STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035243	A. BUILDING _____ B. WING _____	05/16/2019

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LIFESTREAM AT SUN RIDGE	12215 WEST BELL ROAD SURPRISE, AZ 85378

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 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, facility documentation, and policy review, the facility failed to implement their abuse policy by failing to report an allegation of abuse within 2 hours to the State Agency and by failing to submit the results of the investigation to the State Agency within 5 days for one sampled resident (#40). The deficient practice could result in the potential for further abuse. Findings include: Resident #40 was admitted on (MONTH) 10, (YEAR) with [DIAGNOSES REDACTED]. The quarterly Minimum Data Set assessment dated (MONTH) 19, 2019 revealed a score of 15 on the Brief Interview for Mental Status which indicated the resident was cognitively intact. Review of the facility investigative report dated (MONTH) 8, 2019, revealed resident #40 reported to the Administrator (staff #13) and the Director of Social Services (staff #11) that on (MONTH) 7, 2019, the evening nurse (staff #57) did not provide proper care to her. The resident alleged staff #57 purposely put her feeding machine on pause making it beep. The report included the resident stated that when she asked staff #57 to turn the machine off, staff #57 said shut up and did not turn the machine off. The report also included a Certified Nursing Assistant (CNA) was present who stated that when staff #57 unhook the feeding tube, the machine started beeping and the resident started yelling at staff #57. The CNA stated that staff #57 attempted to explain calmly why the machine was beeping but the resident kept screaming at staff #57. The report did not reveal the CNA heard staff #57 tell the resident to shut up. The report also did not include the allegation of abuse was reported to the State Agency or that the results of the investigation was reported to the State Agency. Review of the State Agency data base revealed the abuse allegation was not reported to the State Agency until (MONTH) 13, 2019 at 10:42 AM. An interview was conducted with the Administrator (staff #40) on (MONTH) 13, 2019 at 8:50 AM. The Administrator stated that he was aware that resident #40 believed/stated she had been verbally abused by staff #57. He stated they did not treat the allegation as abuse because there was a witness in the room who overheard the conversation and never heard staff #57 tell the resident to shut up. During an interview conducted with the Director of Nursing (DON/staff #37) on (MONTH) 16, 2019 at 1:42 PM., the DON stated that she spoke with resident #40 on (MONTH) 8, 2019 and that the resident did not report to her an allegation of abuse. She stated that the resident spoke to her about how the nurse had administered her eye drops. The DON further stated that if a resident makes an allegation of abuse, she would report the allegation within the timeframe required. The facility's policy titled Abuse Prevention Program revised (MONTH) 22, (YEAR), revealed the facility will investigate and report any allegations of abuse within timeframes as required by federal requirements.
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, facility documentation, and policy review, the facility failed to report an allegation of abuse within 2 hours to the State Agency for one sampled resident (#40). The deficient practice could result in the potential for further abuse. Findings include: Resident #40 was admitted on (MONTH) 10, (YEAR) with [DIAGNOSES REDACTED]. Review of the facility investigative report dated (MONTH) 8, 2019, revealed resident #40 reported to the Administrator (staff #13) and the Director of Social Services (staff #11) that on (MONTH) 7, 2019, the evening nurse (staff #57) did not provide proper care to her. The resident alleged staff #57 purposely put her feeding machine on pause making it beep. The report included the resident stated that when she asked staff #57 to turn the machine off, staff #57 said shut up and did not turn the machine off. The report did not include the abuse allegation was reported to the State Agency. Review of the State Agency data base revealed the abuse allegation was not reported to the State Agency until (MONTH) 13, 2019 at 10:42 AM. An interview was conducted with the Administrator (staff #40) on (MONTH) 13, 2019 at 8:50 AM. The Administrator stated that he was aware that resident #40 believed/stated she had been verbally abused by staff #57. He stated they did not treat the allegation as abuse because there was a witness in the room who overheard the conversation and never heard staff #57 tell the resident to shut up. During an interview conducted with the Director of Nursing (DON/staff #37) on (MONTH) 16, 2019 at 1:42 PM., the DON stated that if a resident makes an allegation of abuse, she would report the allegation within the timeframe required. The DON stated that she spoke with resident #40 on (MONTH) 8, 2019 and that the resident did not report to her an allegation of abuse. The facility's policy titled Abuse Prevention Program revised (MONTH) 22, (YEAR), revealed the facility will report any allegations of abuse within timeframes as required by federal requirements.
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 review, staff interviews, facility documentation, and policy review, the facility failed to submit the results of an abuse investigation to the State Agency within 5 days for one sampled resident (#40). The deficient practice could result in the potential for further abuse. Findings include: Resident #40 was admitted on (MONTH) 10, (YEAR) with [DIAGNOSES REDACTED]. Review of the facility investigative report dated (MONTH) 8, 2019, revealed resident #40 reported to the Administrator (staff #13) and the Director of Social Services (staff #11) that on (MONTH) 7, 2019, the evening nurse (staff #57) did not provide proper care to her. The resident alleged staff #57 purposely put her feeding machine on pause making it beep. The report included the resident stated that when she asked staff #57 to turn the machine off, staff #57 said shut up and did not turn the machine off. The report also included a Certified Nursing Assistant (CNA) was present who stated that when staff #57 unhook the feeding tube, the machine started beeping and the resident started yelling at staff #57. The CNA stated that staff #57 attempted to explain calmly why the machine was beeping but the resident kept screaming at staff #57.

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 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) The report did not reveal the CNA heard staff #57 tell the resident to shut up. The report also did not include the results of the investigation was reported to the State Agency within 5 days. An interview was conducted with the Administrator (staff #40) on (MONTH) 13, 2019 at 8:50 AM. The Administrator stated that he was aware that resident #40 believed/stated she had been verbally abused by staff #57. He stated they did not treat the allegation as abuse because there was a witness in the room who overheard the conversation and never heard staff #57 tell the resident to shut up. The facility's policy titled Abuse Prevention Program revised (MONTH) 22, (YEAR), revealed the facility will investigate and report any allegations of abuse within timeframes as required by federal requirements.
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 reviews, observations, resident and staff interviews, and review of policy, the facility failed to ensure the administration of medications met professional standards of quality for two residents (#41 and #4). The deficient practice could result in residents not receiving physician ordered medications. Findings include: -Resident #41 was admitted to the facility on (MONTH) 25, (YEAR) with [DIAGNOSES REDACTED]. Review of the quarterly Minimum Data Set (MDS) assessment dated (MONTH) 22, 2019, revealed a score of 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident had no cognitive impairment. Review of the recapitulation of physician orders dated (MONTH) 2019 revealed the following medications: [REDACTED] -Cysto-Protek (dietary supplement): Give one capsule in the morning. -Aspirin 81 milligrams (mg): Give one tablet in the morning. -[MEDICATION NAME] Extra Strength Pain Relief 500 mg: Give two tablets every morning. -[MEDICATION NAME] (nerve pain and anticonvulsant) 100 mg: Give one tablet every morning. -[MEDICATION NAME] (immunosuppressive and anti-parasite) 200 mg: Give one tablet two times daily. -Lactobacillus ([MEDICATION NAME]): Give one capsule every morning. -[MEDICATION NAME] (antihypertensive): Give one tablet every morning. -[MEDICATION NAME] (gastrointestinal agent): Give two tablets before every meal. -Vitamin B-6: Give one tablet every morning. Review of the clinical record revealed no evidence the resident had been assessed to self-administer medications. During an interview conducted with the resident on (MONTH) 13, 2019 at 8:37 a.m., two medication cups containing medications were observed on the resident's bedside table with the breakfast tray. One medication cup contained 8 medications and the other medication cup contained 2 medications. The resident stated that she likes to take her pills with food so sometimes the nurses leave her pills in her room. The resident further stated the nurses sometimes run late and that if the nurses know her, they will leave her pills so she does not have to wait. During another interview conducted with the resident on (MONTH) 14, 2019 at 12:46 p.m., the resident was observed eating lunch. A medication cup containing one pill was observed on the bedside table. The resident stated it was [MEDICATION NAME] and that the nurse had left it so the she could take it when she wanted to. An interview was conducted with a Licensed Practical Nurse (LPN/staff #31) on (MONTH) 16, 2019 at 10:04 a.m. The LPN stated the proper procedure for medication administration includes observing the resident swallowing the medication(s). The LPN stated that it is never okay to leave medications in a resident's room. Staff #31 stated that resident #41 used to ask her to leave her medications in her room so she could take them when she wanted. The LPN stated that she told the resident that she could not do that. The LPN further stated there was a risk other residents may take the medications and nurses would be unable to know for sure the resident actually took all of her medications. During an interview conducted with another LPN (staff #2) on (MONTH) 16, 2019 at 10:12 a.m., the LPN stated that it is against facility policy and standard nursing practice to leave medications in a resident's room. An interview was conducted with the Director of Nursing (DON/staff #37) on (MONTH) 16, 2019 at 10:17 a.m. The DON stated that it is a standard of practice for all nurses to stay with a resident until all medications have been taken. Staff #37 stated that it is not be acceptable for a nurse to leave medications in a resident's room. The DON further stated a resident has to be assessed and approved to self-administer medications and that resident #41 had not been assessed to self-administer medications. The facility's policy on Medication Administration revealed residents may self-administer their medications only if the attending physician, in conjunction with the interdisciplinary team, has determined that the resident has the decision making capacity to do so. -Resident #4 was admitted to the facility on (MONTH) 1, 2019, with [DIAGNOSES REDACTED]. The care plan initiated (MONTH) 14, (YEAR) revealed the resident had hypertension. Interventions included administering antihypertensive medications as ordered. A quarterly MDS assessment dated (MONTH) 6, 2019, revealed a score of 13 on the BIMS which indicated the resident had intact cognition. Review of the recapitulation of physician's orders for (MONTH) 2019, revealed the following orders: -[MEDICATION NAME] 25 mg by mouth in the evening for hypertension dated (MONTH) 16, 2019. -[MEDICATION NAME] 25 mg by mouth every 6 hours for hypertension dated (MONTH) 26, 2019. Review of the Medication Administration Record [REDACTED]. The MAR indicated [REDACTED]. The MAR indicated [REDACTED]. Review of the MAR for (MONTH) 2019 revealed [MEDICATION NAME] was not administered one time because the vital signs were outside of parameters. The MAR indicated [REDACTED]. The MAR indicated [REDACTED]. Review of the MAR for (MONTH) 2019 revealed [MEDICATION NAME] was not given 4 times because the vital signs were out of parameters and that for 3 of those times, no blood pressure was documented. The MAR indicated [REDACTED]. However, the physician orders did not include parameters for [MEDICATION NAME] and [MEDICATION NAME] and review of the progress notes did not reveal documentation regarding why [MEDICATION NAME] and [MEDICATION NAME] were not administered. The progress notes also did not reveal the physician was notified when the [MEDICATION NAME] and [MEDICATION NAME] were not administered. An interview was conducted with a Licensed Practical Nurse (LPN/staff #47) on (MONTH) 15, 2019 at 12:59 p.m. The LPN stated that if the physician order did not include parameters for a blood pressure medication and the resident's blood pressure was low, she would hold the medication and notify the physician. After reviewing the MARs for resident #4, the LPN stated that no parameters had been ordered for [MEDICATION NAME] and [MEDICATION NAME], therefore holding the medications because the vital signs were out of parameters, was not appropriate. She stated that the physician should have been notified when the medications were not administered. The LPN further stated the facility's policy is to administer medications as ordered and that if a medication is not administered based on nursing judgement, the physician is to be notified for further instructions. An interview was conducted with the Director of Nursing (DON/staff #37) on (MONTH) 15, 2019 at 1:39 p.m. The DON stated that it is her expectation that the nurse would notify the physician if a medication was held based on nursing judgement and document it in the clinical record. The DON also stated that the expectation and standard of practice is that medications are administered as ordered. The facility's policy regarding Medication Administration revealed medications shall be administered in a safe and timely manner and as prescribed. Medications must be administered in accordance with the physician orders.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policy review, the facility failed to ensure one sampled resident (#94) did not sustain an injury by failing to ensure the resident's environment was free of an accident hazard. The deficient practice could result in others residents being at risk for injury.

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) Findings include: Resident #94 was admitted to the facility on (MONTH) 14, 2019, with [DIAGNOSES REDACTED]. The resident was discharged (MONTH) 1, 2019. Review of a care plan initiated (MONTH) 15, 2019 revealed the resident had an activities of daily living deficit related to weakness. Interventions included the resident required extensive assistance of one staff for transfers. The admission Minimum Data Set assessment dated (MONTH) 21, 2019, revealed a Brief Interview of Mental Status score of 15 which indicated the resident had no cognition impairment. The assessment also included the resident required extensive assistance of two staff for transfers. Review of a nurse progress note dated (MONTH) 24, 2019, revealed the resident sustained [REDACTED]. The note included the resident bled profusely and that a pressure dressing was applied to stop the bleeding. The note also included the resident stated My skin is so fragile, I just bumped it. The family and physician were notified. Review of the facility's Incident Follow-up and Recommendation Form dated (MONTH) 24, 2019, revealed the resident sustained [REDACTED].#12) from the bed to a wheelchair. It was noted that the end cap was not on the bed fame and included the edges were not jagged. The form included the resident stated that she just bumped it and my skin is so fragile. The incident form also included the end cap was replaced on the bed and treatment was provided to the skin tear. Additional review of the form revealed the predisposing environmental factor was furniture. An interview was conducted with the CNA (staff #12) on (MONTH) 15, 2019 at 8:27 a.m. Staff #12 stated that she was transferring the resident from the bed to a wheelchair when the resident sustained [REDACTED]. The CNA stated that part of the bed is usually covered. She stated the skin tear was large and the resident was bleeding. The CNA stated she notified the nurse and maintenance and that maintenance fixed the bed immediately. The CNA stated that she did not know if beds were checked regularly for safety but that if she observes something wrong with the bed, she will notify staff so that it can be fixed. During an interview conducted with a Licensed Practical Nurse (LPN/staff #85) on (MONTH) 15, 2019 at 2:33 p.m., the LPN stated that she was the nurse on duty when the resident sustained [REDACTED]. She stated that the skin tear was caused by an area on the bed frame that was missing the cover. The LPN stated that the physician was notified and treatment was provided. Staff #85 also stated she called maintenance so that the uncovered part of the bed frame could be fixed. An interview was conducted with the Director of Nursing (DON/staff #37) on (MONTH) 16, 2019 at 11:38 a.m. She stated a CNA was transferring resident #94 when the resident hit her leg on a protruding part of the bed that was not covered with a protective cap. The DON stated the resident sustained [REDACTED]. The DON also stated that the protruding part of the bed that was not covered with the end cap caused the skin tear. Staff #37 stated that after the incident, the protective cap was immediately replaced on the protruding part of the bed. An interview was conducted with the Maintenance Director (staff #86) on (MONTH) 16, 2019 at 11:26 a.m. Staff #86 stated that after the incident with resident #94 on (MONTH) 24, 2019, all the beds in the facility were checked for safety. The Maintenance Director stated that not having the protective cap on that part of the bed created a safety hazard. Staff #86 stated it was facility policy to check all the beds annually for safety. Staff #86 also stated all staff have been informed to report any unsafe resident equipment right away so that it can be repaired. The Maintenance Director stated that he did not recall staff reporting the missing protective cap for resident #94's bed frame part. The facility's policy regarding Bed Inspections revealed it is the policy of this facility to conduct regular inspections of all bed frames as part of a regular maintenance program. The policy also included that if bed equipment is found to be outside of the manufacturer's requirements for any reason, the facility staff will perform maintenance to the bed equipment or remove it from use.
F 0693 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policy review, the facility failed to ensure that one sampled resident (#40) who was receiving enteral nutrition was provided the amount ordered by the physician, by failing to document each shift the amount of enteral nutrition the resident received. The deficient practice could result in residents not receiving the amount of enteral nutrition ordered. Findings include: Resident #40 was admitted on (MONTH) 10, (YEAR) with [DIAGNOSES REDACTED]. Review of the care plan initiated (MONTH) 11, (YEAR) revealed the resident required tube feeding related to her inability to swallow. Interventions included providing the Glucerna tube feeding as ordered. The quarterly Minimum Data Set assessment dated (MONTH) 19, 2019 revealed the resident received 51% or more of her total calories through tube feeding. Review of the clinical record revealed a physician order [REDACTED]. Review of the Medication Administration Record [REDACTED]. Review of the MAR for (MONTH) 2019 revealed six times, on (MONTH) 1 (2 times), 6, 8, 11, and 13, that the amount of Glucerna received on that shift was not documented. On (MONTH) 15, 2019 at 10:36 AM, an interview was conducted with a Licensed Practical Nurse (LPN/staff #1). The LPN stated that she calculates the amount of enteral nutrition a resident received during her shift at the end of her shift and documents the amount. An interview was conducted with the Director of Nursing (DON/staff #37) on (MONTH) 15, 2019 at 12:41 PM. The DON stated that the expectation is that the nurses follow the physician's orders [REDACTED]. The facility's policy on Enteral Nutrition revised (MONTH) 20, (YEAR), revealed adequate nutritional support through enteral feeding will be provided to residents as ordered.
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 of five sampled residents (#8) was not administered an unnecessary drug, by failing to administer pain medication within the ordered parameters. The deficient practice could result in residents receiving pain medications that may not be necessary. Findings include: Resident #8 was admitted on (MONTH) 6, 2019, with [DIAGNOSES REDACTED]. Review of the care plan initiated (MONTH) 7, 2019 revealed the resident had chronic pain related to a lower extremity wound. Interventions included administering pain medications as ordered. A physician's orders [REDACTED]. The admission Minimum Data Set assessment dated (MONTH) 13, 2019 revealed a score of 15 on the Brief Interview for Mental Status which indicated the resident had intact cognition. The assessment also included the resident frequently had pain at a level of 8 out of 10. Review of the Medication Administration Record [REDACTED]. Review of the MAR indicated [REDACTED]. Review of the MAR for (MONTH) 2019 revealed the resident was administered [MEDICATION NAME] more than 10 times for pain levels less than 6. An interview was conducted with a Licensed Practical Nurse on (MONTH) 15, 2019 at 10:36 AM. She stated that before administering a pain medication, she reviews the physician's orders [REDACTED]. On (MONTH) 16, 2019 at 10:04 AM, an interview was conducted with the Director of Nursing (DON/staff #37). She stated that her expectation is for the nurses to follow the physician's orders [REDACTED]. Review of the facility's policy on Administering Medications revised (MONTH) 20, (YEAR), revealed medications shall be administered in a safe and timely manner, and as prescribed. Additionally, the policy included that medications must be administered in accordance with the orders.

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F 0757 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 3)
F 0943 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation.** Based on personnel file reviews, staff interviews, and policy, the facility failed to provide evidence that 1 of 14 sampled staff (#24) was provided training on abuse, neglect, exploitation, misappropriation of resident property, and dementia management. The deficient practice could result in staff not being educated regarding abuse, neglect, exploitation, misappropriation of resident property, and dementia management. Findings include: Review of the personnel file for staff #24, dining service aide, revealed a hire date of (MONTH) 19, (YEAR). The file revealed staff #24 received training in Corporate Compliance and Effective Communication. However, further review of the personnel file revealed no evidence that staff #24 had received training on abuse, neglect, exploitation, misappropriation of resident property, and dementia management. During an interview conducted with a Licensed Practical Nurse (staff #31) on (MONTH) 15, 2019 at 10:49 a.m., the LPN stated that it is required to have abuse and dementia management trainings every year. The facility's policy regarding Employee Orientation and In-service Training revealed the purpose is to provide adequate care to residents by ensuring staff are knowledgeable of their job duties, orientation, and in-service trainings. The policy also included orientation will include elder abuse and characteristics and needs of the residents. The policy further included staff will maintain ongoing training to meet the needs of the residents.