTH) 7, 2019 at 2:05 p.m. Staff #273 stated behaviors manifested by a resident are monitored and documented on the MAR or in the nursing assessments. An interview was conducted with an evening shift CNA (staff #27) on (MONTH) 7, 2019 at 2:17 p.m. Staff #27 stated the resident is a very nice person who requires supervision with ADLs (activities of daily living). She stated that the only behavior the resident has that she could think of is wandering. The CNA stated that she has not observed the resident yelling or displaying aggression to staff or other residents. She also stated that the resident does not have hallucinations, delusions or paranoia. During an interview conducted with a day shift CNA (staff #212) on (MONTH) 8, 2019 at 9:46 a.m., he stated the resident is alert and oriented, does not have behaviors, hallucinations or delusions, does not yell and gets along with other resident and staff. He stated the resident does not isolate herself, attends and participates in activities and the only time the resident is in her room is when the resident wants to take a nap. The CNA further stated the resident will come out of her room to watch TV or attend activity in the dining room or to be with other residents. In an interview with a registered nurse (RN/staff #17) conducted on (MONTH) 8, 2019 at 10:00 a.m., she stated that behavior monitoring is conducted the entire shift and that the number of times a resident displays a behavior is documented on the MAR. She stated that resident #83 is alert and oriented, very pleasant, and is independent with ADLs but requires supervision. The RN stated the resident does not have any behaviors such as hallucinations, delusions, paranoia, and self-isolation. She stated the resident attends and participates in activities all the time. Another interview was conducted with staff #17 on (MONTH) 8, 2019 at 1:10 p.m. Staff #17 stated that the resident is receiving [MEDICATION NAME] for self-isolation. She stated that whenever the resident exhibits self-isolation and/or yelling, it will be documented on the MAR. After reviewing the clinical record, the RN stated that although there is an order to monitor the resident for self-isolation related to the use of an antidepressant medication, she is unable to find documentation the resident was monitored. She stated the order should have been transcribed onto the MAR. During an interview conducted with the Director of Nursing (DON/staff #184) on (MONTH) 8, 2019 at 2:18 p.m., she stated that behaviors displayed by residents with dementia should be documented on the MAR and in the CNA documentations. The DON stated behavior monitoring is conducted every shift. She stated that resident #83 resides on the unit where behaviors displayed are more related to the dementia disease process. The DON stated that the residents in the secured units are seen by the psychiatrist who is responsible in overseeing the use of [MEDICAL CONDITION] medications and ensuring that the use of [MEDICAL CONDITION] medications including antipsychotic has adequate clinical indication for its use. She also stated that she was not aware that the order to monitor for self-isolation was not transcribed onto the MAR. The facility's policy titled Dementia revealed that individuals with dementia will have appropriate management. The policy included the physician will order appropriate interventions to address significant behavior and psychiatric symptoms. The policy also included medications should be targeted to specific symptoms or conditions where they are likely to be beneficial and should be used in the lowest possible doses for the shortest possible time, unless a clinical rationale for higher doses or longer-term use is identified and documented. The policy further included the physician should not simply defer to the consultant for everything related to dementia and behavior problems.
F 0756 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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, facility documentation, staff interviews, and policy review, the facility failed to ensure one resident's (#83) clinical record contained determination documentation by the physician regarding a gradual dose reduction and/or the rationale for the continued use of an anti-psychotic medication. Findings include: Resident #83 was admitted on (MONTH) 26, (YEAR) with [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. Review of the Consultant Pharmacist's Medication Regimen Review dated (MONTH) 27, (YEAR) revealed a note was written to the physician that CMS (Centers for Medicare & Medicaid Services) guidelines states a facility must re-evaluate the use of the antipsychotic medication at the time of admission and/or within 2 weeks of admission and consider whether or not the medication is appropriate and if the medication can be tapered or discontinued. The review included the pharmacist instructed the physician to please re-evaluate the need of [MEDICATION NAME] for possible taper of dose or discontinuation and document rationale in the clinical record. The review also included a handwritten note Dose reduction evaluation was completed on (MONTH) 16, (YEAR). 0 dose reduction. However, this note was not signed by the staff or the physician. Review of the Psychoactive Gradual Dose Reduction review dated (MONTH) 13, (YEAR) to the physician included the resident was receiving [MEDICATION NAME] 0.25 mg by mouth at bedtime. The review also included the facility assessment of the medication benefit included [MEDICAL CONDITION], depression, and social isolation. The form was signed by the physician on (MONTH) 16, (YEAR). However, the section for the physician's determination regarding dose reduction or the clinical rationale for the continued use of the antipsychotic was blank. The Consultant Pharmacist's Medication Regimen Reviews dated (MONTH) 3, (YEAR) and (MONTH) 4, (YEAR) revealed no recommendations regarding the [MEDICATION NAME]. Review of the Psychoactive Gradual Dose Reduction review dated (MONTH) 8, (YEAR) to the physician included the resident was receiving [MEDICATION NAME] 0.25 mg by mouth at bedtime. The review also included the facility assessment of the medication benefit included [MEDICAL CONDITION] and depression as evidenced by social isolation. The form was signed by the physician on (MONTH) 8, (YEAR). Again the section for the physician's determination regarding dose reduction or the clinical rationale for the continued use of the antipsychotic was blank. The Consultant Pharmacist's Medication Regimen Reviews for (MONTH) and (MONTH) (YEAR) revealed no written recommendations by the pharmacist regarding the use of [MEDICATION NAME]. Further review of the clinical record revealed no documentation by the physician regarding the review of [MEDICATION NAME] for GDR or clinical rationale for the continued use of the medication. During an interview conducted with the Director of Nursing (DON/staff #184) on (MONTH) 8, 2019 at 2:18 p.m., she stated the specific behavior associated with the use of any [MEDICAL CONDITION] medications including antipsychotic medications should be ordered by the physician. She stated that if the order does not include specific behaviors, the nurse is expected to call and verify the specific behavior with the physician. The DON said GDR recommendations come from the pharmacist who conducts monthly medication regimen reviews for all the residents. She stated the physician will be informed of the recommendations and will decide whether to agree or disagree with the recommendations and will document in the clinical record his decision with rationale. The DON stated that the residents residing in the secured units are followed by the psychiatrist who is responsible for ensuring [MEDICAL CONDITION] medications have adequate clinical indication for its use. In an interview with the pharmacist conducted on (MONTH) 9, 2019 at 3:13 p.m., he stated that he conducts medication reviews for all residents and that he reviews the antipsychotic medications first. He stated that he ensures the clinical record has documentation for the appropriate diagnosis, indication for use, monitoring of signs and symptoms of side effects, and behaviors related to the use of antipsychotic medications. He stated that he always make a follow up on his previous

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F 0756 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 7) recommendations and ensures that the physician is available to review them. He said if he does not receive a response from the physician, he will notify the DON. The facility's policy regarding Medication Regimen Review revealed the consultant pharmacist shall review the medication regimen of each resident at least monthly. The policy included the pharmacist will document his/her findings and recommendations on the monthly drug review report and will provide a written report to the physician for each resident with an identified irregularity. The policy also included If the physician does not provide a pertinent response, or the pharmacist identifies that no action has been taken, he/she will then contact the Medical Director, or, -if the Medical Director is the Physician of Record-the Administrator The policy revealed copies of drug medication regimen review reports, including physician responses, will be maintained as part of the permanent medical record.
F 0757 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policy review, the facility failed to ensure one resident (#148) was free of unnecessary drugs, by failed to ensure pain medications were administered as ordered by the physician. Findings include: Resident #148 was admitted to the facility on (MONTH) 11, (YEAR), with [DIAGNOSES REDACTED]. Review of the physician's orders [REDACTED]. 7-10. The admission Minimum Data Set (MDS) assessment dated (MONTH) 18, (YEAR) revealed a score of 15 on the Brief Interview for Mental Status (BIMS) indicating the resident was cognitively intact. The assessment also included the resident was on a pain medication regimen. Review of the current care plan regarding pain medication revealed a goal that the resident would be free of any discomfort or adverse side effects from pain medication. Interventions included administering [MEDICATION NAME] medications as ordered by the physician. Review of the Medication Administration Record [REDACTED]. The MAR indicated [REDACTED]. The MAR indicated [REDACTED]. The MAR indicated [REDACTED]. Review of the MAR indicated [REDACTED]. The MAR indicated [REDACTED]. An interview was conducted on (MONTH) 10, 2019 at 1:15 p.m. with a registered nurse (RN/staff # 122). He stated pain medications with parameters have to be followed according to physician orders. He stated if the pain level is outside of the ordered pain medication parameters then the nurse would need to call the physician. An interview was conducted on (MONTH) 10, 2019 at 3:54 p.m. with the Director of Nursing (DON/staff #184). She stated nursing staff are expected to follow the ordered pain medication parameters. She stated it is appropriate for the nurse to administer a low dose of medication if the resident is requesting the lower dose for their pain level. She stated if the resident insist on receiving a pain medication that is for a higher pain level than their current pain level, the nurse is to notify the physician and document on the clinical record. Review of the facility's policy titled Administering Medications revealed medications shall be administered in a safe, timely manner, and as prescribed. The policy included medications shall be administered in accordance with the orders, including any required timeframe.
F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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, facility documentation, staff interviews, and policy review, the facility failed to ensure one resident (#83) was free from an unnecessary [MEDICAL CONDITION] medication and failed to ensure as needed (prn) antipsychotic medications orders were limited to 14 days and/or included the duration for the prn order for one resident (#39). Findings include: -Resident #83 was admitted on (MONTH) 26, (YEAR) with [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. Review of the consent for Treatment with [MEDICAL CONDITION] Medication dated (MONTH) 26, (YEAR) revealed administration of the antipsychotic medication [MEDICATION NAME] was recommended for the [DIAGNOSES REDACTED]. The care plan dated (MONTH) 26, (YEAR) regarding the use of the [MEDICAL CONDITION] medication [MEDICATION NAME] related to [MEDICAL CONDITION] as evidenced by yelling included a goal that the resident will be/remain free of [MEDICAL CONDITION] drug related complications. Interventions included administering the [MEDICAL CONDITION] medication as ordered by the physician, consulting with pharmacy for the physician to consider a dose reduction, discussing with the physician the ongoing need for use of the medication, monitoring for side effects and effectiveness every shift; and reviewing behaviors and interventions and alternate therapies attempted and their effectiveness. The care plan also included the following Black Box warning Elderly patients with dementia-related [MEDICAL CONDITION] treated with antipsychotic drugs are at an increased risk of death. [MEDICATION NAME] is not approved for the treatment of [REDACTED]. The physician's orders [REDACTED]. Review of the Consultant Pharmacist's Medication Regimen Review dated (MONTH) 27, (YEAR) revealed a note was written to the physician that CMS (Centers for Medicare & Medicaid Services) guidelines states a facility must re-evaluate the use of the antipsychotic medication at the time of admission and/or within 2 weeks of admission and consider whether or not the medication is appropriate and if the medication can be tapered or discontinued. The review included the pharmacist instructed the physician to please re-evaluate the need of [MEDICATION NAME] for possible taper of dose or discontinuation and document rationale in the clinical record. The review also included a handwritten note that a dose reduction evaluation was completed on (MONTH) 16, (YEAR) 0 dose reduction. This note was not signed or initialed. Review of the Psychoactive Gradual Dose Reduction Review dated (MONTH) 13, (YEAR) included the resident was on [MEDICATION NAME] 0.25 mg by mouth at bedtime. The review included the target behaviors could be auditory and visual hallucinations, delusional and paranoid statements, and continuous crying out, yelling, screaming or pacing if so continuous as to impair functionality (track # of hours of these continuous behaviors). However, no target behavior was circled. The review also included the facility assessment of the medication benefit included [MEDICAL CONDITION], depression, and social isolation. Additional review of the form revealed [MEDICATION NAME] cannot be used for wandering, impaired memory, unsociability or behaviors that do not represent a danger to the resident or others because the risks exceed the benefits. Further review of the form revealed the physician signed the review on (MONTH) 16, (YEAR). However, the section for the provider to check and document for determination was blank. Psychiatry notes dated (MONTH) 29, (YEAR), (MONTH) 19, (YEAR) and (MONTH) 16, (YEAR) revealed the resident did not exhibit hallucinations and/or delusions and social isolation as a behavior. The quarterly nursing evaluation dated (MONTH) 24, (YEAR) revealed the resident did not displayed delusions, hallucinations, or social isolation. Review of the Psychoactive Gradual Dose Reduction Review dated (MONTH) 8, (YEAR) included the resident was receiving [MEDICATION NAME] 0.25 mg by mouth at bedtime. The facility assessment regarding the medication benefit included [MEDICAL CONDITION] and depression as evidenced by social isolation. This form was signed by the physician on (MONTH) 8, (YEAR). However, the physician did not include whether the medication could be tapered or discontinued nor did the physician include the clinical rationale for the continued use of the medication. The Consultant Pharmacist's Medication Regimen Review for September, October, November, and (MONTH) (YEAR) revealed no recommendations regarding the [MEDICATION NAME].

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035250	A. BUILDING _____ B. WING _____	01/10/2019

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
IMMANUEL CAMPUS OF CARE	11301 NORTH 99TH AVENUE PEORIA, AZ 85345

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

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F 0758 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 8) Additional review of the clinical record revealed no specific diagnosed condition for the administration of [MEDICATION NAME], no evidence that target behavior and side effects related to the use of the [MEDICATION NAME] were monitored and documented, no evidence that a GDR was attempted, and no clinical rationale documentation by the physician why a GDR was contraindicated. During an interview conducted with a Registered Nurse (RN/staff #17) on (MONTH) 8, 2019 at 10:00 a.m., the RN stated that behavior monitoring and the number of the specific behavior are documented on the MAR for each shift. An interview was conducted with the Director of Nursing (DON/staff #184) on (MONTH) 8, 2019 at 2:18 p.m. She stated that behaviors displayed by residents with dementia should be documented on the MAR and in the CNA documentations. The DON stated behavior monitoring is conducted every shift. She stated that the physician should order the specific behavior associated with the use of a [MEDICAL CONDITION] medication and that if there is no order, the nurse is expected to verify the specific behavior with the physician. The DON stated that a GDR recommendation comes from the pharmacist who conducts monthly reviews of residents' medications. She stated that the physician is informed of the recommendation, can agree or disagree with the recommendation, and will document in the clinical record the reason for the determination. The DON stated that the residents in the secured units are seen by the psychiatrist who is responsible for overseeing the use of [MEDICAL CONDITION] medications and ensuring that the use of [MEDICAL CONDITION] medications has adequate clinical indication for its use. In an interview conducted with the pharmacist on (MONTH) 9, 2019 at 3:13 p.m., he stated that he conducts medication reviews for all residents and that he reviews the antipsychotic medications first. He stated that he ensures the clinical record has documentation for the appropriate diagnosis, indication for use, monitoring of signs and symptoms of side effects, and behaviors related to the use of antipsychotic medications. The pharmacist stated that his reviews include reviewing laboratory results and vital signs. He said that he could not make an overall good recommendation if the information was not available. -Resident #39 was admitted on (MONTH) 3, (YEAR) with [DIAGNOSES REDACTED]. Review of the recapitulation of physician's orders [REDACTED]. -[MEDICATION NAME] 2 milligrams (mg) IM (intramuscular injection) every 4 hours as needed (prn) for anxiety ordered (MONTH) 4, (YEAR), -[MEDICATION NAME] 5 mg IM every 4 hours prn for [MEDICAL CONDITION] ordered (MONTH) 4, (YEAR), and -[MEDICATION NAME] 1 mg every 6 hours prn for anxiety ordered (MONTH) 29, (YEAR) However, further review of the orders for [MEDICATION NAME] and [MEDICATION NAME] did not reveal a 14 day end date. An interview was conducted with the DON (staff #184) on (MONTH) 8, 2019. The DON stated that prn [MEDICAL CONDITION] medications must be discontinued after 14 days. She stated that if the medication has not been administered for 30 days, the order must be discontinued. The DON also stated that the time limit for psychoactive and antipsychotic prn medications is 14 days and then a re-evaluation must be conducted. The facility's policy titled, Orders for Medications to Treat Problematic Behavior and Mood stated that Physicians will limit orders for antipsychotic medications to specific conditions or situations for which they may be beneficial, such as: [MEDICAL CONDITION]; [MEDICAL CONDITION] disorder; delusional disorder; psychotic mood disorders ([MEDICAL CONDITION] depression with psychotic features); acute psychotic episodes; brief reactive [MEDICAL CONDITION]; schizophreniform disorder; atypical [MEDICAL CONDITION]; [MEDICAL CONDITION]'s disorder; [MEDICAL CONDITION]'s Chorea; and medical illnesses (including [MEDICAL CONDITION]) with associated psychotic and/or agitated features defined by .psychotic symptoms (hallucinations, paranoia, delusions) that are debilitating or dangerous enough to present a risk to the resident/patient or to others. The policy included that medication doses and duration should be consistent with the frequency, severity and duration of the condition or problem being treated. The policy also included that periodically, the attending physician will evaluate and document conclusions about the status of any symptoms related to mood and behavior, the effectiveness of any medications, and the indications to continue or change current treatment. The policy stated when the resident's behavior is stable (or at least every 6 months), the attending physician will attempt to reduce the dose of the psychopharmacological medications or document the clinical rationale for not doing so. Continued review of the policy revealed Generally, PRN doses should not remain over an extended period (weeks to months) unless they are appropriate to treat to address significant intermittent symptoms. The policy did not address the 14 day limit for [MEDICAL CONDITION] medications.
F 0761 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, and policy review, the facility failed to ensure expired items in the medication rooms and the medication carts were not available for use. Findings include: During a medication room observation conducted on (MONTH) 2, 2019 at 11:30 a.m. with a licensed practical nurse (LPN/staff #255) on the Garden Cove unit, one individually packed [MEDICATION NAME] non-adhesive wound dressing in a cabinet was observed with an expiration date of (MONTH) (YEAR). An interview was conducted with staff #255 immediately following the observation. He stated that the wound dressing was prescribed for a resident that has been discharged . The LPN stated the night nurses check the medication rooms daily and the central supply staff checks the rooms every Sunday for expired medications or items. He further stated that expired items or medications are discarded and not used. A medication room observation was conducted on (MONTH) 2, 2019 at 12:38 p.m. with a LPN (staff #96) on the[NAME]Heights unit. One light blue top blood collection tube was observed with an expiration date of (MONTH) 31, (YEAR) mixed with other unexpired blood collection tubes in a cabinet. During an interview conducted with staff #96 immediately following the observation, she stated that the night shift nurses are responsible for checking the medication rooms for expired items including the blood collection tubes. An observation was conducted of a medication cart on the Sunrise View unit with a LPN (staff #88) on (MONTH) 2, 2019 at 12:46 p.m. Two individually packets of Prosource protein powder (supplement) were observed with an expiration date of (MONTH) 19, (YEAR). Staff #88 stated that the packets were expired and that she does not administer the packets. She removed the packets from her cart and stated that she did not know who placed the packets in her cart. The LPN stated that she checks for expired items every time she re-stocks the cart and prior to medication administration. During a medication cart observation conducted on (MONTH) 8, 2019 at 9:30 a.m. on the Sunshine Square unit with a LPN (staff #58), a small bottle of [MEDICATION NAME] Ophthalmic Solution 1% prescribed for a resident was observed with an expiration date of (MONTH) (YEAR). Staff #58 stated that she administered the medication to the resident this morning (January 8, 2019) at 8:00 a.m. and that she did not notice the medication was expired. She stated that the night shift nurses are supposed to check for expired medications/items daily and the floor nurses are to check for expired items before medication administration. The facility's policy titled Storage of Medications included all drugs and biologicals shall be stored in a safe, secure, and orderly manner and that the nursing staff is responsible for maintaining medication storage. The policy also included The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed.