STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035270	A. BUILDING _____ B. WING _____	12/20/2018

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LA ESTANCIA NURSING AND REHABILITATION CENTER	15810 SOUTH 42ND STREET PHOENIX, AZ 85048

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews and policy review, the facility failed to provide timely care and services, in order to accommodate one residents' (#48) choice to attend church services. Findings include: Resident #48 was readmitted to the facility on (MONTH) 26, (YEAR), with [DIAGNOSES REDACTED]. Review of the annual MDS (Minimum Data Set) assessment dated (MONTH) 28, (YEAR), revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. In Section C. the documentation included that the revealed did not reject care regarding activities of daily living. Review of the activity care plan dated (MONTH) 7, (YEAR) revealed the following: The resident will participate in self-directed activities of her choice on a daily basis; will continue to independently plan leisure time activities daily; the resident's preferences would be honored on a daily basis; provide transportation to the activity and assistance for the engagement as needed and offer a variety of activity types and locations. During an interview with resident #48 on (MONTH) 17, (YEAR) at 9:34 a.m., the resident stated that the facility staff do not get her up and dressed in time to go to church. She stated that she has missed church for the last month. She said if the night staff would get her up and dressed, she would be able to get to church on time. She said that she makes a reservation to be picked up, but has had to cancel multiple times because there was no one to help her get dressed. The resident also stated that staff don't get her up and dressed in time to eat breakfast in the dining room and that she pushes her call light, but staff still don't come to get her dressed. An interview was conducted on (MONTH) 18, (YEAR) at 1:27 p.m. with a certified nursing assistant (CNA/staff #69), who stated that she uses a Hoyer lift to transfer the resident and assists the resident with hygiene tasks. She said the resident only wants two CNA's to transfer her into her wheelchair, but it takes 4 CNA's to transfer the resident into her wheelchair. She stated the night staff are supposed to get the resident up and dressed in the mornings, but they can't when they are short staffed. Staff #69 said that by the time the morning shift starts the resident is already mad, because she was left in bed so long. She stated the morning staff are willing to get the resident up and dressed, but cannot assist the resident during breakfast time, because there are not any CNA's available at that time. During an interview with a CNA (staff #115) conducted on (MONTH) 18, (YEAR) at 1:56 p.m., staff #115 stated that the night CNA's are supposed to get the resident up in the mornings. On (MONTH) 18, (YEAR) at 3:04 p.m., an interview was conducted with a licensed practical nurse (LPN/staff #23), who stated that the night CNA's are supposed to get specific residents up and dressed, which included resident #48. She said the night CNA's do not get the resident dressed when they are short staffed and this occurs approximately one time per week. An interview was conducted with a LPN (staff #103) on (MONTH) 18, (YEAR) at 3:18 p.m. During the interview, staff #103 said that there are supposed to be three CNA's working on the night shift for the unit where resident #48 resides, and the CNA's working the night shift are supposed to get resident #48 up and dressed along with a few other residents, but if there are only two CNA's on the night shift, they are not able to get everyone up and dressed. She stated the resident has not been up and dressed at least half of the time over the past two weeks. Staff #103 said the resident is also missing breakfast in the dining room on a weekly basis. She said the resident doesn't mind getting up early, because it takes a long time to dress her and she wants to be dressed in time to eat breakfast in the dining room with her friends. Staff #103 said the resident doesn't like to eat in her room and the CNA's on the morning shift don't have time to get the resident up and dressed before breakfast; as the CNA's are busy handing out breakfast trays by 7:30 a.m. She said the Assistant Director of Nursing (ADON/staff #72) signed and agreed that the resident could get up during the night shift, except when the night CNA's are short staffed. When asked what the resident does on the days that she is not up and dressed in time to eat breakfast in the dining room, staff stated that the resident eats breakfast in her room. An interview was conducted on (MONTH) 19, (YEAR) at 12:15 p.m. with the Assistant Director of Nursing (ADON/staff #72). Staff #72 stated that she does her best to accommodate the residents' needs for assistance with activities of daily living. She said that she was pretty sure that resident #48 was on the list to be dressed by the night staff, but if there are only two CNA's working the night shift on the unit where resident #48 resides, then the CNA's are suppose to dress the resident and leave her in bed. She stated there are sign-in-sheets and sign-out-sheets when residents leave and that she would provide the last four weekends to see if the resident went out for church; however, the sheets were not provided. Staff #72 stated that she is aware the resident likes to go to church and thought she was going to church each weekend. She also said that she was not aware the resident was missing breakfast in the dining room, because staff did not get her up and dressed in time. Review of the facility's Staffing policy revealed the facility will provide qualified and appropriate staffing levels to meet the needs of the patient population.
F 0623 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interviews, the facility failed to ensure that a notice of transfer and discharge was sent to the representative of the Office of the State Long Term Care Ombudsman for one resident (#101). Findings include: Resident #101 was readmitted on (MONTH) 8, 2012, with [DIAGNOSES REDACTED]. Review of the closed clinical record revealed a nurses note dated (MONTH) 1, (YEAR) at 3:29 p.m., which included the resident had complained of indigestion, chest pain and did not feel well. Per the note, the resident was transferred to the hospital. According to a MDS (Minimum Data Set) assessment dated (MONTH) 1, (YEAR), the resident had been discharged to the hospital and return was not anticipated. Further review of the closed clinical record for resident #101 revealed there was no documentation that the State Ombudsman had been provided a copy of the notice of discharge. An interview was conducted on (MONTH) 19, (YEAR) at 9:32 a.m., with the Social Services Director (staff #65). Staff #65

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

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F 0623 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) stated that the facility only notifies the State Ombudsman of a resident's discharge, if the Ombudsman had been directly involved with the resident. Staff #65 stated that he did not know they were required to notify the State Ombudsman of all resident discharges. An interview was conducted on (MONTH) 19, (YEAR) at 9:37 a.m. with the Nurse Executive (staff #3), who stated the Social Services Director was the staff designated to notify the State Ombudsman of all resident discharges. She said that she was unaware that the State Ombudsman was not being notified.
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 policies and procedures, the facility failed to ensure professional standards of quality were met regarding the administration of an antipsychotic medication for one resident (#11). Findings include: Resident #11 was readmitted at the facility on (MONTH) 14, (YEAR), with [DIAGNOSES REDACTED]. Review of the clinical record revealed the resident was receiving [MEDICATION NAME] (antipsychotic) in (MONTH) and (MONTH) (YEAR). A Significant Change in Status MDS (Minimum Data Set) assessment dated (MONTH) 14, (YEAR), included a BIMS (Brief Interview for Mental Status) score of 8, indicating the resident had moderate cognitive impairment. The MDS included the resident received an antipsychotic on a routine basis. The CAA (Care Area Assessment) Summary also included that [MEDICAL CONDITION] drugs triggered and the care area was to be care planned. Review of the comprehensive care plan included the resident was on [MEDICATION NAME] for a mood disorder. One of the interventions was to administer [MEDICAL CONDITION] medication as ordered. A physician's order dated (MONTH) 2, (YEAR) included for [MEDICATION NAME] 0.5 mg (milligrams) at bedtime for a [DIAGNOSES REDACTED]. This order was transcribed into the MAR (medication administration record) for (MONTH) (YEAR) and was administered as ordered. Per the MAR, this order was discontinued on (MONTH) 22, (YEAR). However, there was no physician's order to discontinue [MEDICATION NAME] 0.5 mg at bedtime. Further review of the (MONTH) (YEAR) MAR revealed for [MEDICATION NAME] 1 mg, give half a tablet to equal 0.5 mg by mouth daily at bedtime for a [DIAGNOSES REDACTED]. A physician's order dated (MONTH) 22, (YEAR) included to add a [DIAGNOSES REDACTED]. Continued review of the (MONTH) (YEAR) MAR revealed that [MEDICATION NAME] 0.5 mg was administered every other day from (MONTH) 22 through 31. However, there was no physician's order to administer [MEDICATION NAME] 0.5 mg every other day. Review of the physician's order signed recap for (MONTH) (YEAR) revealed an order for [REDACTED]. An interview was conducted with a licensed practical nurse (LPN/staff #111) on (MONTH) 20, (YEAR) at 10:57 a.m. At this time, the resident's clinical record was reviewed. Staff #111 stated that according to the physician's order recap for (MONTH) (YEAR), the current order for [MEDICATION NAME] was 0.5 mg (half of 1 mg tablet) daily at bedtime and that this was ordered on (MONTH) 22, (YEAR). Regarding the MAR, he stated that the order was transcribed correctly in the MAR, but he did not know why it was administered every other day instead of daily as ordered by the physician. During an interview with the Assistant Director of Nursing (ADON/staff #72) conducted on (MONTH) 20, (YEAR) at 1:10 p.m., she stated when a nurse receives an order for [REDACTED]. She said the night nurses check the record every night to ensure that all orders written during the day were transcribed correctly onto the electronic record. She said the medical records staff also verify that the order was transcribed correctly onto the electronic record. She said the facility's system prompts the nurse that a medication administration box was not marked or was not completed. Further, she said if for some reason a medication was not given, the nurse is supposed to document the reason in the electronic and/or paper charting. An interview with the Director of Nursing (DON/staff #3) was conducted on (MONTH) 20, (YEAR) at 1:35 p.m. Staff #3 stated that when there are changes in the orders, the nurse writes the order, transcribes it into the clinical record and administers the medication as ordered. She stated the oncoming shift nurse checks for and ensures that any or all orders received prior to their shift were entered in the resident's record including the MAR. She said at the end of each month, a registered nurse conducts an order recap review for all residents at the facility and ensures that all orders are accurate and transcribed in the MAR and administered as ordered. At this time, the resident's clinical record was reviewed with the DON. She stated that she did not know why [MEDICATION NAME] was administered to the resident every other day instead of daily at bedtime as transcribed in the MAR and the physician orders. In a later interview with the DON conducted on (MONTH) 20, (YEAR) at 2:12 p.m., she stated that she and another nurse could not find any physician's order in the clinical record for the every other day administration of [MEDICATION NAME] and could not find any reason why the medication was administered every other day instead of daily. A policy on Medication Administration stated A licensed nurse, Med Tech, or medication aide, per State regulations, will administer medications to patients. Accepted standards of practice will be followed .

F 0692 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews and policies and procedures, the facility failed to ensure one resident (#70) maintained acceptable parameters of nutritional status. Findings include: Resident #70 was admitted to the facility on [DATE], discharged to the hospital on [DATE], and readmitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Review of the clinical record revealed the resident's admission weight on 10/10/18 was 195 pounds (lbs) and the readmission weight on 10/25/18 was 230 lbs. The baseline care plan initiated on 10/25/18 regarding dietary revealed the resident was at risk for weight loss and was on a puree diet. The goals were to maintain the current weight and prevent weight loss. The only intervention listed was the use of dentures. Review of the physician's orders [REDACTED]. A nursing Medicare Note dated 10/26/18 revealed the resident refused dinner, but took medications in applesauce without difficulty. A nursing note dated 10/29/18 revealed the resident refused breakfast and lunch, due to the texture of pureed foods. The note included the physician was notified the resident was refusing meals. Review of the resident's weight record revealed two weights were documented on 10/29/18. The first weight was 168.7 lbs and the second weight was 167.4 lbs. The ST evaluation and plan of treatment dated 10/30/18 included the resident was referred due to exacerbation of risk for aspiration, coughing and choking during oral intake, and decreased safety during oral intake. The evaluation included recommendations for a puree diet, nectar thick liquids, and close supervision while eating. The evaluation also included the resident's MPOA (Medical Power of Attorney) was agreeable to the plan of treatment. A physician's orders [REDACTED]. A Nutritional Data Set and Progress note dated 10/31/18 revealed the resident's weight of 230 lbs. was a significant weight gain from the previous weight of 195 lbs. and that it could be possible error in weights. The note included the resident was a moderate nutritional risk due to an average of 50% oral intake and the dislike of pureed foods as evidenced by refusal of meals. The note also included a trial of Med Pass twice a day (nutritional supplement) to prevent significant weight loss and that gradual weight loss may be beneficial related to the BMI (Body Mass Index) of 39.5. The note further included weekly weights will be ordered and to continue to monitor oral intake. A nursing Medicare Note dated 10/31/18 revealed the resident refused most meals and did not like the puree diet with nectar-thick liquids. The admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident's cognitive skills for daily decision making was severely impaired. The assessment included the resident had no swallowing difficulties and was on a mechanically altered diet.

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F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) The current comprehensive care plan included the resident was at risk for alteration in nutrition related to the dislike of the puree diet as evidenced by refusal of meals. The goal was that the resident will consume greater than or equal to 75% of each meal and will not have significant weight changes. Interventions included supplement as ordered, encourage greater than 75% intake of fluids and meals and record intake, offer alternates or supplement if less than 50% consumption, report changes in chewing and/or swallowing promptly, and weekly weights for 4 weeks and then monthly if stable. A Dietary Progress Note dated 11/14/18 revealed the significant weight loss of around 60 lbs. in less than a month is unlikely and suspected to be from inaccurate weights. The note also revealed the BMI was 28.7. The note included the nurse reported the resident dislikes the puree diet, eats very little of meals, and refuses meals at times. The note also included the weight decline since admission is likely related to poor intake. The note revealed a trial of 4 ounces of Med Pass twice daily between meals will be implemented and to continue to monitor weights and oral intake for further nutrition intervention. Review of the physician's orders [REDACTED]. The Medication Administration Record [REDACTED]. According to the MAR, there was no documentation the resident was administered the Med Pass at 2:00 PM on 11/15/18 and 11/24/18. The MAR indicated [REDACTED]. The (MONTH) weekly weights included the following: 11/4/18 was 170 lbs., 11/11/18 was 167.4 lbs., 11/18/18 was 167.3 lbs., and 11/25/18 was 162.3 lbs. Review of the MAR for (MONTH) (YEAR) revealed the resident refused Med Pass on 12/15, 12/16, and 12/17, (YEAR) due to not liking the taste. The (MONTH) weights included the following: 12/03/18 was 157.6 lbs., 12/05/18 was 156.1 lbs., 12/10/18 was 155 lbs., and 12/17/18 was 152.1 lbs. A review of meal intake percentages from breakfast on 12/01/18 to breakfast on 12/20/18 revealed the following: 19 were documented as Poor (25-49% eaten) 12 were marked as Good (75-100% eaten - mostly breakfast) 3 marked as Fair (50-74%) 3 marked as refused 2 marked with an unreadable mark 19 had no percentages/amounts documented Further review of the clinical record did not reveal any additional nutritional interventions, despite the continued weight loss. A physician's orders [REDACTED]. During an observation conducted of the resident at breakfast on 12/17/18 at 8:40 AM in the dining room, the resident was observed declining to eat oatmeal. A Certified Nursing Assistant (CNA) was also observed providing the resident with a few spoons of thickened water and refused to take any more. An interview was conducted on 12/20/18 at 10:26 AM with a CNA (staff #69), who stated the resident does not like pureed food, as she just spits it out. The CNA stated the family brings the resident food like chicken nuggets and that she eats it. Staff #69 stated the family had stated the resident eats well and will drink thickened liquids, but will not drink thickened water. An interview was conducted on 12/20/18 at 10:54 AM with the Speech Language Pathologist (SLP/staff #96), who stated residents are screened the first business day after admission orders [REDACTED]. Staff #96 stated that if services are needed, the services will be ordered. The SLP stated that she worked with resident #70 for about a week, but that she did not make much progress. Staff #96 stated that she was not aware of another order for an evaluation. During an interview conducted on 12/20/18 at 11:27 AM with the Director of Nursing (DON/staff #3), the DON stated the registered dietician makes her aware of residents that have concerns with weight. The DON stated that if an order was written for another ST evaluation it should have been done the next business day and that waiting for another 2 business days is a delay. The DON stated that she spoke with the SLP about this resident a week or two ago regarding the stroke, dysphagia, not liking the diet, wanting regular food, and not eating well. Staff #3 stated the SLP reiterated what had already been done right after admission in late October. The DON also stated that the resident's family had spoken to staff about the resident not liking the diet and that they bring her food items. An interview was conducted on 12/20/18 at 2:09 PM with the registered dietician (staff #134). She stated that she makes visits to the facility twice a week and that she makes it a high priority to complete a nutrition assessment for high risk residents. Staff #134 stated that she attempts to see high risk residents monthly, but that recently it has been quarterly. She stated that if a resident has a significant weight loss, weekly weights are ordered and that she documents a note each time the weight declines. She stated that she had not been provided this resident's weights for the past month until 12/20/18. Review of the facility's policy titled Nutrition/Hydration Management included The implementation of an individual patient's nutrition/hydration management occurs within the care delivery process. Staff will consistently observe and monitor patients for changes and implement revisions to the plan of care as needed. The policy also included developing an interdisciplinary plan of care for enhancing oral intake and promoting adequate nutrition and hydration .include interventions for patients who have functional difficulties which may affect ability to eat or drink independently. The facility's policy titled Weights and Heights included Patients are weighed upon admission and/or re-admission, then weekly for four weeks and monthly thereafter. Additional weights may be obtained at the discretion of the interdisciplinary care team. The policy also included the purpose is To obtain baseline weight and identify significant weight change and possible causes of significant weight change.
F 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** Based on resident and staff interviews and policies and procedures, the facility failed to ensure there was sufficient nursing staff to meet the needs of multiple residents. Findings include: -On (MONTH) 17, (YEAR) at 8:47 a.m., an interview was conducted with a resident who stated that one weekend, he pressed the call light and waited for more than 30 minutes for staff to come and help him with personal care and to transfer to the bathroom. He stated that he urinated on the floor and that no one changed his bedding or cleaned up the urine on the floor.-On (MONTH) 17, (YEAR) at 9:28 a.m., another resident stated that since he has been admitted (few weeks ago) he has waited 15 to 30 minutes about five different times to get a drink of water. -On (MONTH) 17, (YEAR) at 9:34 a.m., a resident stated that staff have not gotten her up and dressed in time to go to church on multiple occasions. She stated that she has missed church for the last month. She said if the CNA's on the 3rd shift (night shift) would get her up and dressed, she would be able to get to church on time. The resident stated that she has had to cancel her reservation for a ride to church multiple times, because there were no staff available to get her up and dressed. She stated that after reporting this issue to the administrator (staff #132), the CNA's started getting her up and dressed if there were three of them working, but not if there were only two CNA's working. The resident stated that she is able to use the toilet but has soiled her brief, because there was not a CNA available to help transfer her from the wheelchair to the toilet. She said that she has had to wait 20 to 30 minutes for a CNA to come and change her brief. She stated the first shift does not respond to call lights quickly if they are in the dining room, and the second shift cannot help her transfer to the toilet when staff are in the dining room. The resident stated that sometimes she has to wait until shift change for staff to help her to the toilet. She stated that she has had a bowel movement in her brief 2-3 times, because she could not wait any longer. She further said that they are really short staffed on the weekends. An interview was conducted on (MONTH) 18, (YEAR) at 1:27 p.m. with a CNA (staff #69). She stated the night staff are supposed to get this resident up and dressed in the mornings, but they are unable too when they are short staffed. Staff #69 said the resident is mad by the time the day shift starts. She stated that they are willing to get the resident up and dressed, but breakfast time starts at 7:30 a.m., and there are no CNA's available to help the resident.

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F 0725 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 3) During an interview conducted with a CNA (staff #115) on (MONTH) 18, (YEAR) at 1:56 p.m., staff #115 stated that the night CNA's are supposed to get the resident up in the mornings. On (MONTH) 18, (YEAR) at 3:04 p.m., an interview was conducted with a licensed practical nurse (LPN/staff #23). The LPN stated the night CNA's are supposed to get specific residents up and dressed, including this resident. She also stated the night CNA's do not get the resident dressed when they are short staffed, which occurs approximately one time per week. An interview was conducted with a LPN (staff #103) on (MONTH) 18, (YEAR) at 3:18 p.m. The LPN stated there are supposed to be three CNA's working on the night shift on the unit where this resident resides, but if there are only two CNA's working, they are not able to get up the residents that are supposed to be up and dressed on their shift. She stated that this resident has not been up and dressed at least half of the time over the past two weeks. Staff #103 said this resident also likes to eat breakfast in the dining room with her friends, but when the CNA's are unable to get her up on their shift, the resident eats breakfast in her room. An interview was conducted on (MONTH) 19, (YEAR) at 12:15 p.m. with the Assistant Director of Nursing (ADON/staff #72). She said that she was pretty sure that resident #48 was on the list to be up and dressed by the night staff, but if there are only two CNA's working the night shift, the CNA's are supposed to dress this resident and leave her in bed. She stated that she is aware that the resident likes to go to church and thought she was going to church each weekend. The ADON also stated that she was not aware that the resident was missing breakfast in the dining room, because staff did not get her up and dressed in time. -On (MONTH) 17, (YEAR) at 9:44 a.m., an interview was conducted with another resident who stated that it takes too long for staff to answer the call light. He stated that he waits anywhere from 15 minutes to an hour on a regular basis and that sometimes he has to go out into the hall to find staff to help him. -On (MONTH) 17, (YEAR) at 9:45 a.m., an interview was conducted with a resident who stated that he occasionally waits over 1 hour for staff to respond to his call light. -On (MONTH) 17, (YEAR) at 10:52 a.m., a resident stated that she has to wait about a half hour every day to have her call light answered on every shift. -On (MONTH) 17, (YEAR) at 10:55 a.m., another resident stated that about 4 weeks ago, he had to wait about 1 hour and 15 minutes to be changed on the second shift. He stated that he often has to wait 30 minutes to have staff change his brief, and that staff are supposed to be helping him transfer to the bathroom. The resident stated that his biggest concern is the lack of staffing in the facility and that staffing is really short on the weekends. He stated that on the average, it takes a CNA (Certified Nursing Assistant) up to 30 minutes to come to his room when he puts his call light on. Review of the Resident Council Meeting notes dated (MONTH) 21, (YEAR), revealed that one resident had concerns about not being taken to the bathroom in a timely manner and that nursing had come up with a plan to help around meal times. The notes also included that another resident reported seeing two CNA's talking at the nurses' station, while call lights were ringing. Review of the Resident Council Meeting notes dated (MONTH) 14, (YEAR), revealed that several residents residing on the long-term care hall reported that the CNA's on the third shift come into the residents' rooms, turn off the call light, and then leave without asking the residents what they need. Review of the Resident Council Meeting notes dated (MONTH) 30, (YEAR), revealed complaints that it was taking staff one hour or more to answer call lights. Review of the Resident Council Meeting notes dated (MONTH) 12, (YEAR), revealed that call lights were still not being answered in a timely manner and that residents wanted to know the outcome of the call light audit. An interview was conducted on (MONTH) 19, (YEAR) at 12:15 p.m. with the Assistant Director of Nursing (ADON/staff #72), who stated that she does her best to accommodate the residents' needs for assistance with activities of daily living. When asked about the Call Light policy which states that call lights are to be answered promptly, she said that promptly means staff should go and see the resident and acknowledge that the call light is on. She said a resident should not have to wait more than 10 minutes. At this time, a call light monitoring sheet was reviewed with staff #72, who stated that the nurses are monitoring call light response times. The sheet included the following questions: Have you ensured that call lights have been answered in a timely manner? Have there been any concerns voiced from patient/residents/families regarding the timeliness of answering call lights and are they in reach? There was nothing on the form to quantify the meaning of timeliness. Staff #72 stated that she is responsible for the staff scheduling, but was not able to explain how staffing levels are reviewed on an ongoing basis or how to ensure that the appropriate levels of care are provided. About half way through the interview, the DON joined the interview. The DON stated that care should be provided within 15 to 20 minutes. She said that staff have been instructed to see what the resident needs within 5 minutes, but may not be able to help at that moment. The DON said if the CNA is not able to help at that moment, the CNA is to leave the call light on and come back when the CNA is able to provide assistance. When asked about toileting, the DON said that if a resident needs to go to the toilet, the CNA should take the resident to the toilet unless the CNA is feeding residents. She said that it is difficult to know which to do first, as we don't want the CNA's to leave the residents while they are feeding them. She confirmed that during this time, trays are also being handed out to the residents. Review of the facility's policy regarding Staffing revealed the facility will provide qualified and appropriate staffing levels to meet the needs of the patient population. The policy included the facility maintains appropriate staffing levels with qualified personnel 24 hours a day 7 days a week on each shift to assure that patients are safe and their needs are met. A policy titled, Call Lights included that staff will respond to call lights and communication devices promptly.
F 0761 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews and policy review, the facility failed to ensure medications and supplies were secured on a treatment cart and a medication cart. Findings include: An observation was conducted on [DATE] at 10:20 AM of treatment cart #2, which was located in a resident hallway. The cart was equipped with a keypad lock, however, the cart was found to be unlocked. At this time, the hallway was busy with residents, family members/visitors, housekeepers, Certified Nursing Assistants, and other non-nursing staff who were passing by the unlocked cart. The cart was observed to contain needles, syringes, and topical ointments which were prescribed to residents, such as [MEDICATION NAME] cream and powder, [MEDICATION NAME] 1% cream, Santyl and [MEDICATION NAME]. The cart also contained a box of syringes containing 0.9% Sodium Chloride solution, sterile dressing supplies, ostomy supplies, wound cleanser, Dakin's solution, [MEDICATION NAME], hydrogen peroxide, and a 1000 milliliter bottle of Acetic Acid solution. During this same observation, a medication cart was observed next to treatment cart #2. On the top of the medication cart were two medication blister packs. One of the blister packs contained two [MEDICATION NAME] 10 mg tablets. The medication cart was unattended by a nurse. An interview was conducted on [DATE] at 10:52 AM with a Licensed practical Nurse (LPN/staff #23), who stated the treatment cart hasn't been able to be locked for a couple of days. She stated that she talked with other nurses about it, but no other action was taken. She stated the cart should be locked, because of the medications contained in the cart. Staff #23 also said that she was not aware of the blister packs on top of the medication cart and that there was medication remaining in the blister pack. Staff #23 stated that the blister pack should not have been left out. Following the interview, staff #23 took the treatment cart to maintenance and discovered the battery for the cart had died and was replaced. Staff #23 stated she wasn't aware that the cart locks had batteries. An interview was conducted on [DATE] at 1:05 PM with the Director of Nursing (DON/staff #3), who stated the blister packs should not be left out with medications still in them and that they should be locked up when not in use. The DON also

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	035270	A. BUILDING _____ B. WING _____	12/20/2018

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F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4) stated the treatment carts should be locked. Review of the facility's policy titled, Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles included 3.3 Facility should ensure that all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, facility documents and policy and procedures, the facility failed to implement infection control procedures for the handling of soiled laundry and equipment cleaning, failed to implement additional corrective action regarding concerns with Urinary Tract Infections (UTIs), and failed to ensure that the water safety management program included all of the necessary components. Findings include: -Regarding the Laundry Services: During an observation on 12/18/18 at 8:03 AM of the facility's laundry services, a laundry staff member (staff #44) retrieved an apron from a shelf which contained a box of gloves and mop heads. Staff #44 then put on the apron and secured it at the neck and back, resulting in the apron only covering her clothing in the front, from mid-chest to knees. Staff #44 then donned gloves. As she sorted the soiled linens, the soiled linens were observed to touch her arms and the sleeves of her shirt. Following the observation, staff #44 was interviewed. During the interview, staff #44 stood with her arms folded in front across the apron. Staff #44 then removed the apron and placed it back on the shelf on top of an opened box of gloves. Staff #44 stated the apron is used over and over and she could not say when the apron was last washed. Staff #44 stated when she is finished sorting soiled linens she washes her hands and arms, but admitted that she cannot apply the apron without getting contaminated and can not prevent contamination of her shirt sleeves. Staff #44 stated as she folds the clean linens, they touch her arms and clothing as well. An interview was conducted on 12/18/18 at 10:30 AM with the Director of Nursing (DON/staff #3), who stated the laundry staff should have been wearing the yellow gowns when sorting laundry. Review of a policy titled, Soiled Linen Handling revealed that soiled linen is moved in a safe and sanitary manner to prevent cross contamination. The sorting section included that employees wear proper personal protective equipment (PPE) and perform hand hygiene when sorting and handling linen. Review of a policy titled, Clean Linen Handling revealed the purpose is to ensure that clean linen is handled to avoid cross-contamination. -Regarding the equipment cleaning: During an observation on 12/17/18 at 12:27 PM, a mechanical lift (model Reliant 600) was observed in the hall outside of room [ROOM NUMBER]. The entire frame of the lift was soiled with black and gray dirt and dried liquids. Loose dirt and debris were also observed on the base of the lift. During an observation on 12/18/18 at 8:20 AM, a bariatric mechanical lift and a sit-to-stand mechanical lift were observed in the hall near the housekeeping office. Both lifts had soiled frames, dried liquids and debris on the bases. An interview was conducted on 12/18/18 at 8:20 AM with the acting Healthcare Services Manager (staff #49), who stated that she didn't believe there was any cleaning schedule for the equipment, but thought if the lifts were placed in the hall by the housekeeping office that they would be cleaned. She stated it would be possible for a lift to not be placed in that hall for 6 months or more and therefore; would not be cleaned. Review of the facility policy titled, Cleaning and Disinfecting revealed the cleaning and disinfecting of patient care items and environment will be based on the risk of infection. The purpose was to prevent the spread of infection from items and to ensure reusable medical equipment is cleaned and disinfected appropriately. The policy described Practice Standards which included, Non-Critical items are objects that do not come into contact with mucus membranes, but do come in contact with intact skin (e.g., blood pressure cuff, glucose meters, stethoscope, activity supplies, sensory manipulatives, and craft supplies). These items require cleaning between patient use. -Regarding the infection surveillance process: Review of the facility's infection control surveillance tracking and trending documentation revealed that an increase in UTI's in the facility had been identified in (MONTH) (YEAR). An interview was conducted on 12/18/18 at 9:15 AM with a Licensed Practical Nurse/Assistant Director of Nursing/Infection Control Nurse (staff #72), who identified the increase in UTIs in (MONTH) (YEAR). Staff #72 stated that in (MONTH) (YEAR), the facility had 44 infections, 28 were UTIs, 14 of which occurred in the facility. Staff #72 stated that as a result of the findings, she had a Registered Nurse perform perineal care observations with some of the Certified Nursing Assistants (CNAs) on (MONTH) 6, (YEAR). Review of the perineal care observation sheets conducted on 5/06/18 revealed a RN observed 16 CNA's perform perineal care. Of the 16 observations, the following results were documented: -1 CNA correctly performed pericare and changed gloves appropriately -13 CNA's had to be reminded to change gloves after pericare and before dressing the patient -1 CNA had to be reminded to wipe front to back -1 CNA washed from the back to front and did not properly expose all areas of the genitalia to clean adequately, did not change gloves after pericare and before handling clothes, and placed an open brief with the inside of the brief resting over the back of a wheelchair. A follow-up interview was conducted on 12/18/18 at 9:20 AM with staff #72, who stated that she did not do any other follow up, teaching/inservice retraining, follow-up observations or any other action after receiving the data and concerns regarding the pericare observations. She stated that she did provide an inservice on handwashing on 5/19/18, but it did not include proper pericare practice. -Regarding the water safety program A review of the facility's Legionella Water Management Plan revealed the plan was reviewed on 1/12/18, however, the plan did not contain the following: a risk assessment; flow diagrams of the water flow in the building; control methods (other than temperature); plan for corrective actions (other than temperature or city water outage start up); management of a Legionella outbreak in regards to assessment of the water system; and flushing/cleaning of the system and testing, when applicable. An interview was conducted on 12/19/18 at 9:35 AM, with the Maintenance Supervisor (staff #86). He stated there was a team that worked on this, but he didn't realized all of the components for the diagram and plan needed to be included. Review of the facility policy titled, Water management revealed that the facility will use water management practices to reduce the risk of growth and spread of Legionella and other opportunistic pathogens in the building water systems. The policy included: Core elements of the Water management Plan are: 1. Establish Water management Plan team 2. Describe Center's water system using text and flow diagram 3. Risk assessment with control methods and corrective actions 4. Monitoring control measures 5. Corrective actions 6. Verification and validation 7. Documentation and communication.
F 0881 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Implement a program that monitors antibiotic use.** Based on staff interviews and review of facility documents, the facility failed to develop and implement an Antibiotic Stewardship Program. Findings include: An interview was conducted on 12/18/18 at 9:15 AM with a Licensed Practical Nurse/Assistant Director of Nursing/Infection Control Nurse (staff #72) regarding the facility's Antibiotic Stewardship Program. Staff #72 stated that she works with the Medical Director of the facility, and as the program is put together it will include the Director of Nursing and the Pharmacist. Staff #72 stated the facility looks at antibiotics to make sure the correct antibiotic is ordered and she will ask the Medical Director about the necessity of antibiotics. Staff #72 stated the facility does not yet have a team together to develop a stewardship program or any meeting minutes of time spent with the Medical Director discussing antibiotics. Staff #72 stated she has no documentation of anything that was put together at this point for the Stewardship

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F 0881 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 5) program. An interview was conducted on 12/18/18 at 1:28 PM with the Medical Director (staff #135), who stated that he and staff #72 meet to go over a few cases to see if the antibiotics were appropriate. The Medical Director stated that the Antibiotic Stewardship is more of an informal thing at this facility. The Medical Director further stated they have not done too much yet, but there are plans to do more. The facility did not have a policy regarding Antibiotic Stewardship. Review of the facility's agreement with their consulting pharmacy titled, Antibiotic Stewardship, Consultant Pharmacist dated 10/31/17 included the following: In addition to customary duties, the Consultant Pharmacist will participate in the following Antibiotic Stewardship Program Duties: 1. On a monthly visit, will review medication and medical records for patient prescribed antibiotics and make appropriate recommendations. Focus of review includes: a. Antibiotic course for appropriateness of administration and/or indication; b. Documentation of adverse event, if applicable; c. Microbiologic culture data, if available, to assess proper in-service process Additionally, the Consultant Pharmacist can participate in the following duties at the request of facility leadership: 1. Participate in the Antibiotic Stewardship subcommittee that sets standards for antibiotic prescribing practices for all healthcare providers prescribing antibiotics using practice guidelines, local resistance patterns, and institution formularies .
F 0883 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop and implement policies and procedures for flu and pneumonia vaccinations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, staff interviews, facility documents, Center for Disease Control (CDC) recommendations and policy and procedures, the facility failed to implement a pneumonia vaccine program using the current guidelines and standards for five residents (#'s 9, 15, 74, 10 and 21). Findings include: -Resident #74 was admitted to the facility on [DATE] and readmitted on [DATE]. Documentation on the patient problem list included the resident received a [MEDICATION NAME] vaccine on 11/17/14. The documentation did not include which type of pneumococcal vaccine was administered (i.e. 23-valent pneumococcal [MEDICATION NAME] vaccine-PPSV23 or the 13-valent pnemococcal conjugate vaccine-PCV13). Review of the Immunization Informed consent revealed, I have already received the pneumococcal vaccine on 11/17/14, however, the consent form was never signed or dated. -Resident #10 was admitted to the facility on [DATE]. Review of the patient problem list included no documentation regarding historical status of the [MEDICATION NAME]. Review of the Immunization Informed consent revealed the resident gave consent to receive the pneumococcal vaccine. Standing Orders dated 6/06/18 included may give pneumonia vaccine every 5 years. The orders did not indicate which vaccine should be administered. In addition, the guidelines to administer the vaccine every 5 years is outdated from the current standards, and the algorithm to determine which vaccine should be administered. There was also no documentation that the resident received the vaccine or that the resident/representative were educated regarding the risks and benefits of the vaccine. -Resident #21 was admitted to the facility on [DATE]. The patient problem list documented the resident refused the pneumococcal vaccine, however, no date was documented. Review of the Immunization informed consent included the resident/representative refused the pneumococcal vaccine. However, there was no evidence that the resident/representative were educated on the risks and benefits of receiving the vaccine. -Resident #15 was admitted on [DATE] and readmitted on [DATE]. Review of the problem list documented the resident received a [MEDICATION NAME] in 11/17. Review of the Immunization Informed consent revealed, I have already received the Pneumococcal vaccine on 11/17. This form was signed by the resident and dated 4/17/18. There was no documentation that the resident was screened in order to determine current immunization needs, based on the current ACIP/Center for Disease Control recommendations. -Resident #9 was admitted on [DATE]. Documentation on the patient problem list included the resident received a [MEDICATION NAME] on 10/4/16. The documentation did not include which type of pneumococcal vaccine was administered. Review of the Immunization Informed consent revealed, I have already received the Pneumococcal vaccine on 10/4/16. This form was signed by the resident representative on 6/18/18. There was no documentation that the resident was screened in order to determine current immunization needs, based on the current CDC recommendations. An interview was conducted on 12/18/18 at 9:15 AM with a Licensed Practical Nurse/Assistant Director of Nursing/Infection Control Nurse (staff #72), who stated if the physician has written a vaccine order, they attempt to get the consents. Staff #72 said there are two different types of pneumonia vaccines based on age and whether or not they need it repeated. Staff #72 stated the admission nurse obtains the consents and provides the education. At this time, staff #72 was unable to show that the correct type of immunization was reflected on the resident's history, consents or on the orders, or that educational material related to the pneumonia vaccines was provided to residents/representatives. An interview was conducted on 12/18/18 at 12:34 PM with the Registered Nurse/Admission Nurse (RN/staff #118), who stated that when a resident is admitted she enters the orders into the computer, including the facility's standing orders. Staff #118 stated she asks the resident if they have had the pneumonia vaccine in the last 5 years, which is the protocol she has always used. She stated that she was never provided any educational material for the residents regarding the pneumonia vaccines. Staff #118 further stated that she was not aware there were different types of vaccines and that residents should be screened for the appropriate one or that the frequency is less than 5 years. An interview was conducted on 12/18/18 at 1:28 PM with the Medical Director (staff #135), who stated that he was not aware that there were different types of pneumonia vaccines and that the time frame of once every five years was no longer in effect. Staff #135 stated he has to read about that and get up to speed. Review of the facility's policy titled, Pneumococcal Vaccination - Prevnar 12 (PCV13) or [MEDICATION NAME] (PPSV23) revealed that the facility will provide the opportunity to receive the pneumococcal vaccine to all patients and it would occur under the Medical Director's authorization with an order, resident/health care decision maker consent, and in adherence with the current Advisory Committee on Immunization Practices (ACIP) and CDC standards. For residents under age 65, the facility will follow the current CDC adult immunization recommendations. The policy also included the current CDC algorithm for determining the type and frequency of vaccines. The facility adopted the above policy on (MONTH) 1, (YEAR) and did not provide the previous policy. However, staff interviewed were not aware of the current guidelines or the current policy. Review of the CDC immunization guidelines revealed the following recommendations from the ACIP: Two pneumococcal vaccines are currently licensed for use in the United States: the 13-valent pneumococcal conjugate vaccine (PCV13) and the 23-valent pneumococcal [MEDICATION NAME] vaccine (PPSV23). The ACIP currently recommends that a dose of PCV13 be followed by a dose of PPSV23 in all adults aged greater than or equal to [AGE] years of age, who have not previously received pneumococcal vaccine. The recommended intervals between PCV13 and PPSV23 given in series differ by age and risk group and the order in which the two vaccines are given. On (MONTH) 25, (YEAR), ACIP changed the recommended interval between PCV13 followed by PPSV23 (PCV13-PPSV23 sequence) from 6-12 months to greater than or equal to 1 year for immunocompetent adults aged greater than or equal to [AGE] years.