STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035111	A. BUILDING _____ B. WING _____	06/13/2019

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LAKE PLEASANT POST ACUTE REHABILITATION CENTER	20625 NORTH LAKE PLEASANT ROAD PEORIA, AZ 85382

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 0641 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, policy review, and review of the Resident Assessment Instrument (RAI) manual, the facility failed to ensure a Minimum Data Set (MDS) assessment accurately reflected the discharge status of one of 3 sampled residents (#80). The deficient practice has the potential to affect continuity of care. Findings include: Resident #80 was admitted to the facility on (MONTH) 27, 2019 with [DIAGNOSES REDACTED]. The discharge care plan revealed that the resident's discharge goal was to return to the community. Review of the physician's orders [REDACTED]. A discharge summary progress note dated (MONTH) 19, 2019 revealed resident #80's health had improved sufficiently and the resident no longer needed the services of the facility. The note stated the post discharge plan of care was the resident was being discharged to the community. Review of the clinical record revealed the resident discharged from the facility to the community on (MONTH) 21, 2019. However, review of the resident's discharge MDS assessment dated (MONTH) 21, 2019, revealed the resident was coded as having been discharged to an acute hospital. An interview was conducted on (MONTH) 13, 2019 at 8:58 a.m. with the MDS coordinator (staff #118). She stated that it was an accuracy issue and the MDS was not coded correctly. She said she strives to be accurate all the time, and was still in the window to modify the information. An interview was conducted on (MONTH) 13, 2019 at 9:04 a.m. with the Director of Nursing (DON/staff #115). She noted the error and stated they would fix it right away. The facility policy titled Resident Assessment (MDS 3.0) stated it is the policy of the facility to ensure that the assessment accurately reflects the resident's status. The RAI manual for the MDS included that the importance of accurately completing and submitting the MDS cannot be over-emphasized. Further, Federal regulations require that the assessment accurately reflects the resident's status. When coding for discharge location, the RAI manual instructs to review the medical record including the discharge plan and discharge orders for documentation of discharge location.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff and resident interviews, observations, and policy review, the facility failed to ensure that physician's orders for a wheelchair cushion were implemented for one of 18 sampled residents (#47). The deficient practice has the potential to cause the resident unnecessary discomfort and potential skin breakdown. Findings include: Resident #47 was admitted on (MONTH) 18, 2019 with [DIAGNOSES REDACTED]. On (MONTH) 19, 2019, two physician's orders were noted: One was for a wheelchair cushion and the other for monitoring the wheelchair cushion every shift. Review of the admission Minimum Data Set (MDS) assessment dated (MONTH) 1, 2019 revealed that the resident was coded as being at risk for pressure ulcers. The resident's pressure ulcer care plan noted that the resident was at risk for skin breakdown related to impaired mobility. Risk factors included [MEDICAL CONDITIONS], and fragile skin. One of the interventions included utilizing a wheelchair cushion. Review of the Treatment Administration Record (TAR) for (MONTH) 1 through 10, 2019 revealed that the resident was coded as having had the wheelchair cushion on her wheelchair during all shifts except on the day shift on (MONTH) 3 and (MONTH) 7. For these dates, the MAR indicated [REDACTED]. The nursing notes were reviewed from (MONTH) 1 through 10, 2019. There was no indication as to what happened with the wheelchair cushion on (MONTH) 3 or (MONTH) 7. There was no further documentation concerning the wheelchair cushion in the nursing notes. On (MONTH) 10, 2019 at 11:12 a.m., an interview was conducted with resident #47. She stated her bottom hurt really, really bad from sitting in her wheelchair. She said she thought a wheelchair cushion would help a lot. An observation of the resident was conducted on (MONTH) 10, 2019 at 1:02 p.m The resident was in her wheelchair with no wheelchair cushion present. On (MONTH) 11, 2019, the resident was observed at 9:00 a.m., 10:59 a.m., 12:51 p.m., and 3:24 p.m. in her wheelchair with no wheelchair cushion present. The TAR was reviewed for (MONTH) 11, 2019 and it indicated that the wheelchair cushion was in place during the day shift. On (MONTH) 11, 2019 at 1:30 p.m., an interview was conducted with a Certified Nursing Assistant (CNA/staff #33). She stated the resident does have a wheelchair cushion, but that sometimes she puts it away in her closet and then forgets it is there. Staff #33 said she helps the resident find her things sometimes, and that she usually finds them in the resident's closet. However, she stated she hasn't seen the resident's wheelchair cushion for a while. On (MONTH) 11, 2019 at 3:16 p.m., an interview was conducted with a Registered Nurse (RN/staff #28). She stated that monitoring of the resident's wheelchair cushion pops up on the MAR (Medication Administration Record) on a twice daily basis and that it's the nurses' responsibility to ensure/document that the cushion is there. She said if it's not in the resident's chair, staff look for it in the resident's room. If the cushion still can't be found, there are extra cushions in the back of the therapy room and staff can get her another one since it's not a specialty item. An interview was conducted on (MONTH) 12, 2019 at 8:36 a.m. with the Physical Therapy Assistant (PTA/staff #94). She stated there are extra wheelchair cushions in the therapy room and in central supply. She said that if a resident's cushion is misplaced, staff can come and get another one as they have extra. She said that since this resident does not require a specialty cushion, a new one can be obtained at any time if hers is misplaced. On (MONTH) 12, 2019 at 8:54 a.m., an interview was conducted with the Director of Nursing (DON/staff #115). She stated her expectation is for nursing to follow the physician's orders. The facility policy titled Physician's Orders stated it is the policy of the facility to accurately implement orders in accordance with the resident's plan of care. The policy further noted that medication, treatment or related procedure orders are transcribed in the TAR accordingly.

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1)
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 6 sampled residents (#23 and #179) were free from unnecessary drugs, by failing to administer drugs according to the physician ordered parameters. The deficient practice could result in low blood pressures and residents receiving drugs which may not be necessary. Findings include: -Resident #23 was admitted on (MONTH) 2, 2019 with [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. The resident's hypertension care plan, dated (MONTH) 3, 2019, noted that the resident had [MEDICAL CONDITION]. The goal for the care plan was that the resident was to be free from signs or symptoms of complications of cardiac problems. Interventions included to give medications for hypertension and document the response to medication. The admission Minimum Data Set (MDS) assessment dated (MONTH) 12, 2019 included that the resident had a Brief Interview for Mental Status (BIMS) score of 12, which indicated mild cognitive impairment. Review of the Medication Administration Record (MAR) for (MONTH) 3, 2019 through (MONTH) 16, 2019 revealed the resident received the carvedilol when his SBP was below physician ordered parameters on nine occasions: -April 3 for a SBP of 105 mmHg -April 4 for a SBP of 91 mmHg -April 6 for a SBP of 91 mmHg -Twice on (MONTH) 7 both SBPs of 107 mmHg -April 9 for a SBP of 92 mmHg -April 10 for a SBP of 99 mmHg -April 11 for a SBP of 85 mmHg -April 14 for a SBP of 93 mmHg Review of the nursing notes for (MONTH) 3, (YEAR) through (MONTH) 16, 2019 revealed no documentation to show the medication had been held when the SBP was below the physician ordered parameters. On (MONTH) 16, 2019, the physician's orders [REDACTED]. Review of the MAR for (MONTH) 16, 2019 through (MONTH) 31, 2019 revealed the resident received the carvedilol when his SBP was below the physician ordered parameters on two occasions: -April 27 for a SBP of 90 mmHg -May 8 for a SBP of 92 mmHg Review of the nursing notes for (MONTH) 16, 2019 through (MONTH) 31, 2019 revealed no documentation to show the medication had been held when the SBP was below the physician ordered parameters. An interview was conducted on (MONTH) 12, 2019 at 2:13 p.m. with a Licensed Practical Nurse (LPN/staff #72). She stated that before she administers a blood pressure medication, she makes sure the resident's BP is within the ordered parameters and if it's too low, she holds the medication. An interview was conducted on (MONTH) 13, 2019 at 9:06 a.m. with the Director of Nursing (DON/staff 115). She stated it was rare to have parameters on a medication, but she expects the nurses to follow them. She agreed that the resident had received a blood pressure medication outside of the physician ordered parameters. -Resident #179 was admitted on (MONTH) 30, (YEAR) with [DIAGNOSES REDACTED]. A Minimum Data Set (MDS) assessment dated (MONTH) 6, (YEAR) included that resident #179 had a BIMS (Brief Interview for Mental Status) score of 15, which indicated she was cognitively intact. An Initial Admission Record dated (MONTH) 30, (YEAR) included that the resident had [MEDICAL CONDITION]. A physician's progress note dated (MONTH) 6, (YEAR) included that the resident had gained 7 pounds (lbs) and the resident felt that she was swollen. The note included that the resident had mild/moderate bilateral lower extremity [MEDICAL CONDITION], and [MEDICATION NAME] (a diuretic medication) was to be started. A physician's orders [REDACTED]. A written care plan dated (MONTH) 6, (YEAR) included that the resident was on diuretic therapy related to [MEDICAL CONDITION]. Interventions documented in the care plan included to administer medication as ordered, and (MONTH) cause dizziness, postural [MEDICAL CONDITION], fatigue, and an increased risk for falls. Review of the Medication Administration Record (MAR) for (MONTH) (YEAR) revealed the [MEDICATION NAME] was given outside of the physician's orders [REDACTED]. -November 8, (YEAR) for SBP of 86 mmHg -November 12, (YEAR) for SBP of 87 mmHg Continued review of the clinical record did not reveal any additional documentation that [MEDICATION NAME] had been held on (MONTH) 8, and 12, (YEAR). An interview was conducted on (MONTH) 11, 2019 at 12:53 p.m. with a LPN (Licensed Practical Nurse/staff #20). The nurse stated that when blood pressure parameters are ordered for the use of a medication (including [MEDICATION NAME]) the nurse checks the resident's blood pressure prior to administering the medication and if the blood pressure is too low, the medication is not given and the physician is notified. An interview was conducted on (MONTH) 12, 2019 at 10:35 a.m. with the Director of Nursing (DON/staff #115). The Director stated that when a nurse is providing a medication with a physician's orders [REDACTED]. The Director stated that the nurse should not have given the [MEDICATION NAME] 20 mg to resident #179 on (MONTH) 8, and 12, (YEAR). A policy and procedure titled Administration of Medication included a statement that medications shall be administered as prescribed by the attending physician and medications must be administered in accordance with the written orders of the attending physician including following parameter orders for blood pressure.