STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **035126**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **10/31/2018**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LIFE CARE CENTER OF NORTH GLENDALE	**13620 NORTH 55TH AVENUE GLENDALE, AZ 85304**

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 -** Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** Based on observations, staff interviews, and policy, the facility failed to ensure residents were treated with dignity during dining. Findings include: -On (MONTH) 22, (YEAR) at 12:24 p.m., a dining observation was conducted of the 4th floor dining room and the assisted dining room. Numerous residents were observed to have their food plates placed on the table in the plastic serving palate/warming palate and on plastic trays. An interview was conducted with the 4th floor unit Registered Nurse (RN) manager (staff #37) on (MONTH) 24, (YEAR) at 11:45 a.m. The RN stated that the residents' food plates needed to be taken out of the serving palates/warming palates and placed on the table. The manager also stated that it was not very homelike to serve the food in the palates or on the trays. -During a dining observation conducted of the 3rd floor dining room on (MONTH) 25, (YEAR) at 8:26 a.m., two residents were observed to have their food plates in warming palates on the table. An interview was conducted with the Certified Nursing Assistant (CNA/staff #54) who was in the 3rd floor dining room observing residents. The CNA stated that he was new and thought he had been shown to leave the residents' plates on the warming palate. During an interview conducted with the RN charge nurse (staff #38) on (MONTH) 25, (YEAR) at 8:28 a.m., the RN stated that it was a hit or miss that sometimes the staff remove the plates from the warming palates and sometimes they do not. The charge nurse stated that the residents' plates should not be served in the palates. An interview was conducted with the 3rd floor RN (staff #17) on (MONTH) 25, (YEAR) at 8:44 a.m. who was at the door of the 3rd floor dining room. He stated that if he had seen the residents' plates in the palates, he would have instructed the CNA to removed the plates from the palates or removed them himself. The facility's policy regarding resident dignity revealed the facility would promote residents' independence and dignity during dining.
F 0576 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure residents have reasonable access to and privacy in their use of communication methods.** Based on resident and staff interviews and policy and procedure, the facility failed to ensure residents' mail was delivered upon receipt of the mail by the facility. Findings include: On (MONTH) 24, (YEAR) at 2:25 p.m., a meeting was conducted with residents who participated in the Resident Council. During the meeting residents stated that mail was delivered to the facility on Saturdays, but that the facility did not distribute the Saturday mail until Monday. During an interview conducted with a receptionist (staff #235) on (MONTH) 29, (YEAR) at 8:32 a.m., the receptionist stated that mail is delivered to the facility on Saturdays and that the mail is placed in the business office. An interview was conducted with the business office employee (staff #240) on (MONTH) 29, (YEAR) at 8:35 a.m. Staff #240 stated that the Saturday mail is placed in the business office so that it can be sorted by the business office staff to make sure that facility mail such as checks, are not delivered to the residents. Staff #240 stated that once the Saturday mail is sorted, the mail is delivered to the Activity Department along with the Monday mail. Staff #240 could not explain how mail address solely to the facility could be delivered to the residents. On (MONTH) 29, 2019 at 8:42 a.m., an interview was conducted with the Activity Director (staff #221). Staff #221 stated that residents' mail delivered to the facility on Saturdays is delivered to the Activity Department on Monday along with the Monday's mail. Staff #221 stated that she was not sure why the mail was not delivered to the residents on Saturday but that the residents have a right to receive their mail when it arrives to the facility. Staff #221 further stated it could be disappointing to a resident to be expecting a card or mail from a family member or friend, such as a birthday card, and it was not delivered upon receipt by the facility. The facility's policy regarding Resident Rights revealed the resident has a right to send and receive mail and to receive letters, packages and other materials delivered to the facility promptly and unopened.
F 0578 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews and policy and procedures, the facility failed to ensure there was documentation that one resident (#146) was reassessed for decision making abilities and that her goals and wishes were reassessed, prior to making a change in the resident's Advance Directives. Findings include: Resident #146 was admitted to the facility on (MONTH) 11, 2012, with [DIAGNOSES REDACTED]. Review of the clinical record revealed an Advanced Directive form, which was signed by the resident dated (MONTH) 15, 2013. The Advance Directive form indicated that the resident chose a full code status. An Advanced Directive dated (MONTH) 28, 2014 also revealed the resident was a full code status, indicating the resident wanted resuscitation should an emergent situation arise. Review of the care plan conference records dated (MONTH) 10, (YEAR) and (MONTH) 11, (YEAR) revealed documentation that the resident was a full code. A physician's progress note dated (MONTH) 14, (YEAR) included the resident was her own Medical Power of Attorney (MPOA) and participated in her own medical management. The note included the resident had an advanced directive, and in the section

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 0578 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) for intubation and resuscitation it was marked yes. A Significant Change in Status Minimum Data Set (MDS) assessment dated (MONTH) 4, (YEAR), revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. A social service progress note dated (MONTH) 17, (YEAR) included the resident was alert, was able to make her needs known and remained independent with decisions related to her daily routine. The note also included that the resident had elected a full code status. Review of the physician order [REDACTED]. Review of an Advance Directive care plan revealed the resident was a full code. The goal included the resident's Advance Directives were in effect and their wishes will be carried out. Approaches included notify physician of resident's wishes regarding life-prolonging procedures and initiate emergency response/CPR. A face sheet dated (MONTH) 10, (YEAR) included documentation that the resident was listed as the responsible party and was a full code. A nurse practitioner progress note dated (MONTH) 14, (YEAR), revealed the resident was alert and oriented times 4. Further review of the resident's clinical record revealed an Advance Directive form, which was dated (MONTH) 20, (YEAR). The documentation included that the resident was a DNR (Do Not Resuscitate) status. This form was signed by the resident's family member. The reason listed as to why the resident did not sign the document stated the resident was blind. A physician's orders [REDACTED]. There was also a red DNR status form in the resident's chart. Despite a change in the resident's DNR status on (MONTH) 20, (YEAR), there was no clinical record documentation that the resident had been reassessed, in order to determine if the resident's decision making abilities had changed, nor any documentation that the resident's goals and wishes were reassessed regarding her Advance Directives, as a result of a significant change in the resident's medical condition. A nursing progress note dated (MONTH) 22, (YEAR) included that the nurse practitioner discussed wound management with the resident and was encouraged to follow up with the vascular center, and that the resident had agreed to do so. The note also included the resident refused the compression stockings and was informed of the possible adverse effects of not applying compression and not elevating her legs. Nursing progress notes dated (MONTH) 27, (YEAR) and (MONTH) 9, (YEAR) revealed the resident was alert and oriented times three and was able to make her needs and wants known. A quarterly MDS assessment dated (MONTH) 3, (YEAR) included the resident had a BIMS score of 14, which indicated that the resident was cognitively intact. A nursing progress note dated (MONTH) 5, (YEAR) revealed the resident was alert and oriented and able to make her needs known. Review of a social services assistant progress note dated (MONTH) 15, (YEAR), revealed the resident had elected a full code status (instead of a DNR). The note also included resident #146 was alert, oriented, confused, forgetful, blind, and was able to make her needs known and was independent with decisions related to her daily routine. The note further included Family/resident have elected full code status. Review of a care plan conference record dated (MONTH) 24, (YEAR), revealed the resident's Advance Directive status was changed to DNR on (MONTH) 20, (YEAR). Nursing notes dated [DATE] revealed the nurse was unable to obtain an oxygen saturation, the resident appeared to be non-responsive to verbal and tactile stimuli, including a sternal rub, vitals signs were unable to be obtained, and the resident's skin was cold. A second nurse and the Registered Nurse supervisor were called and vital signs were checked and could not be obtained. A physician's orders [REDACTED]. Clinical record documentation included that the resident had expired at 10:39 p.m. on [DATE]. An interview was conducted with a certified nursing assistant (CNA/staff #133) on (MONTH) 25, (YEAR) at 10:23 a.m. She stated that the resident was alert and oriented and could tell staff what she wanted. An interview was conducted with the Administrator (staff #253) on (MONTH) 25, (YEAR) at 1:25 p.m. She stated that the information regarding the change of Advance Directive had occurred in August, and was probably due to the resident's decline. She stated that the resident's family was very involved in the decision-making process. In an interview with the Director of Nursing (staff #45) on (MONTH) 26, (YEAR) at 2:54 p.m., she stated that when there is a change in a resident's Advance Directive, the nurse will contact the physician, the care plan is updated, and all staff will be notified of the change. She stated that she has known the resident for a long time and the family member had always seemed to be the decision maker. Staff #45 could not say whether the family member was the resident's PO[NAME] She said the resident was alert and oriented and could tell staff what she wanted. She further stated that if the resident could not make a decision regarding Advance Directive, it is understood that the resident would be a full code. An interview was conducted with a Licensed Practical Nurse (LPN/staff #88) at 1:35 p.m. on [DATE]. She said the process regarding Advance Directive is that the nurse will go over the paperwork with the resident or the family depending on the resident's cognition. She stated that alert and oriented residents can determine their own Advance directive. She said that even if an alert resident has a POA or a direct family member involved, the resident will be able to make their own decisions regarding Advance Directives. She said that she knew this resident and that she was alert and able to make her own decisions. She said that she knows if a resident is a full code or DNR, based on the facesheet and the orders in the electronic computer system. An interview with the unit manager (staff #12) was conducted at 1:50 p.m. on [DATE]. She said that as the unit manager, she is involved with the Advance Directive paperwork. She said that in general, a resident who is alert and oriented and able to make their own decisions will determine their code status, even if they have a POA or other responsible party. She said that this resident really wasn't alert and oriented, and that is why the family member signed the DNR paperwork. She said that she had noticed a decline over several months and that she called the family member and said that it was time to reconsider her code status and if aggressive measures were desired. She said the family member agreed, but wanted to discuss the option with the resident first. She stated that a few days later, the resident's family member told her that she had discussed the code status with the resident, and the resident wanted to be a DNR. She further stated that there was no documentation in the clinical record indicating that the resident was spoken to about the Advance Directive change. She said the paperwork by the family was accepted, because the family member had said that the resident was involved in the decision. She stated that she did not have any direct conversations with the resident about the code status change. She said that since the the resident was a DNR, no CPR was started. Another interview was conducted with staff #45 at 2:15 p.m. on [DATE]. She said that she was familiar with the resident and the fact that her Advance Directives were changed to DNR in (MONTH) (YEAR). She said that the resident had a steep decline over the last few months of her life and that they had discussed hospice with the resident and family. She said they declined it, but wanted to change the code status to DNR. She said the family member was involved in the resident's care. In an interview with a Nurse Practitioner (staff #254) at 3:10 p.m. on [DATE], she stated that she has been caring for the resident for some time. She said that as the resident was declining, she called the family member and said that it was time to have a conversation regarding hospice care or comfort care and that they should discuss if a full code was still desired. She said when she discussed this with the family member, the family member wanted to discuss this with the resident. She said later, the family member said it was discussed with the resident and the decision was made for a DNR status. She stated that she could see how the resident not signing the most recent Advance Directives because of her vision looks odd, but the resident struggled physically and even signing a paper would be difficult for her. Review of the facility's Advance Directive policy revealed the resident has the right to self-determination regarding their medical care. This includes the right of an individual to direct his or her own medical treatment, including withholding or withdrawing treatment. An Advance Directive is defined as a written instruction regarding care and treatment, and recognized under state law in relation to the provision of such care when the resident is incapacitated.
F 0600 **Level of harm -** Actual harm **Residents Affected -** Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.**

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F 0600

Level of harm - Actual harm

Residents Affected - Few

(continued... from page 2)
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on clinical record review, staff interviews, facility documentation and policies and procedures, the facility failed to ensure one resident (#99) was free from neglect.
Findings include:
Resident #99 was admitted to the facility on (MONTH) 21, (YEAR) and readmitted on (MONTH) 29, (YEAR). [DIAGNOSES REDACTED].
A Fall Risk assessment dated (MONTH) 15, (YEAR) revealed the resident was at risk for falls.
A quarterly Minimum Data Set (MDS) assessment dated (MONTH) 4, (YEAR) revealed a Brief Interview for Mental Status score of 3, which indicated the resident had severe cognitive impairment. The MDS included the resident had sustained a fall with injury since the previous assessment. The MDS also included the resident required extensive assistance with bed mobility, transfers, toilet use and was frequently incontinent of bowel and bladder.
Review of a care plan revealed the resident was at risk for injury related to falls. A goal included that the resident would not sustain a serious injury requiring hospitalization . Interventions included call light in reach, toilet after meals, and do not leave resident unattended while toileting.
Review of the CNA (Certified Nursing Assistant) Care Guide revealed toileting directives which included to assist the resident with toileting as needed and do not leave resident unattended on the toilet.
Review of the nursing progress note dated (MONTH) 4, (YEAR) at 6:37 p.m., revealed the nurse was told by another resident that resident #99 was on the floor. The resident complained of pain in her legs and right hip and the right leg was slightly rotated inward. The on call nurse practitioner was notified and orders were received for a right hip x-ray. Per the note, the x-ray was done, which revealed a [MEDICAL CONDITION] hip. Orders were received to send the resident to the emergency room for evaluation and treatment. The resident left the facility via gurney at 9:15 p.m.
A nursing progress note dated (MONTH) 5, (YEAR) revealed the resident was admitted to the hospital.
Review of the hospital History and Physical report dated (MONTH) 5, (YEAR) revealed the resident was brought to the emergency room for further evaluation for hip pain, which happened after a fall. The x-ray showed an acute comminuted, displaced right femoral neck and intertrochanteric femur fracture. The plan included to admit the resident to the medical floor and for an orthopedic evaluation in the morning.
Review of the facility's investigative report revealed the resident sustained [REDACTED]. A CNA (staff #118) reported that the resident needed to use the restroom, so she assisted the resident to the bathroom. She said that she told the resident to turn on the call light when she was done, because she was going to grab some towels for her shower. The report further included that the resident was left unattended in the bathroom while a CNA (staff #118) stepped out of the room to gather towels and the resident fell landing on her right side, resulting in a [MEDICAL CONDITION] hip. The report also included that staff #118 was educated on (MONTH) 4, (YEAR) by the RN regarding strict adherence to Kardex directives, which included that the resident is not to be left unattended while toileting.
In an interview with the Director of Nursing (DON/staff #45) on (MONTH) 26, (YEAR) at 11:30 a.m., the DON stated that she and the nursing supervisor investigated this accident and completed a Quality Assurance Improvement Plan for this issue. She stated that it was one CNA who left the resident unattended on the toilet, when she stepped just outside the door to get some linens, in preparation for the resident's shower. She further stated that it was clearly noted on the Care Guide that the resident was not to be left unattended in the bathroom. The DON stated that the CNA was educated on the spot and that all of the CNA's were in-serviced, and that follow up observations of care were done.
Review of the facility's Quality Assurance Performance Improvement Plan revealed that after the incident, staff #118 and all nursing staff were educated regarding following resident's care plans and supervision of residents. The documentation also included monitoring of CNA practices by the licensed nurses and nursing administration over several weeks.
A telephone interview was conducted on (MONTH) 26, (YEAR) at 12:07 p.m., with a Licensed Practical Nurse (LPN/staff #77), who was on duty at the time of the resident's fall. Staff #77 stated that she thought resident #99 told her that she was trying to get up from the toilet and fell . Staff #77 stated that she notified the nursing supervisor of the fall.
A telephone interview was attempted with staff #118 however, the CNA was on leave and did not return any calls.
Review of the facility policy titled, Protection of Residents: Reducing the Threat of Abuse and Neglect revised (MONTH) (YEAR), revealed that each resident has the right to be free from abuse and neglect. The policy included that neglect means the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Neglect may be the result of a pattern of failures or may be the result of one or more failures involving one resident and one staff person.
The policy further included that all residents will be protected from all types of abuse and neglect. The facility will have structures and processes in place to provide the needed care and services to all residents.

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 policies and procedures, the facility failed to ensure that a violation involving neglect for one resident (#99) was reported to the State Survey Agency.
Findings include:
Resident #99 was admitted to the facility on (MONTH) 21, (YEAR) and readmitted on (MONTH) 29, (YEAR). [DIAGNOSES REDACTED].
A Fall Risk assessment dated (MONTH) 15, (YEAR) revealed the resident was at risk for falls.
A quarterly Minimum Data Set (MDS) assessment dated (MONTH) 4, (YEAR) revealed a Brief Interview for Mental Status score of 3, which indicated the resident had severe cognitive impairment. The MDS included the resident had sustained a fall with injury since the previous assessment. The MDS also included the resident required extensive assistance with bed mobility, transfers, toilet use and was frequently incontinent of bowel and bladder.
Review of a care plan revealed the resident was at risk for injury related to falls. A goal included that the resident would not sustain a serious injury requiring hospitalization . Interventions included call light in reach, toilet after meals,
and do not leave unattended while toileting.
A review of the CNA (Certified Nursing Assistant) Care Guide revealed toileting directives which included to assist the resident with toileting as needed and do not leave resident unattended on the toilet.
Review of the nursing progress note dated (MONTH) 4, (YEAR) at 6:37 p.m. revealed the nurse was told by another resident that resident #99 was on the floor. The resident complained of pain in her legs and right hip and the right leg was slightly rotated inward. The on call nurse practitioner was notified and orders were received for a right hip x-ray. Per the note, the x-ray was done, which revealed a [MEDICAL CONDITION] hip. Orders were received to send the resident to the emergency room for evaluation and treatment. The resident left the facility via gurney at 9:15 p.m.
Review of the hospital History and Physical report dated (MONTH) 5, (YEAR) revealed the resident was brought to the emergency room for further evaluation for hip pain, which happened after a fall. The x-ray showed an acute comminuted, displaced right femoral neck and intertrochanteric femur fracture. The plan included to admit the resident to the medical floor and for an orthopedic evaluation in the morning.
Review of the facility's investigative report revealed the resident sustained [REDACTED]. A CNA (staff #118) reported that the resident needed to use the restroom, so she assisted the resident to the bathroom. She said that she told the resident to turn on the call light when she was done, because she was going to grab some towels for her shower. The report further included that the resident was left unattended in the bathroom while a CNA (staff #118) stepped out of the room to gather towels and the resident fell landing on her right side, resulting in a [MEDICAL CONDITION] hip. The report also included that staff #118 was educated on (MONTH) 4, (YEAR) by the RN regarding strict adherence to Kardex directives, which included that the resident is not to be left unattended while toileting.
In a telephone interview conducted on (MONTH) 26, (YEAR) at 12:07 p.m. with a Licensed Practical Nurse (LPN/staff #77), staff #77 stated that it did not cross her mind that this might have been neglect.
In a telephone interview conducted on (MONTH) 26, (YEAR) at 12:28 p.m. with a Registered Nurse (RN/staff #36), staff #36 stated that not providing care in accordance with the care plan could be considered neglect.

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F 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) An interview with the Executive Director (staff #253) and the Director of Nursing (DON/staff #45) was conducted on (MONTH) 29, (YEAR) at 1:13 p.m. Staff #45 stated that the incident was not reported to the State Agency, because it did not cross their minds that this incident was neglect. Review of the facility policy titled, Protection of Residents: Reducing the Threat of Abuse and Neglect revised (MONTH) (YEAR), revealed that each resident has the right to be free from abuse and neglect. Neglect means the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Neglect may be the result of a pattern of failures or may be the result of one or more failures involving one resident and one staff person. The policy further included that all violations involving abuse and neglect are reported immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serous bodily injury, to the Administrator of the facility and to the State Survey Agency, in accordance with State law through established procedures. The policy also dictated that the results of the investigation must be reported to the State Survey Agency, within 5 working days from the date of the incident. Failure to do so will mean that the facility is not in compliance with the Federal regulations.
F 0641 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and the Resident Assessment Instrument (RAI) manual, the facility failed to ensure MDS (Minimum Data Set) assessments for two residents (#29 and #61) were accurate. Findings include: -Resident #29 was admitted (MONTH) 6, (YEAR), with a [DIAGNOSES REDACTED]. A quarterly MDS assessment dated (MONTH) 26, (YEAR), revealed the resident received a hypnotic medication during the 7 day look-back period. However, review of the recapitulation of physician's orders [REDACTED]. An interview was conducted on (MONTH) 30, (YEAR) at 11:07 a.m. with the MDS nurse (staff #39). After reviewing the physician's orders [REDACTED]. Staff #39 stated the resident was administered an antianxiety medication and not a hypnotic medication. The MDS nurse stated the MDS assessment should have been coded for the antianxiety. The RAI manual instructs to review the resident's medical record for documentation that any of these medications (antipsychotic, antianxiety, antidepressant, hypnotic, anticoagulant, antibiotic, diuretic, and opioid) were received by the resident during the 7 day look-back period and record the number of days the resident received the medications. -Resident #61 was admitted (MONTH) 11, (YEAR), with [DIAGNOSES REDACTED]. A review of the resident's clinical record revealed a physician's orders [REDACTED]. A Significant Change of Condition MDS assessment dated (MONTH) 14, (YEAR), revealed the resident had not received any Restorative Nursing Assistant (RNA) services during the 7 day look-back period. Review of the RNA documentation for (MONTH) (YEAR) revealed the resident received RNA services twice during the 7 day look-back period. An interview was conducted with staff #39 on (MONTH) 29, (YEAR) at 11:38 a.m. After reviewing the physician's orders [REDACTED].#39 stated that the resident did received RNA services during the 7 day look-back period and that the MDS assessment should have been coded for RNA services. She further stated that she did not review the documentation from RNA services when she was coding the MDS assessment. The RAI manual instructs to review the restorative nursing program notes and/or flow sheets in the medical record and record the number of days the restorative nursing program was performed during the 7 day look-back period. Review of the RAI manual for the MDS assessment also revealed the importance of accurately completing and submitting the MDS assessment cannot be over emphasized. The MDS assessment is the basis for the development of an individualized care plan.
F 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observations, staff interviews, and review of policies and procedures, the facility failed to ensure one resident (#54) was free from a medication error. Findings include: Resident #54 was admitted to the facility on (MONTH) 29, (YEAR), with [DIAGNOSES REDACTED]. The most recent recapitulation of physician's orders [REDACTED]. During an observation of medication administration conducted on (MONTH) 25, (YEAR) at 7:27 a.m., a Licensed Practical Nurse (LPN/staff #3) was observed to administer one multivitamin with minerals tablet to resident #54. The resident was then observed to put the tablet in her mouth and swallow the medication. Staff #3 was not observed to administer the [MEDICATION NAME] medication. During a review of the current physician's orders [REDACTED]. A review of the Medication Administration Record [REDACTED]. An interview was conducted with staff #3 on (MONTH) 25, (YEAR) at 3:20 p.m. Staff #3 stated that she realized she had made an error earlier today, when she administered resident #54 medications. She stated that she administered the multivitamin with minerals instead of the [MEDICATION NAME]. The LPN stated that after she realized the error, she immediately notified the physician of the error which is standard nursing practice. Staff #3 further stated that she had initialed the (MONTH) (YEAR) MAR indicated [REDACTED]. An interview was conducted with the Director of Nursing (staff #45) on (MONTH) 31, (YEAR) at 4:35 p.m. She stated it is the expectation that all nurses follow physician orders [REDACTED]. The facility's policy regarding physician orders [REDACTED]. Review of the facility's policy regarding medications revealed a physician order [REDACTED].
F 0676 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, staff interviews and policy and procedures, the facility failed to provide the appropriate care and services for one resident (#146), in order to maintain or improve the resident's abilities during dining. Findings include: Resident #146 was admitted on (MONTH) 11, 2012, with [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS) assessment dated (MONTH) 3, (YEAR), revealed a Brief Interview for Mental Status (BIMS) score of 14 which indicated the resident was cognitively intact. The MDS assessment also included the resident required limited assistance of one person with eating. Review of the care plan dated (MONTH) 9, (YEAR), revealed the resident was at nutritional risk and that the goal would be no significant weight change. Interventions included placing the resident's food in bowls to promote self-dining, informing the resident where the food is located (related to [MEDICAL CONDITION]), and providing the resident the amount of assistance/supervision as needed. A nursing progress note dated (MONTH) 10, (YEAR) revealed the resident needs assistance with eating and eats with assistance in the dining room. A lunch dining observation was conducted on (MONTH) 23, (YEAR) at 11:55 AM. Resident #146 was observed bent over the table with the top of her head touching the edge of the table and her left hand resting on the top of her head. The resident was observed to use her right hand to open one of the bowls of food and attempt to feed herself. During this observation the other bowls of food remained covered and untouched and no staff was observed to assist the resident with her meal or reposition her. During a breakfast dining observation conducted in the assisted dining room on (MONTH) 25, (YEAR) at 7:52 AM, resident #146

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **035126**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **10/31/2018**
NAME OF PROVIDER OF SUPPLIER **LIFE CARE CENTER OF NORTH GLENDALE**		STREET ADDRESS, CITY, STATE, ZIP **13620 NORTH 55TH AVENUE GLENDALE, AZ 85304**	

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F 0676 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 4) was observed bent over to the left with her chin nearly touching her abdomen. A certified nursing assistant was observed to serve the resident her meal which consisted of a bowl of cream of wheat, a bowl of yogurt, a bowl with a fried egg, two glasses of juice, and a carton of milk. The CNA opened the carton of milk and inserted a straw and left. The resident was observed to locate her spoon and bowl of cream of wheat after several attempts. The resident was observed having difficulty feeding herself, getting a half of spoonful of the cream of wheat in her mouth and dropping the other half in her lap. At 8:10 AM, one of the CNAs assisted the resident with two bits of yogurt and then left to assist another resident. The resident continued to attempt to feed herself. At 8:28 AM the resident was wheeled out of the dining room by a CN[NAME] The bowl of cream of wheat was still 3/4 full and the bowl of yogurt was almost full. The bowl with the fried egg and the 2 glasses of juice were still covered and untouched. No staff was observed to reposition the resident and no other staff was observed to assist the resident with eating. During an interview conducted with a CNA (staff #133) on (MONTH) 25, (YEAR) at 10:23 AM., the CNA stated that the resident is able to verbalize her needs and that she wants to be independent with eating. She stated that the resident requires supervision, cueing, and assistance with meals and that it takes the resident a long time to feed herself. The CNA stated that the resident does not always allow her to assist her with her meals. She also stated that other than the leg rest, the resident does not have any other positioning devices in place. An interview was conducted on (MONTH) 25, (YEAR) at 12:28 PM with the Director of Rehabilitation (staff #255). She stated that a therapy screening is conducted quarterly and as needed for all residents. Staff #255 stated that if a resident has postural issues, such as leaning to one side or forward, the resident would be screened for supportive/adaptive devices that could be put in place, such as wedge cushions, trunk support and arm support to maintain and improve the resident's quality of life. She stated that if the resident is leaning forward because of a kyphotic condition, the resident would be assessed for possible interventions (i.e., adaptive equipment that could be used, such as the use of a tilt wheelchair). Staff #255 stated a forward lean is one of the hardest to deal with but that there is a lot of potential for improvement of quality of life. She stated that if the resident refused the screening or supportive/adaptive devices, it would be care planned. An interview was conducted with the resident on (MONTH) 25, (YEAR) at 1:05 PM. The resident stated that she has trouble eating and has asked the nurse to provide her with a lower table so that she can reach her food better. The resident stated that the nurses stated that they would assist her with eating. She stated that she needs assistance but that the staff does not always assist her. The resident stated that therapy did not recommend the use of any positioning device like wedge cushions or a pillow to assist her in an upright position and that the devices would probably help her and that she would not refuse them. On (MONTH) 25, (YEAR) at 1:25 PM, an interview was conducted with the administrator (staff #253). She stated that therapy offered to screen the resident, but that the resident and family declined on (MONTH) 24, (YEAR). The administrator was unable to state whether the resident and family had declined therapy or the therapy recommendation. The facility's policy titled Nutrition Intervention Program Overview revealed that to encourage food and beverage intake, special attention is directed towards creating a positive and fulfilling dining experience. The policy included that dining skills are also evaluated in order to provide a dining experience that enhances quality of life and is supportive of each resident's individual needs. The policy also included the resident's interdisciplinary care plan addresses dining skill levels and interventions based on an interdisciplinary evaluation.
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 observations, clinical record reviews, resident and staff interviews, facility documentation and policy review, the facility failed to ensure that nutritional care and services were provided to two residents (#127 and #146). Findings include: -Resident #127 was admitted to the facility on (MONTH) 1, 2010 and readmitted on (MONTH) 23, (YEAR), with [DIAGNOSES REDACTED]. According to a significant change Minimum Data Set (MDS) assessment dated (MONTH) 21, (YEAR), the resident had moderate cognitive impairment and required total assistance with transfers and supervision with eating. The MDS also included the resident did not have any weight loss of 5% or more in the last month or a loss of 10% or more in the last 6 months. Review of the NP (nurse practitioner) progress note dated (MONTH) 10, (YEAR) revealed the resident had weight loss which was not expected and had a 25% weight loss in the past year. The plan included monthly weight monitoring and continued dietary follow-up. According to the clinical record, the resident went out to the hospital on (MONTH) 19, (YEAR) and was readmitted to the facility on (MONTH) 23, (YEAR). Review of the nutrition care plan dated (MONTH) 23, (YEAR) revealed the resident was at nutritional risk and was on a mechanical soft diet with nectar thick liquids. The goal was for resident to have no significant weight changes. Approaches included diet as ordered, large protein portions at all meals, multivitamins with minerals, 30 ml (milliliter) of Pro-Source Plus (supplement) twice daily and 4 oz of House supplement daily. The Aspiration Risk care plan dated (MONTH) 23, (YEAR) included the resident had a [DIAGNOSES REDACTED]. Approaches included diet as ordered, monitor intake and weights and provide supervision with eating. Review of the weight record revealed the resident weighed 206 lbs on (MONTH) 24, (YEAR). A NP note dated (MONTH) 24, (YEAR) revealed the resident was negative for weight loss. The documentation included the resident had dysphagia which was described as currently worse. Per the note, the diet was down-graded to pureed diet with thickened liquids. The nutrition data collection/assessment dated (MONTH) 26, (YEAR) included for large protein portions three times daily. Per the documentation, there were no supplements ordered. A nutrition note dated (MONTH) 26, (YEAR) included the resident required limited assistance with meals and that meal intake was 88%. The note included that the diet was changed to regular puree, honey thick liquids, double egg portions at breakfast and large meat portions with lunch and dinner. A physician's order dated (MONTH) 1, (YEAR) also included for 1 package of Juven (nutritional supplement) in 6 oz of sugar free beverage by mouth twice daily. The order for the Juven was transcribed into the MAR (medication administration record) for (MONTH) (YEAR) and was administered as ordered. Review of the weight record revealed that on (MONTH) 8, (YEAR), the resident weighed 196 lbs. This was a 10 lb weight loss (4.85% weight loss) in 14 days. A nutrition note dated (MONTH) 9, (YEAR) included the resident had a 10 lb weight loss in 2 weeks since readmission. The note also included the resident received a multivitamin with minerals daily, 4 oz of NSA (no sugar added) House supplement daily and 30 ml of Pro-Source Plus twice daily. The plan was to discuss the resident's condition at the weekly NAR (Nutrition at Risk) meeting and monitor meal intake percentages for trends. Review of Section III of the Nutrition Data Collection/assessment dated (MONTH) 12, (YEAR) revealed the resident required increased protein needs and had a gradual weight loss. The diet was regular puree and honey thick liquids. Nutrition interventions included multivitamin with minerals, 4 oz NSA House supplement daily and 30 ml Pro-Source Plus twice daily. However, review of the clinical record revealed there were no orders for the resident to receive a multivitamin with minerals, NSA House supplement or for Pro-Source Plus in (MONTH) (YEAR). There was also no documentation that the resident received a multivitamin with minerals, NSA House supplement or for Pro-Source Plus in (MONTH) (YEAR). Review of a dietary note dated (MONTH) 12, (YEAR) revealed the following interventions: multivitamins with minerals, 4 oz NSA House supplement and for 30 ml Pro-Source Plus twice daily. Per the note, the resident had additional nutritional needs related to wound healing. It also noted that high calorie and protein supplements were in place. The quarterly nutrition data collection/assessment dated (MONTH) 19, (YEAR) also included the resident was receiving 4 oz of House supplement daily and 30 ml of Pro-Source Plus twice daily. A nutritional progress note dated (MONTH) 24, (YEAR) included the resident continued to have gradual weight loss. Per the documentation, the resident received nutritional support with extra calories, protein and multivitamin with minerals. Interventions included multivitamin with minerals, 4 oz House Supplement and ProSource Plus twice daily.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 0692

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

(continued... from page 5)
Review of the recapitulation of physician orders for (MONTH) (YEAR) revealed the following order: may follow dietary recommendations regarding diet.
Despite documentation that the resident was supposed to be receiving a multivitamin with minerals, 4 oz House Supplement and ProSource Plus twice daily, there were no physician orders for these dietary recommendations for (MONTH) and (MONTH) (YEAR).In addition, these dietary recommendations were not transcribed onto the MAR/TAR (Medication and Treatment Administration
Records) for (MONTH) and (MONTH) (YEAR). There was no clinical record documentation that the resident received the multivitamin with minerals, 4 oz House Supplement and ProSource Plus twice daily.
During an interview with a CNA (certified nursing assistant/staff #133) conducted on (MONTH) 25, (YEAR) at 10:23 a.m., she stated that weights are taken by the RNA's (restorative nursing assistant) on a weekly basis. She stated if there is weight loss she or the RNA will report it to the nurse, who will then instruct them on new interventions to address the resident's weight loss.
An interview with the Director of Nursing (DON/staff #45) was conducted on (MONTH) 26, (YEAR) at 2:54 p.m. She stated that when a resident has weight loss, the nurse will notify the physician and will look for the reason for the weight loss. She said if no reason is found, then it would be brought to the NAR meeting and supplements would be put in place as interventions. Staff #45 said if supplements are recommended, the dietary technician writes the recommendation and gives it to the nurse, who will then call the NP or the physician. She stated that if there's a recommendation that was not carried out, there must be documentation of the reason in the clinical record. She said that if an order is written for the recommendation, it should be transcribed onto the MAR or TAR and should be administered as ordered. Further, she said that if the MAR and TAR does not show evidence that dietary recommendations were administered, then the recommendations and/or orders for supplements must not have been carried out.
-Resident #146 was admitted at the facility on (MONTH) 12, 2012, with [DIAGNOSES REDACTED].
Review of a nutrition review summary dated (MONTH) 22, (YEAR), revealed the resident was at nutritional risk and needed 1425-1710 cal per day as evidenced by 65-78% of meal intake. The note included the resident was on a mechanical soft diet and meal intake was 90%. The note also included the resident was legally blind, required food in bowls and that staff were to identify food location.
A nutrition care plan updated on (MONTH) 8, (YEAR) included the resident was at nutritional risk as evidenced by [MEDICAL CONDITION], impaired vision and a mechanically altered diet with thin liquids related to chewing deficits. A goal was for the resident to have no significant weight change 5% x 30 days or 7.5% x 90 days. Approaches included the resident eats in the dining room and for food to be in bowls to promote self dining related to poor vision, and to inform resident where foods are located.
Review of the weight record revealed that on (MONTH) 4, (YEAR) the resident weighed 131 lbs.
Record of resident's meal intake percentages for (MONTH) (YEAR) revealed the resident required supervision defined as oversight, encouragement and cueing with set-up help only with eating. It also included the resident consumed an average of 76-100% of each meal. However, towards the end of the of the month it showed a decline to 51-75% of each meal especially for dinner.
According to a Significant Change in Status MDS assessment dated (MONTH) 4, (YEAR), the resident had a Brief Interview for Mental Status score of 15, indicating the resident was cognitively intact. The MDS included the resident was independent with one person physical assistance with eating, was on a mechanically altered diet and did not have any oral/dental issues.Review of the weight record revealed that on (MONTH) 4, (YEAR), the resident weighed 125 lbs. The documentation included that this was a 3% weight loss from (MONTH) 4.
A care plan for the potential for alteration in comfort due to a [DIAGNOSES REDACTED]. Interventions were to provide comfort measures which included repositioning.
Review of an activities of daily living (ADL's) care plan with a target date of (MONTH) 9, (YEAR), revealed the resident has a [DIAGNOSES REDACTED]. The goal was the resident would participate as able with ADL's. Interventions were to provide the amount of supervision needed, staff to assist with ADL's and food in bowls so resident can more easily retrieve the food.
A vision care plan with an updated date of (MONTH) 9, (YEAR), included the resident had impaired vision and was legally blind. Approaches included to place items within easy reach and orient to placement, provide adaptations to maintain resident involvement, and to identify the type/location of food on plate as needed.
An Activity Evaluation dated (MONTH) 12, (YEAR) revealed the resident needed assistance with meal set up and eating and required cueing.
Review of the resident's meal intake percentages for (MONTH) (YEAR) revealed the resident continued to require supervision with set-up help only with eating. It also included that the resident continued to consume an average of 51-75% of each meal.
Despite documentation that the resident's meal intake percentages had declined, and that the resident sustained [REDACTED].
Review of the weight record revealed the resident weighed 125 pounds on (MONTH) 8, (YEAR).
Review of the resident's meal intake percentages for (MONTH) (YEAR) revealed the resident continued to require supervision with set-up help only with eating most of the time. It also included that the resident's meal intake percentage varied and averaged between 25-50%, which was a decrease from July.
Review of the weight record revealed the resident weighed 116 lbs on (MONTH) 6, (YEAR). Per the documentation, this was a weight loss of 10% (from a comparison weight taken on (MONTH) 2, (YEAR)), and a weight loss of 3% from the weight taken on (MONTH) 8.
A dietary note dated (MONTH) 6, (YEAR) included the resident had a 5 lb (3.85%) weight loss in 3 months. It also included the resident was legally blind and required food in bowls and for staff to identify the location of the food. The plan included discussing the resident's condition at the weekly NAR (Nutrition At Risk) meeting and monitoring labs, weight reports and meal intake percentages for trends.
The Resident At Risk Meeting documentation dated (MONTH) 6, (YEAR) revealed a handwritten note under the section titled Concern/Issue, Team Recommendation included to see dietary progress note from (MONTH) 6, (YEAR).
A physician's order dated (MONTH) 6, (YEAR) included for 8 oz of Ensure (nutritional supplement) two times a day and to document percentage taken.
This order was transcribed onto the MAR for (MONTH) (YEAR).
The Nutrition Report revealed the resident's average meal intake percentage changed from 63% (week ending (MONTH) 31) to 52% for week ending (MONTH) 7, (YEAR). Per the report, there was a weight loss of 9 lbs.
A dietary note dated (MONTH) 10, (YEAR) included the resident sustained [REDACTED]. Recommendations included for Ensure twice daily and that the supplement will provide 700 calories/40 grams protein. The plan included to continue to monitor labs, weight reports and meal intake percentages for trends.
A dietary note dated (MONTH) 13, (YEAR) revealed the resident was alert and oriented x 3 and was able to make needs known. The resident had a poor appetite and required assistance and cueing with eating.
According to the (MONTH) (YEAR) MAR, the resident was administered the Ensure as ordered.
A physician's order dated (MONTH) 24, (YEAR) included to discontinue the Ensure and administer 8 oz of House Shake two times a day and to document percentage taken.
Record of the resident's meal intake percentages for (MONTH) (YEAR) revealed they ranged between 25-50%.
The Nutrition Data note completed by the clinical manager dated (MONTH) 2, (YEAR) included the resident had a significant weight change of 9 lbs, which was a decrease in 1 month. Average daily percentage consumption of meals was documented as 75-100% for breakfast, lunch and dinner. Current diet included mechanical soft with 8 ounces of Ensure twice daily as a supplement. Per the note, the resident did not have a problem with chewing or swallowing and was independent with dining.
Review of the weight record revealed that on (MONTH) 7, (YEAR), the resident's weight was 111 lbs, which was a weight loss of 10% from a comparison weight taken on (MONTH) 2, and a weight loss of 3% from the weight taken on (MONTH) 6.
A dietary note dated (MONTH) 10, (YEAR) included the resident had a significant weight loss of 5 lbs (4.3%) in 1 month and was re-weighed, and the weight was confirmed. It also included the following meal intake percentages: 55% for the week of (MONTH) 19; 74% for the week of (MONTH) 26; 59% for the week of (MONTH) 3; and 55% for the week of (MONTH) 10. The note
included the resident was on a mechanical soft diet with thin liquids and whole milk three times daily, and received 8 oz of Ensure twice daily.
Another dietary note written by a nurse dated (MONTH) 10, (YEAR) included the resident was blind, continued with a gradual

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F 0692 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 6) decline, had poor oral intake and had a weight loss of 5 lbs in 1 month. Per the note, the resident eats in the assisted dining room and requires assistance with eating. The Nutritional Data Collection/assessment dated (MONTH) 11, (YEAR) revealed the resident's weight was down by 14 lbs (11%) in 60 days, with the resident eating more than 50% of meals and increased calorie supplement and a multivitamin with minerals. The documentation included the resident required a mechanical soft diet and had chewing deficits. Interventions included for 8 oz of Ensure, 8 oz of House Shake twice daily, fortified cream of wheat and fortified foods with lunch and dinner. During an interview conducted on (MONTH) 23, (YEAR) at 9:39 a.m., resident #146 stated that she had some weight loss which was good at first, but she does not want to continue to loose weight. She stated that she eats in the dining room and does not receive assistance. An observation was conducted on (MONTH) 23, (YEAR) from 11:55 a.m. to 12:15 p.m., of the resident in the assisted dining room sitting in her wheelchair at a table. The resident was bent over with her head toward her abdomen and her head was almost touching the edge of the table. This dining room table was approximately 2 inches lower than the other tables in the dining room. During the observation, the resident was served three bowls of food. The resident then attempted to feed herself with her head bent over and her forehead almost touching the edge of the table, while she put the spoon in her mouth. The resident ate from the same bowl of food and the other two bowls of food remained covered and untouched. During the observation, there were staff in the assisted dining room, however, no staff were observed to cue the resident, repositioned the resident or assist the resident with her meal. Another observation was conducted on (MONTH) 25, (YEAR) at 7:29 a.m., of resident #146 sitting in her wheelchair in the assisted dining room. Her upper body was hunched over toward her left hip, and her chin was nearly touching her abdomen. Her head was bent so far forward that the top of her head almost reached the height of the table. At this time, a CNA (Certified Nursing Assistant) served the resident three bowls of food which contained cream of wheat, yogurt and a fried egg, and two 8 oz glasses of juice and a carton of milk. The CNA removed the items from the tray and placed them in front of the resident, but did not remove the lids from the bowls. The CNA opened the carton of milk and put a straw in it and then walked away. The CNA did not reposition the resident or tell the resident the location of the food items. The resident was then observed trying to find the bowls of food and the spoon. At 8:01 a.m., a CNA removed the lids from the bowls, however, the CNA did not reposition the resident, as the resident continued to be hunched over, nor did the CNA assist the resident with her meal. The resident was observed trying to find the spoon and the bowls of food. After several attempts, the resident managed to get a half of a spoonful of cream of wheat into her mouth and the other half fell in her lap. At 8:10 a.m., a CNA started to assist the resident with her meal. The CNA and was going back and forth between resident #146 and another resident. When the CNA was assisting the other resident, resident #146 tried feeding herself with her head bent way forward. At 8:23 a.m., the resident was observed to be eating from the same bowl of food. At 8:28 a.m., another CNA entered the dining room and told the resident that she needed to be cleaned. The CNA did not ask the resident if she was done with her meal. The bowl of food that the resident was eating from was still 3/4 full, and the other three bowls of food and the two 8-oz glasses of juice remained untouched. The CNA then removed the resident from the dining room. During an interview with a CNA (staff #133) conducted on (MONTH) 25, (YEAR) at 10:23 a.m., she stated that resident #146 is alert and oriented and can tell staff what she needs. She stated the resident requires supervision, cueing and assistance with meals, because it takes her a long time to eat. An interview with the medical records director (staff #231) was conducted on (MONTH) 25, (YEAR) at 11:10 a.m. She stated there was no nutritional assessment found for resident #146 from (MONTH) through (MONTH) (YEAR), because the dietician was on vacation and there was no one who covered in their absence. Another interview was conducted on (MONTH) 25, (YEAR) at 1:05 p.m., with resident #146. She stated that she was having trouble with eating so she asked the nurses to provide her with a lower table, so she could reach her food better. She said that she wants and needs assistance with eating, but staff do not always provide her assistance with eating. She stated that she could probably eat more than she does, if she had assistance with her meals.The resident further stated that therapy did not recommend any positioning device to be used to help keep her in an upright position, and that she did not refuse a positioning device. She stated that one would probably help her. In an interview with the dietician (staff #251) dated (MONTH) 26, (YEAR) at 8:35 a.m., she stated that she comes to the facility every week and reviews identified high risks residents, which include residents who are underweight, eating poorly, receiving tube feedings and those with wounds. She stated that the following percentages of weight loss will have interventions put into place: 3% in a week, 5% in 30 days, 7.5% in 90 days and 10% in 6 months. She also stated interventions will initially include an assessment of food preferences, use of supplements, and assistance with dining which includes cueing residents during meals. She stated that she relies on the dietary techs who are very good at documenting weights and reporting weight loss and informing her whether interventions in place are working or not. She further stated that if the resident's weight loss is not 5% or more, she will not necessarily put interventions into place, but she will assess other factors that may be contributing to the resident's weight loss. Review of a policy regarding the Nutrition Intervention Program revealed the facility is committed in ensuring that each resident maintains acceptable parameters of nutritional status as indicated by clinical measures, such as body weight and ensuring that residents receive a therapeutic diet when there is a nutritional problem. The policy included that residents are provided nutritional care and services consistent with their comprehensive assessment and that their needs are addressed with appropriate interventions which are consistent with the resident's assessed needs. The policy further included that interventions are implemented or clinical justification is provided if not done.
F 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observations, staff interview and policy review, the facility failed to ensure that food was served in a sanitary manner. Findings include: A dining observation was conducted on (MONTH) 25, (YEAR) at 8:00 a.m. A resident was being assisted with their breakfast, by a Registered Nurse (RN/staff #14). The RN picked up the resident's toast with her bare hand and offered it to the resident. The resident took bites of the toast, while the RN continued to hold the toast with her bare hand. During this same dining observation, staff #14 was observed to assist another resident with their breakfast meal. The RN picked up a sweet roll with her bare hand and offered it to the resident. The resident took bites of the sweet roll, while the RN continued to hold the sweet roll with her bare hand. After the observations, an interview was conducted with the RN. The RN stated that she was not assigned to feed residents, but that she enjoys helping out with meals. She stated that she did use her bare hand on the toast and the sweet roll and that she was unaware that she needed a glove. A review of a policy titled, Safe Food Handling revealed that all food purchased, stored, and distributed is handled with accepted food-handling practices and per federal, state and local requirements.