STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035146	A. BUILDING _____ B. WING _____	**11/06/2018**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LIFE CARE CENTER OF PARADISE VALLEY	**4065 EAST BELL ROAD PHOENIX, AZ 85032**

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 0552 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that residents are fully informed and understand their health status, care and treatments.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, staff interviews and policy and procedure, the facility failed to ensure two residents (#102 and #126) were informed of the risks and benefits of [MEDICAL CONDITION] medications. Findings include: -Resident #102 was admitted to the facility on (MONTH) 2, (YEAR) and readmitted on (MONTH) 17, (YEAR), with [DIAGNOSES REDACTED]. Review of the admission Minimum Data Set assessment dated (MONTH) 9, (YEAR), revealed a Brief Interview for Mental Status score of 14 which indicated the resident was cognitively intact. Review of a physician's orders [REDACTED]. The [MEDICAL CONDITION] medication care plan dated (MONTH) 18, (YEAR), revealed the resident was receiving an antianxiety medication. The Pharmacy Consultation Report dated (MONTH) 20, (YEAR) revealed that a signed and dated informed consent form, which would have indicated the resident had been fully informed regarding the risks and benefits of the medication, was not found in the resident's medical record. The recommendation was that one should be obtained. A physician's orders [REDACTED]. The Pharmacy Consultation Report dated (MONTH) 14, (YEAR), revealed a repeated recommendation that a signed and dated informed consent form be placed in the resident's medical record. Review of the clinical record revealed the [MEDICATION NAME] order was renewed on (MONTH) 26, (YEAR) and (MONTH) 26, (YEAR). A review of the Medication Administration Record [REDACTED]. On (MONTH) 3, (YEAR), a signed and dated informed consent form was obtained and placed it in the clinical record. Further review of the clinical record revealed no evidence that the risks and benefits of [MEDICATION NAME] were explained to the resident or responsible party prior to (MONTH) 3, (YEAR). During an interview conducted on (MONTH) 2, (YEAR) with a Licensed Practical Nurse (LPN/staff #192), the LPN stated an informed consent is obtained prior to administering a psychoactive medication. An interview was conducted with the Director of Nursing (DON/staff #95) on (MONTH) 2, (YEAR). The DON stated that an informed consent must be obtained before a [MEDICAL CONDITION] medication is administered. She stated that if the consent is not signed, indicating that the resident and/or the resident's representative have been explained the risks and benefits of the medication; the [MEDICAL CONDITION] medication will not be administered to the resident. -Resident #126 was admitted on (MONTH) 4, (YEAR) with [DIAGNOSES REDACTED]. An admission MDS (Minimum Data Set) assessment dated (MONTH) 11, (YEAR), included that resident #126 had severely impaired cognition, problems with short and long term memory, and was rarely able to be understood. A physician's assistant progress note dated (MONTH) 16, (YEAR), revealed the resident was observed to be very vocal and easily agitated. The note also included a plan that the resident would be prescribed [MEDICATION NAME] 125 mg (milligrams) twice daily for agitation and to monitor symptoms. A physician's orders [REDACTED]. Continued review of physician's orders [REDACTED]. - A physician's orders [REDACTED]. - A physician's orders [REDACTED]. Review of the Medications Administration Records for (MONTH) and (MONTH) (YEAR) revealed the resident was administered the [MEDICATION NAME]. However, no documented evidence was the found in the clinical record that the resident's POA (Power of Attorney) was informed of the risks and benefits of [MEDICATION NAME]. A physicians order dated (MONTH) 21, (YEAR), revealed an order for [REDACTED]. During an interview conducted on (MONTH) 31, (YEAR) at 12:31 p.m. with a RN (Registered Nurse/staff #13), the RN stated that when a medication is ordered by the physician to be administered as a mood stabilizer, an informed consent would be obtained. An interview was conducted on (MONTH) 31, (YEAR) at 12:41 p.m. with a LPN (Licensed Practical Nurse/staff #200). The LPN stated that if a physician orders [REDACTED]. The nurse further stated that for [MEDICATION NAME] ordered for agitation, she would obtain consent from the resident/resident's representative before administering the [MEDICATION NAME]. During an interview conducted on (MONTH) 31, (YEAR) at 1:10 p.m. with the Director of Nursing (staff #95), the Director stated that consent needs to be obtained for [MEDICATION NAME] if it is ordered as a mood stabilizer for behaviors. The facility's policy titled Informed Consent revealed a statement that informed consent is an agreement or permission accompanied by full explanation. The policy included that all residents have the right to give informed consent. The policy also included that obtaining informed consent includes that the resident and (when applicable) the family are given a clear, concise explanation of the residents condition, the proposed treatment, and the benefits and risks of the proposed treatment.
F 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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 and staff interviews, the facility failed to ensure that advance directives for one resident (#284) was accurately documented in his clinical record. Findings include: Resident #284 was admitted to the facility on (MONTH) 24, (YEAR) with [DIAGNOSES REDACTED]. Review of the clinical record revealed an undated Advanced Directives signed by the resident that the resident desired cardiopulmonary resuscitation and other resuscitative efforts on his behalf. A physician's orders [REDACTED].>The nursing notes dated (MONTH) 28, (YEAR), revealed the resident was alert and oriented.

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** - Few	(continued... from page 1) During an interview conducted on (MONTH) 31, (YEAR) at 3:15 p.m. with a licensed practical nurse (LPN/staff #152), she stated that regarding the advance directives and the physician's orders [REDACTED]. The LPN was unable to state when the advanced directive was signed by the resident, but did say that according to her notes the resident was a full code. An interview was conducted on (MONTH) 31, (YEAR) at 3:30 p.m. with a LPN (staff #80), who stated that there was a discrepancy with the resident's advance directives and the physician's orders [REDACTED]. The LPN further stated that the advanced directive was completed when the resident was admitted . During an interview conducted on (MONTH) 1, (YEAR) at 10:19 a.m. with the Director of Nursing (DON/staff #95), she stated that the admitting nurse completes the advanced directive on admission and puts it in the clinical record for the physician to review. The DON stated that the Do Not Resuscitate order in the chart was a transcription error by the nurse when she was entering the order into the electronic medical record.
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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, personnel files, hospital documentation and policy review, the facility failed to ensure one resident (#71) was free from neglect. Findings include: Resident #71 was admitted to the facility on (MONTH) 11, 2008, with [DIAGNOSES REDACTED]. A quarterly Minimum Data Set (MDS) assessment dated (MONTH) 22, (YEAR) included a Brief Interview for Mental Status score of 15, which indicated the resident was cognitively intact. The MDS assessed the resident to require extensive assistance with bed mobility, transfers and hygiene. Review of a care plan for at risk for respiratory distress due to [MEDICAL CONDITION] revealed to maintain a patent airway and have minimal episodes of shortness of breath and no respiratory distress. Approaches included to encourage/assist resident to an upright position when short of breath, observe and report signs and symptoms of respiratory distress (i.e., confusion, rapid breathing, blue lips, sweating, and reports that he cannot breathe) notify physician with changes in lung sounds or increased episodes of shortness of breath, administer oxygen as ordered, and monitor for signs and symptoms of respiratory distress. A handwritten nursing note dated (MONTH) 24, (YEAR) at 1:30 p.m. by a licensed practical nurse (staff #29) included the following: Resident awake, disoriented, unable to verbalize, mumbles words slurred speech. Breathing labored. Pulse ox @ 80% RA (room air). Put resident on 10 liters of oxygen via mask and head of bed up. Skin cold and clammy. Blood pressure was 160/100, heart rate at 110, respirations at 26, and temperature was 99.5 (axillary). Resident is full code and 911 was called. Physician was notified and in agreement with sending resident out to the emergency room . Pulse ox went up to 93% on 10 liters of oxygen. Review of a change in condition nursing progress note dated (MONTH) 24, (YEAR) and entered at 3:06 p.m. by staff #205 (registered nurse) revealed the following: Resident started getting lethargic and disoriented this morning. Around 12:30 p.m. as two Certified Nursing Assistants (CNAs) were cleaning him he started to go unresponsive. Only awakened with sternal rub. Pulse ox started getting lower into the 80's and put 2 Liters of oxygen on him and the pulse ox went back up into the 90's. Temperature was 100. Blood pressure was 92/50. Reported to physician and Emergency Medical Services (EMS) was called and intravenous fluids were started. Resident did not awaken easily even with a sternal rub. Other nurses were assisting with assessing the resident until 911 was called and he was transferred to the hospital. He was last seen normal and baseline last night. An addendum nursing note dated 6/24/18 and signed by staff #205 at 5:35 p.m. included the following: Resident was slightly altered around 6 am to 11 am and then progressively got worse at 12:30 p.m. where his condition was significantly noticed. According to the hospital records dated (MONTH) 24, (YEAR), the resident was brought to the emergency room due to acute onset of altered mental status. Upon arrival the patient was in obvious acute [MEDICAL CONDITION] and was intubated accordingly. The resident was then admitted and sent to the intensive care unit for acute [MEDICAL CONDITION] and the need for mechanical ventilation. An interview was conducted with the Administrator (staff #209) on (MONTH) 1, (YEAR) at 11:30 a.m. She stated that she had no knowledge of an allegation of neglect between resident #71 and staff #205, therefore she did not complete an investigation. She stated that all allegations of neglect need to be investigated immediately. An interview was conducted on (MONTH) 2, (YEAR) at 8:50 a.m. with the Assistant Director of Nursing (staff #37). She stated that she was a witness when the prior Director of Nursing (DON) interviewed staff #205 regarding the incident with resident #71. She stated the DON told staff #205 that resident #71 had a change of condition and when a CNA (staff #39) told her (staff #205) to check on the resident right away, she did not respond to the request. She stated that staff #39 had to go to the first floor and get another nurse to assess the resident, and the resident was then sent out to the emergency room via 911. A phone call was placed to staff #205 on (MONTH) 2, (YEAR) at 9:14 a.m. She stated that she could not remember if she had been involved with this incident and had been terminated. Although she agreed to discuss the issue later in the day, she did not answer the telephone during multiple attempts. A review of the personnel file for staff #205 revealed she resigned effective (MONTH) 3, (YEAR) and was not eligible for rehire. Staff #205 had a license that was active and in good standing and there was evidence that she had been provided education and training on abuse and neglect. In addition, staff #205 had been provided a RN job description which was signed by her. The job description contained the following: 2) The nurse must possess the ability to make independent decisions when circumstances warrant such action. 3) The nurse must be able to evaluate resident needs through ongoing assessment based on changes in the resident's condition. An interview was conducted with CNA (staff #39) on (MONTH) 2, (YEAR) at 9:45 a.m. She stated that she knew the resident very well, as he had been in the facility for many years. She stated on the day of the incident with resident #71, she was not assigned to provide direct care to him, however, she made the time to check on the resident. Staff #39 said that at approximately 1:00 p.m. on (MONTH) 24, (YEAR), she checked on the resident and he was not right. She said that when she tried to talk to him he did not respond. She said she shook him but he did not respond. She stated she quickly found the nurse (staff #205) and told her she needed to come to the resident's room right away to check him, as he was not doing well. Staff #39 stated that staff #205 told her that maybe the resident had too much medicine and it just made him sleepy. Staff #39 said that she asked staff #205 if she was going to do anything about the situation and staff #205 told her No. Staff #39 stated she then quickly ran to the first floor of the facility and found a Licensed Practical Nurse (LPN/staff #29), who came right away and called 911. Staff #39 stated that when staff #205 refused to come and look at the resident it was not right. She stated that she told the Assistant Director of Nursing (ADON/staff #37) about the incident. An interview was conducted with staff #37 on (MONTH) 2, (YEAR) at 1:52 p.m. She stated that staff #205 did not go to the resident's room, even though staff #39 asked her to check on the resident right away. She said that staff #29 came from the first floor to help. An interview was conducted with staff #29 on (MONTH) 2, (YEAR) at 2:39 p.m. She stated that she recalled the incident with resident #71, who resided on the second floor of the facility. Staff #29 stated she was working on the first floor on the day of the incident. She said that staff #39 came to her and asked her to come right away to check on resident #71. Staff #29 stated that the CNA said that she told staff #205 to check on the resident and staff #205 told her that she was not going to go to the resident's room. Staff #29 stated the resident had slurred speech, was mumbling and made no sense. She stated she immediately called the physician, 911 was called and the resident was sent out to the emergency room . Staff #29 stated she tried to talk with staff #205, because staff #205 had not done anything for the resident. She stated that this would be neglect. Staff #29 stated that she notified the prior DON of the incident. An interview was conducted with the current DON (staff #95) on (MONTH) 2, (YEAR) at 3:15 p.m. She stated that a nurse not providing care to a resident in distress would be considered neglect and did not meet the standards of nursing practice. Review of a facility policy regarding Neglect revealed the following: Neglect is failure to provide goods and services necessary to avoid physical harm. All residents have the right to be free from neglect. It is the policy and practice of

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F 0600 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 2) this facility that all residents be free of neglect.
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, hospital documentation and policy review, the facility failed to report an incident of neglect involving one resident (#71) to the State Survey Agency. Findings include: Resident #71 was admitted to the facility on (MONTH) 11, 2008, with [DIAGNOSES REDACTED]. A handwritten nursing note dated (MONTH) 24, (YEAR) at 1:30 p.m. by a licensed practical nurse (staff #29) included the following: Resident awake, disoriented, unable to verbalize, mumbles words slurred speech. Breathing labored. Pulse ox @ 80% RA (room air). Put resident on 10 liters of oxygen via mask and head of bed up. Skin cold and clammy. Blood pressure was 160/100, heart rate at 110, respirations at 26, and temperature was 99.5 (axillary). Resident is full code and 911 was called. Physician was notified and in agreement with sending resident out to the emergency room . Pulse ox went up to 93% on 10 liters of oxygen. Review of a change in condition nursing progress note dated (MONTH) 24, (YEAR) and entered at 3:06 p.m. by staff #205 (registered nurse) revealed the following: Resident started getting lethargic and disoriented this morning. Around 12:30 p.m. as two Certified Nursing Assistants (CNAs) were cleaning him he started to go unresponsive. Only awakened with sternal rub. Pulse ox started getting lower into the 80's and put 2 Liters of oxygen on him and the pulse ox went back up into the 90's. Temperature was 100. Blood pressure was 92/50. Reported to physician and Emergency Medical Services (EMS) was called and intravenous fluids were started. Resident did not awaken easily even with a sternal rub. Other nurses were assisting with assessing the resident until 911 was called and he was transferred to the hospital. He was last seen normal and baseline last night. An addendum nursing note dated 6/24/18 and signed by staff #205 at 5:35 p.m. included the following: Resident was slightly altered around 6 am to 11 am and then progressively got worse at 12:30 p.m. where his condition was significantly noticed. According to the hospital records dated (MONTH) 24, (YEAR), the resident was brought to the emergency room due to acute onset of altered mental status. Upon arrival the patient was in obvious acute [MEDICAL CONDITION] and was intubated accordingly. The resident was then admitted and sent to the intensive care unit for acute [MEDICAL CONDITION] and the need for mechanical ventilation. An interview was conducted with the Administrator (staff #209) on (MONTH) 1, (YEAR) at 11:30 a.m. She stated that she had no knowledge of the allegation of neglect between resident #71 and staff #205, therefore she did not report it to the State Agency. An interview was conducted with the Director of Nursing (DON/staff #95) on (MONTH) 2, (YEAR). She stated that any allegation of neglect has to be immediately reported to the DON and Administrator, who then notify all of the mandated agencies. She stated she did not have any documentation from the prior DON regarding this incident. Review of a facility policy on Neglect revealed that all personnel will promptly report any incident or suspected incident of resident abuse/neglect to facility administration. The policy also included that Federal requirements mandate that facilities must ensure all allegations of neglect are immediately reported to the State Survey Agency.
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, hospital documentation and policy review, the facility failed to investigate an allegation of neglect for one resident (#71). Findings include: Resident #71 was admitted to the facility on (MONTH) 11, 2008, with [DIAGNOSES REDACTED]. A handwritten nursing note dated (MONTH) 24, (YEAR) at 1:30 p.m. by a licensed practical nurse (staff #29) included the following: Resident awake, disoriented, unable to verbalize, mumbles words slurred speech. Breathing labored. Pulse ox @ 80% RA (room air). Put resident on 10 liters of oxygen via mask and head of bed up. Skin cold and clammy. Blood pressure was 160/100, heart rate at 110, respirations at 26, and temperature was 99.5 (axillary). Resident is full code and 911 was called. Physician was notified and in agreement with sending resident out to the emergency room . Pulse ox went up to 93% on 10 liters of oxygen. Review of a change in condition nursing progress note dated (MONTH) 24, (YEAR) and entered at 3:06 p.m. by staff #205 (registered nurse) revealed the following: Resident started getting lethargic and disoriented this morning. Around 12:30 p.m. as two Certified Nursing Assistants (CNAs) were cleaning him he started to go unresponsive. Only awakened with sternal rub. Pulse ox started getting lower into the 80's and put 2 Liters of oxygen on him and the pulse ox went back up into the 90's. Temperature was 100. Blood pressure was 92/50. Reported to physician and Emergency Medical Services (EMS) was called and intravenous fluids were started. Resident did not awaken easily even with a sternal rub. Other nurses were assisting with assessing the resident until 911 was called and he was transferred to the hospital. He was last seen normal and baseline last night. An addendum nursing note dated 6/24/18 and signed by staff #205 at 5:35 p.m. included the following: Resident was slightly altered around 6 am to 11 am and then progressively got worse at 12:30 p.m. where his condition was significantly noticed. According to the hospital records dated (MONTH) 24, (YEAR), the resident was brought to the emergency room due to acute onset of altered mental status. Upon arrival the patient was in obvious acute [MEDICAL CONDITION] and was intubated accordingly. The resident was then admitted and sent to the intensive care unit for acute [MEDICAL CONDITION] and the need for mechanical ventilation. An interview was conducted with the Administrator (staff #209) on (MONTH) 1, (YEAR) at 11:30 a.m. She stated that she had no knowledge of an allegation of neglect between resident #71 and staff #205, therefore she did not complete an investigation. She stated that all allegations of neglect need to be investigated immediately. Review of a policy regarding Neglect revealed the following: Review of a facility policy regarding Neglect revealed the following: Neglect is failure to provide goods and services necessary to avoid physical harm. All residents have the right to be free from neglect. The policy included that all allegations of neglect will be promptly and thoroughly investigated.
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 policy review, the facility failed to ensure a Minimum Data Set (MDS) assessment was accurate for one resident (#128). Findings include: Resident #128 was admitted to the facility on (MONTH) 12, (YEAR), and discharged (MONTH) 13, (YEAR) against medical advice with [DIAGNOSES REDACTED]. Review of the resident's face sheet revealed the resident was discharged on (MONTH) 13, (YEAR) at 8:08 a.m. to a private home or apartment with no home health services. However, the discharge-return not anticipated MDS assessment dated (MONTH) 13, (YEAR), revealed the resident had an unplanned discharge to an acute hospital. An interview was conducted with a MDS nurse (staff #86) on (MONTH) 1, (YEAR) at 1:09 p.m., who stated that she interviews the resident/family and staff and reviews documentation from the hospital, physician's orders [REDACTED]. to obtain information to complete the MDS assessment. Staff #86 stated that the resident's discharge MDS assessment should have been coded as discharged to the community, rather than to an acute hospital. During an interview conducted with the Director of Nursing (DON/staff #95) on (MONTH) 2, (YEAR) at 12:17 p.m., she stated that the expectation is that MDS assessments should be accurate. Review of the facility's policy titled, Certification of Accuracy of the MDS revealed the purpose is To obtain the signature of all person who completed any part of the MDS. Legally, it is an attestation that to the best of your knowledge, the

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F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) information you entered on the MDS accurately reflects the patient's status. The primary responsibility for accuracy lies with the person selecting the MDS item response.
F 0645 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**PASARR screening for Mental disorders or Intellectual Disabilities** **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 a Level I PASRR (Preadmission Screening and Resident Review) screening for possible serious mental disorders and/or intellectual disability was completed before admission for one resident (#7). Finding includes: Resident #7 was admitted on [DATE] with [DIAGNOSES REDACTED]. A quarterly MDS (Minimum Data Set) assessment dated (MONTH) 23, (YEAR) revealed a BIMS (Brief Interview for Mental Status) score of 2 which indicated the resident was severely cognitive impaired. The MDS assessment also included a [MEDICAL CONDITION] diagnosis, that the resident received antipsychotic and antidepressant medications, and that the resident had hallucinations, delusions, and verbal behavioral symptoms directed towards others. The current care plan regarding [MEDICAL CONDITION] with associated agitated features included interventions for a psychological/psychiatrist referral as needed and to report changes in mood to social services as needed. Review of the physician's orders [REDACTED]. However, further review of the clinical record did not reveal a Level I PASRR screening for serious mental disorder and/or intellectual disability had been completed before admission to ensure the resident was offered the most appropriate setting to meet his needs. During an interview conducted with medical records (Staff # 53) on (MONTH) 2, (YEAR) at 12:00 PM, staff #53 stated that she unable to locate any documentation that a Level I PASRR screening had been completed for resident #7. An interview was conducted with the social services assistant (staff #5) on (MONTH) 2, (YEAR) at 12:05 PM, who stated that she was unable to locate a Level I PASRR screening for this resident. An interview was conducted with the Director of social services (staff #191) on (MONTH) 2, (YEAR) at 12:20 PM. She stated that the Level I PASRR is obtained by admissions and that if one is not obtained, the resident is usually a Level I PASRR. During an interview conducted with the Director of Nursing (DON/Staff #95) on (MONTH) 2, (YEAR) at 12:40 PM, the DON stated that the PASSRs are supposed to be obtained on admit. The DON stated that residents receive appropriate treatments depending upon their PASRR levels. She further stated that she would have to ask social services regarding which level of treatment resident #7 is receiving. The facility's policy regarding Pre-admission Screening revealed Preadmission Screening and Resident Review (PASRR) is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care. PASRR requires that 1) all applicants to a Medicaid-certified nursing facility be evaluated for serious mental illness (SMI) and/or intellectual disability; 2) be offered the most appropriate and least restrictive setting for their needs (in the community, a nursing facility, or acute care settings); and 3) receive the services they need in those settings. The policy also included that social services are to ensure a Level I PASRR screening is completed on all potential admissions.
F 0655 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policy, the facility failed to provide one resident (#120) and their representative with a summary of the baseline care plan. Findings include: Resident #120 was admitted to the facility on (MONTH) 10, (YEAR), with a [DIAGNOSES REDACTED]. The baseline care plan was initiated on (MONTH) 10, (YEAR) which included the resident's identified needs and interventions. It also were included the following sections that not marked and left blank: -Initial review date -Resident /Representative Baseline Care Plan Review The nursing admission assessment dated (MONTH) 11, (YEAR) revealed the resident was alert and oriented to person, place, and situation and can communicate needs. The admission Minimum Data Set assessment dated (MONTH) 17, (YEAR), revealed a BIMS (Brief Interview for Mental Status) score of 15 which indicated the resident had intact cognition. Further review of the clinical record did not reveal documented evidence that the resident and the resident's representative were provided a summary of the baseline care plan. During an interview conducted with a Licensed Practical Nurse (LPN/staff #152) on (MONTH) 5, (YEAR) at 2:54 p.m., the LPN stated that the admission nurse/assistant director of nursing (ADON) creates and completes the residents' baseline care plans upon admission. An interview was conducted with the ADON (staff #37) on (MONTH) 5, (YEAR) at 2:56 p.m., who stated that the baseline care plan is initiated upon resident admission and completed within 48 hours. She stated that the baseline care plan will include the resident's identified needs, strengths, and weaknesses and that the development and implementation of a resident's care plan is ongoing. The ADON stated that the baseline care plan is reviewed with the resident or their responsible party and that a summary of the baseline care plan will be provided to the resident within 72 hours. She further stated the signature on the baseline care plan indicates that the resident/responsible party was provided a copy of the plan and that the signed copy of the baseline care plan will be placed in the clinical record. The ADON also stated that she was unable to say why resident #120 was not provided a summary of the baseline care plan. The facility's policy regarding Baseline Care Plan included that a baseline care plan will be developed for every resident within 48-72 hours of admission. The policy also included that the baseline care plan will be reviewed with the resident/representative and that the resident/representative will be provided with a copy of the baseline care plan.
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a clinical record review, staff interviews, and policies review, the facility failed to ensure a care plan was revised for one resident (#72). Findings include: Resident #72 was admitted to the facility on (MONTH) 31, (YEAR) and readmitted (MONTH) 23, (YEAR), with [DIAGNOSES REDACTED]. Review of the physician's orders [REDACTED]. However, review of the current care plan regarding contractures revealed an intervention for a left upper extremity hand splint to be applied per physician order. During an interview conducted on (MONTH) 2, (YEAR) at 10:11 a.m. with a certified nursing assistant (staff #157), she stated that the resident does not have a splint for his upper extremities. An interview was conducted on (MONTH) 2, (YEAR) at 10:18 a.m. with a licensed practical nurse (staff #62), who stated that the care plan is initiated by the admitting nurse when a resident is admitted and that the care plan is revised by the MDS (Minimum Data Set) coordinator. An interview was conducted on (MONTH) 2, (YEAR) at 11:46 a.m. with the MDS coordinator (staff # 86). She stated that when new orders are obtained, the care plan is revised to reflect the physician's orders [REDACTED]. During an interview conducted on (MONTH) 2, (YEAR) at 12:02 p.m. with the Director of Nursing (staff #95/DON) and the Division Director of Clinical Services (staff #206), the DON stated that nursing staff are responsible for care plan

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F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4) revisions. Review of the facility's policy titled Contractures revealed all residents with contractures will be evaluated and a treatment plan will be included in the individualized care plan. In addition, the plan will be implemented and evaluated at least monthly. The facility's policy regarding restorative nursing revealed the restorative nursing functions can be within one of the following categories .splint or brace assistance. The policy also included the development and implementation of the patient's restorative care plans is the ongoing responsibility of the interdisciplinary team and that the care plan will be reviewed and revised as indicated.
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, staff interviews, and policy and procedures, the facility failed to meet professional standards of quality, by failing to ensure that medications for one resident (#102) were administered as ordered and by failing to implement physician orders [REDACTED].#60). Findings include: -Resident #102 was admitted on (MONTH) 2, (YEAR) and readmitted on (MONTH) 17, (YEAR), with [DIAGNOSES REDACTED]. Review of the admission Minimum Data Set (MDS) assessment dated (MONTH) 9, (YEAR), revealed a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident was cognitively intact. Regarding the [MEDICATION NAME]: A care plan initiated on (MONTH) 11, (YEAR) for hypertension included a goal that hypertension would be minimized with medications and diet as ordered. Interventions included to administer medications as ordered, observe blood pressure as ordered, and to report signs and symptoms of hypertension/[MEDICAL CONDITION] to the physician. A physician's orders [REDACTED]. Review of the Medication Administration Records from (MONTH) (YEAR) through (MONTH) (YEAR) revealed multiple times that the [MEDICATION NAME] was administered when the resident's systolic blood pressure was less than 120. An interview was conducted on (MONTH) 1, (YEAR) with a licensed practical nurse (LPN/staff #82), who stated that the medication should be administered according to the parameters ordered by the physician. Regarding the [MEDICATION NAME]: The care plan regarding pain initiated on (MONTH) 11, (YEAR) revealed a goal that the resident would not have discomfort. Interventions included pain medications as ordered. Review of the physician's orders [REDACTED]. A physician's orders [REDACTED]. Review of the Medication Administration Record [REDACTED]. An interview was conducted on (MONTH) 2, (YEAR) at 1:48 PM with a LPN (staff #192). The LPN stated that prior to administering [MEDICATION NAME], she would calculate the amount of [MEDICATION NAME] that had already been administered to the resident. She stated that if administering the as needed [MEDICATION NAME] would exceed 3 grams, she would not administer the medication. During an interview conducted on (MONTH) 2, (YEAR) at 3:02 PM with the Director of Nursing (DON/staff #95), she stated that her expectation is that the nurses administer medications following the ordered parameters. The DON stated that the expectation is that the nurses would not administer medications outside of the ordered parameters. -Resident #60 was admitted to the facility on (MONTH) 16, (YEAR), with [DIAGNOSES REDACTED]. The admission physician orders [REDACTED]. Review of the nutritional care plan dated (MONTH) 16, (YEAR), revealed a goal that the resident would not sustain a significant weight loss in the next six months. Approaches included to monitor for significant weight loss and to weigh the resident and record the results. Review of the monthly weights from (MONTH) 21 through (MONTH) 7, (YEAR) revealed the resident had some weight loss. Review of the clinical record revealed there was no evidence that weights had been obtained from (MONTH) 8, (YEAR) through (MONTH) 10, (YEAR) as ordered. According to the weight record, the resident's weight was obtained on (MONTH) 11, (YEAR), and showed additional weight loss. A physician's orders [REDACTED]. Further review of the clinical record revealed the resident's weight was not obtained until (MONTH) 12, (YEAR). In addition, there was no documentation that the resident's weight was obtained on (MONTH) 20 and 27, (YEAR). An interview was conducted with a Certified Nursing Assistant (staff #146) on (MONTH) 2, (YEAR) at 12:50 p.m. She stated that weights are completed by the RNA staff and entered into the computerized system. An interview was conducted with the Dietician (staff #207) on (MONTH) 2, (YEAR) at 1:17 p.m. She stated that she did not know why the physician orders [REDACTED].#60. An interview was conducted with the Director of Nursing (staff #95) on (MONTH) 2, (YEAR) at 3:15 p.m. She stated it is standard nursing practice that nurses follow the physician's orders [REDACTED]. The facility's policy regarding physician orders [REDACTED].
F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a clinical record review, observations, staff interviews, and policies review, the facility failed to ensure one resident (#72) with limited range of motion (ROM) received appropriate services to increase and/or prevent further decrease in range of motion. Findings include: Resident #72 was admitted to the facility on (MONTH) 31, (YEAR) and readmitted (MONTH) 23, (YEAR), with [DIAGNOSES REDACTED]. The annual Minimum Data Set (MDS) assessment dated (MONTH) 18, (YEAR) revealed the resident scored a 13 on the Brief Interview for Mental Status (BIMS) indicating the resident was cognitively intact. The assessment also included the resident required extensive assistance with most activities of daily living and had a functional impairment to one side of his upper and lower extremities. Review of the care plan dated (MONTH) 31, (YEAR) revealed the resident had contractures as evidence by left upper extremity elbow, wrist and digit in flexion position, and bilateral knee and ankle contractures. The care plan goal was that the resident would not develop further decline in contractures. Interventions included therapy screening as indicated, passive range of motion with daily care, and a palmar guard to the left hand. On (MONTH) 15, (YEAR), the care plan was revised to include a left upper extremity hand splint per physician orders. Additional review of the care plan revealed a care plan regarding activities of daily living that included an intervention for restorative nursing assistants (RNA) to provide passive range of motion to the left upper and lower extremities and active range of motion to the right upper and lower extremity three times a week. Review of the restorative care flow sheet dated (MONTH) (YEAR) revealed a plan that the resident would receive passive range of motion (PROM) to the left upper and lower extremities and active ROM (AROM) to the right upper and lower extremities three times a week for 8 weeks. The documentation revealed the resident refused RNA (MONTH) 3-4, (YEAR) and included that on (MONTH) 9, (YEAR) RNA services were unable to be completed because the resident was combative. A note dated (MONTH) 9, (YEAR) revealed the resident was discontinued from the RNA program due to combative behaviors. Review of the therapy multidisciplinary screening forms dated (MONTH) 25, (YEAR) revealed the resident had bilateral knee contractures (no mention of the left upper extremity contracture). The documentation included that due to agitation and cognitive status, the resident does not follow proper positioning or contracture management protocol. The therapy multidisciplinary screening form dated (MONTH) 22, (YEAR), revealed that there was no change to ROM and strength. The documentation included a referral for the resident to participate in RNA for bed mobility and transfer

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F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 5) training. Review of the restorative care referral form dated (MONTH) 22, (YEAR), revealed a level two restorative nursing program for PROM to the left lower extremity and AROM to the right lower extremity, transfers and bed mobility three times a week for eight weeks. The restorative care flow sheet for (MONTH) (YEAR) revealed PROM was provided on (MONTH) 25 and (MONTH) 27, (YEAR) to the bilateral extremities for 15 minutes. Review of restorative care flow sheet for (MONTH) (YEAR) revealed the resident received PROM to the bilateral extremities for 15 minutes on (MONTH) 1, 2, 9, 10, 12, 16, 19, and 24. Review of the restorative care flow sheet for (MONTH) (YEAR) revealed the resident received PROM to bilateral extremities for 15 minutes on (MONTH) 1, 8, 14, 15, and 22. Multiple observations were conducted on (MONTH) 31, (YEAR) through (MONTH) 2, (YEAR). The resident was observed with no splint or devices to his left upper extremity. During an interview conducted on (MONTH) 29, (YEAR) at 12:23 p.m. with the resident's representative, she stated that the resident is unable to open his left hand and that she unaware of what the staff are providing regarding the resident's limited range of motion. An interview was conducted on (MONTH) 31, (YEAR) at 9:23 a.m. with a certified nurse assistant (CNA/staff #88). She stated that the resident requires total assistance with activities of daily living. The CNA also stated that the resident has a contracture to the left arm and is not receiving therapy or RNA services. During an interview conducted on (MONTH) 1, (YEAR) at 1:08 p.m. with a licensed practical nurse (LPN/staff #200), the LPN stated that the resident requires total assistance with care, has left sided weakness, and is currently receiving RNA services. An interview was conducted on (MONTH) 1, (YEAR) at 1:40 p.m. with the physical therapy director (staff #150). He stated that residents are screened on admission and quarterly to determine if they are appropriate for therapy or RNA services. He stated that RNA services provide basic restorative activities to keep residents active. An interview was conducted on (MONTH) 1, (YEAR) at 2:00 p.m. with the Assistant Director of Nursing (ADON/staff #37) who stated that she over sees the RNA program. The ADON stated that therapy evaluates the residents and make recommendations for RNA services. She stated resident #72 has been on and off RNA services but is currently receiving RNA services for strengthening and stretching and has a splint. After reviewing the clinical record, the ADON stated that the resident started RNA services on (MONTH) 22, (YEAR) and received services as documented on the restorative flow sheet. During an interview conducted on (MONTH) 2, (YEAR) at 12:02 p.m. with the Director of Nursing (DON/staff #95) and the Division Director of Clinical Services (staff #206), the DON stated that therapy will screen a resident and determine if that resident will benefit from RNA services. After they reviewed the clinical record, the DON stated that the RNA services are to be provided as written and that RNA services were provided as documented on the RNA flow sheets. The Division Director stated that based on the quarterly physical therapy evaluations dated (MONTH) 22, (YEAR), she is unable to determine if the resident has contractures or limited range of motion but that the evaluation states the resident had no change in ROM. Review of the facility's policy titled Restorative Nursing revealed the purpose of the policy is to implement a restorative nursing system that meets the individual needs of each patient and assist each patient in reaching the highest practicable level of physical, mental, and psychosocial functioning. The policy included the activities must be individualized to the resident's needs, planned, monitored, and evaluated, and documented in the medical record. Review of the facility's policy titled Contractures revealed all residents with contractures will be evaluated and a treatment plan will be included in the individualized care plan. The policy also included the plan will be implemented and evaluated at least monthly.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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 observations, clinical record review, facility documentation, staff interviews, and policy procedures, the facility failed to ensure that a fall care plan intervention was implemented for one resident (#49) and failed to ensure one resident (#526) was provided adequate supervision. Findings include: -Resident #49 was admitted on (MONTH) 9, (YEAR) and readmitted on (MONTH) 30, (YEAR), with [DIAGNOSES REDACTED]. The admission Minimum Data Set (MDS) assessment dated (MONTH) 16, (YEAR), revealed a Brief Interview of Mental status Score of 15 which indicated the resident was cognitively intact. The MDS assessment included that the resident required extensive assistance of two persons for bed mobility and was totally dependent on two persons for transfers. Review of the fall risk care plans initiated (MONTH) 20, (YEAR) revealed a goal that the resident risk of injury due to falls will be minimized related to fall intervention. The interventions included a dycem cushion in the wheelchair. A fall risk assessment dated (MONTH) 30, (YEAR) revealed the resident was at moderate risk for falls with a prior history of one to two falls within the last six months. Review of the Event Nurses notes dated (MONTH) 4, (YEAR), revealed the resident was found on the floor next to the sink, laying on her belly with a bump on her forehead. The nurses note included the root cause of the fall was the resident falling out of the wheelchair. During an observation conducted of the resident in the wheelchair on (MONTH) 30, (YEAR) at 8:55 a.m., no dycem cushion was observed in the wheel chair. Review on the Event Nurses notes dated (MONTH) 30, (YEAR) revealed the resident had another fall at 13:30 p.m. The note included the resident was found in a sitting position on top of the footrest of the wheelchair. The note further included A nursing therapy referral done for assessment of wheelchair positioning and possible dycem placement if appropriate. An observation was conducted on (MONTH) 31, (YEAR) at 12:10 p.m. of the resident in bed and no dycem cushion was observed in the wheelchair. An interview was conducted on (MONTH) 31, (YEAR) at 08:45 a.m. with a Licensed practical Nurse (LPN/staff #29) who stated that resident has had multiple falls. The LPN stated that staff makes sure the call light is within the resident's reach and that they conduct frequent visual checks of the resident. During an interview conducted on (MONTH) 31, (YEAR) at 12:12 p.m. with a Certified Nurses assistant (CNA/staff #189), staff #189 stated that resident is not a fall risk, she has behaviors. The CNA stated that the only prevention they are implementing is to try to involve the resident in activities and not leave her in the room by herself. The CNA further stated that no other preventative measure were in place. During an interview conducted on (MONTH) 31, (YEAR) at 12:20 p.m. with a Registered Nurse unit manager (RN/staff #66), she stated that the resident is a fall risk and that she had a fall yesterday. The RN stated that the physician ordered a physical therapy evaluation for wheel chair positioning. She stated that the fall prevention interventions in place are having the call light within reach, checking on the resident every couple of hours, and checking her position when she is in the wheelchair. The unit manager further stated that sliding is the root cause of the resident's falls and that there is nothing that they are doing for the sliding. She stated the PT will have to evaluate the sliding. An interview was conducted on (MONTH) 31, (YEAR) at 12:37 p.m. with the Director of Nursing (DON/staff #95). Staff #95 stated that a root cause analysis is done after each fall and that any new interventions would be added to the care plan. She also stated that she expects her staff to follow the interventions that are on the care plan. The DON stated that if there is no dycem in the wheelchair, the unit manager, interdisciplinary team, certified nursing assistants, and nursing staff were responsible to ensure the care plan interventions were implemented. -Resident #526 was admitted to the facility on (MONTH) 30, (YEAR) with [DIAGNOSES REDACTED]. Review of the annual MDS assessment dated (MONTH) 17, (YEAR), revealed the resident had long-term and short-term memory problems and was severely cognitive impaired for daily decision making. The current care plan initiated on (MONTH) 18, (YEAR) revealed the resident was at risk for physical injury from falls

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F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 6) related to dementia and poor safety awareness. Interventions included providing environmental adaptions and reinforcing safety awareness. Further review of the care plan revealed the resident had impaired cognitive skills with interventions that included the staff would anticipate and provide daily care as indicated. The Fall Risk assessment dated [DATE] revealed a score of 22. Ten or above indicates interventions should be implemented. Review of nursing progress notes revealed the resident had fallen once per month from (MONTH) (YEAR) through (MONTH) (YEAR). On (MONTH) 29, (YEAR) at 3:09 PM, the resident was observed climbing out of his wheelchair into his bed. The bed was observed in a high position. The resident was observed to be shaking as he slowly situated himself on the bed, resting on his hands, knees, and face with his back and buttocks in the air. After several seconds, the resident slumped down onto his left side. During this observation, several staff members including CNAs were observed passing the resident's doorway looking in and not intervening. An interview was conducted on (MONTH) 1, (YEAR) at 1:05 PM with a licensed practical nurse (LPN/staff # 82). She stated that she checks on residents identified as high fall-risk about every 10 minutes when she is working. The LPN stated that she frequently have residents that are high risk for falls sit near the nurses' station. She stated that she would recommend keeping the resident's bed in the low position. On (MONTH) 1, (YEAR) at 2:30 PM, resident #526 was observed sitting alone in the wheelchair at the elevator. When the elevator door opened, a staff member was observed to exit. She asked the resident what he was doing there sitting by himself. The resident stated that he wanted a candy bar. The staff member redirected him and moved his wheelchair down the hall to an activity. An interview was conducted on (MONTH) 2, (YEAR) at 3:02 PM with the director of nursing (DON/staff #95). She stated that if a resident has advanced dementia, the resident should not to be left alone in their room, should be encouraged to attend supervised activities, and would be provided a one to one supervision. Review of the facility's policy on Incident Management revealed residents at risk for incidents are identified, care planned, and procedures are implemented designed to reduce the incident risk and minimize the potential for occurrence. The policy included that each resident receives adequate assistance and oversight as defined in the individualized plan of care that reduces the risks for incidents.
F 0698 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Past noncompliance - remedy proposed** **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 that pre and post [MEDICAL TREATMENT] assessments were completed for one resident (#434). Findings include: Resident #434 was admitted on [DATE], with [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. Review of the clinical record revealed the resident had a [MEDICAL TREATMENT] port in place for [MEDICAL TREATMENT] use. Further review of the clinical record revealed there were no pre and post [MEDICAL TREATMENT] assessments which were completed from admission through (MONTH) 29, (YEAR). An interview was conducted with a Licensed Practical Nurse (staff #140) at 11/01/18 at 12:10 p.m. Staff #140 stated that the floor nurses do pre/post [MEDICAL TREATMENT] assessments on residents before they leave for [MEDICAL TREATMENT] and upon return. She stated that they previously documented the information on a Pre/Post [MEDICAL TREATMENT] sheet, but since they have moved to a new computer system, she has not been documenting this. An interview was conducted with the Director of Nursing (DON/staff #95) on 11/01/18 at 2:28 p.m. The DON stated that it is her expectation that all patients on [MEDICAL TREATMENT] have an order to have their [MEDICAL TREATMENT] port site assessed pre/post [MEDICAL TREATMENT]. Staff #95 also stated that she expects [MEDICAL TREATMENT] assessments to be documented every time before a resident leaves for, and returns from [MEDICAL TREATMENT]. The DON added that if the information has not been documented, it is because they have switched to a new system and they have not worked out the problems. Review of the [MEDICAL TREATMENT] policy revealed that based on the comprehensive assessment of the patient, the facility must ensure that patients who require [MEDICAL TREATMENT] receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan and the patients goals and preferences. The policy states that [MEDICAL TREATMENT] patients shall receive constant care pre and post [MEDICAL TREATMENT], and that the [MEDICAL TREATMENT] port site shall be checked on a daily basis with physician notification for any bleeding/hemorrhage, septic shock, or signs of infection. The policy further included to obtain vital signs of the patient upon return from [MEDICAL TREATMENT], routine dressing changes with each treatment at [MEDICAL TREATMENT], and to maintain [MEDICAL TREATMENT] transfer forms in the patients medical record.
F 0744 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, hospital documentation, staff interviews and policy review, the facility failed to ensure that one resident (#120) with dementia received the appropriate treatment and services to attain their highest practicable well-being. Findings include: Resident #120 was admitted at the facility on (MONTH) 10, (YEAR), with a [DIAGNOSES REDACTED]. The hospital discharge summary dated (MONTH) 10, (YEAR), included the resident became agitated in the emergency department and required [MEDICATION NAME] (antipsychotic). The documentation also included the resident had severe agitation, which became better on [MEDICATION NAME] (antipsychotic/generic name Quetiapine). The documentation included a hospital [DIAGNOSES REDACTED]. Review of the hospital discharge medication orders included for Quetiapine 25 mg 1 tablet by mouth two times a day for 30 days. The hospital discharge instructions also included to ask the physician or other care provider to review the medications with the resident. The PASRR (Pre-Admission Screening and Resident Review) dated (MONTH) 10, (YEAR) included that the resident did not have any mental disorders and did not have a [DIAGNOSES REDACTED]. Per the documentation, the resident had a primary [DIAGNOSES REDACTED]. According to the baseline care plan dated (MONTH) 10, (YEAR), the resident was blind. The nursing admission assessment dated (MONTH) 11, (YEAR) revealed the resident was alert and oriented to person, place and situation and did not have any behaviors. A physician's progress note dated (MONTH) 11, (YEAR) revealed the resident was very pleasant and had significant agitation at the hospital requiring admission to the ICU (Intensive Care Unit) and a psychiatric evaluation. Physical examination included the resident was alert and oriented x 4 and had severe agitation and acute metabolic [MEDICAL CONDITION]. The plan included adjusting the [MEDICATION NAME] and psychiatric evaluation as needed. A physician's orders [REDACTED]. The psychoactive medication informed consent for the use of [MEDICATION NAME] dated (MONTH) 11, (YEAR) included hospital [MEDICAL CONDITION] AEB yelling, as the reason why the medication was prescribed. A nurse practitioner progress note dated (MONTH) 12, (YEAR) included the resident developed acute confusion and severe agitation in the hospital. Per the note, the resident was alert and oriented x 3, had depression and had unspecified dementia with behavioral disturbance. The goal was to decrease in the incidence of delusions/hallucinations. Interventions were for [MEDICATION NAME] and to monitor behaviors. An admission MDS (Minimum Data Set) assessment dated (MONTH) 17, (YEAR) included a BIMS (Brief Interview for Mental Status) score of 15, indicating the resident has intact cognition, had no acute onset of mental status changes from baseline, and

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F 0744 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 7) had no potential for depression symptoms. The MDS also included no potential indicators of [MEDICAL CONDITION] such as; hallucinations or delusions. Per the MDS, the resident did not have any physical or verbal behavioral symptoms. Review the MAR (medication administration record) for (MONTH) (YEAR) revealed that [MEDICATION NAME] was administered to the resident as ordered by the physician. This medication was first administered to the resident on (MONTH) 11. Review of the Behavior/Intervention Monthly Flow Record for (MONTH) (YEAR) revealed the resident was monitored for a behavior of yelling out and that non-pharmacologic interventions were administered to the resident from (MONTH) 11, through (MONTH) 22. There was no evidence found in the clinical record that monitoring of resident behavior was done and NPI were administered to the resident after (MONTH) 22, (YEAR). The physician order [REDACTED]. However, the clinical record showed documentation that the resident was monitored for side effects related to [MEDICATION NAME] use starting (MONTH) 23, (YEAR). Review of a NP note dated (MONTH) 25, (YEAR) revealed the resident was alert and oriented x 2 and was cooperative. Per the note, the resident had unspecified dementia with behavioral disturbance and the plan was to continue current dose of [MEDICATION NAME] A physician's progress note dated (MONTH) 26, (YEAR) included staff had reported that the resident's mentation was close to baseline. The note included the resident had acute metabolic [MEDICAL CONDITION] and severe agitation and that this has now improved and was better on [MEDICATION NAME]. The plan included adjusting the dose of [MEDICATION NAME] and for a psychiatric evaluation as needed. A physician's orders [REDACTED]. However, the [DIAGNOSES REDACTED]. Review of the psychoactive medication informed consent for the use of [MEDICATION NAME] dated (MONTH) 3, (YEAR) included hallucinations as the reason why the medication was prescribed. However, continued review of the clinical record revealed no evidence that the resident had hallucinations and/or delusions from (MONTH) 11, through (MONTH) 5, (YEAR). In an interview with a licensed practical nurse (LPN/staff #192) conducted on (MONTH) 2, (YEAR) at 1:48 p.m., she stated when a resident is prescribed an antipsychotic, she will ensure that a consent for its use is signed by the resident or responsible party. She stated there must be a [DIAGNOSES REDACTED]. She said target behaviors will be written in the order and documented as as evidenced by and that these target behaviors together will be monitored for the entire shift. She further stated the monitoring will be documented in the nursing notes, MARs and behavior monitoring flowsheet. During an interview with a certified nursing assistant (CNA/staff #103) conducted on (MONTH) 5, (YEAR) at 2:11 p.m., she stated the resident is alert and oriented and can tell staff her needs and wants. She stated the resident has periods of confusion and starts screaming especially after meals. She stated the resident reports seeing shadows because the resident is blind. She also stated the resident does not have any other behaviors other than screaming/yelling out after meals. An interview with a LPN (staff #51) was conducted on (MONTH) 5, (YEAR) at 2:31 p.m. Staff #51 stated the resident is alert and oriented and able to verbalize needs. She stated the resident has a problem with her left eye vision and has yelling as a behavior. She said the resident usually yells when she can not find her call light; and,she does not know of any other behaviors the resident has. She said the resident does not have hallucinations or delusions. When asked what the [MEDICATION NAME] for resident #120 was prescribed for, she stated that she could not determine the target behavior related to the use of this medication. On (MONTH) 5, (YEAR) at 2:56 p.m., staff #51 stated that she reviewed the resident's clinical record with the Assistant Director of Nursing (ADON/staff #37). Staff #51 stated the resident is on [MEDICATION NAME] for hallucinations. Review of the policy on Psychopharmacological Medication Management revealed the purpose was to support effective utilization of psychopharmacological medications in the appropriate treatment of [REDACTED]. It also included that based on the comprehensive assessment, a resident who has not used an antipsychotic are not given this drug, unless the therapy is necessary to treat a specific condition as diagnosed and documented in the medical record. Continued review of the policy revealed that each resident receives only those psychopharmacological medications for the duration clinically indicated to treat the resident's assessed condition(s) and appropriate diagnosis. Per the policy, documentation in the resident's medical record includes but is not limited to: mental illness diagnosis, psychopharmacologic medication, type of behaviors which are new or worsening of behavior times and precipitation factors, if known. The policy also stated that Based on the assessment findings, the IDT (interdisciplinary team) will evaluate if the psychopharmacological medication therapy is appropriate by considering the following: Indications and [DIAGNOSES REDACTED].
F 0758 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, staff interviews, facility documentation, and policy review, the facility failed to ensure as needed (PRN) [MEDICAL CONDITION] medications for two residents (#102 and #120) had documentation of the rationale to continue their use longer than the required timeframe, and failed to ensure that target behaviors and side effects associated with the use of [MEDICAL CONDITION] medications were consistently monitored. Findings include: -Resident #120 was admitted to the facility on (MONTH) 10, (YEAR), with a [DIAGNOSES REDACTED]. The PASRR (Pre-Admission Screening and Resident Review) dated (MONTH) 10, (YEAR) included the resident did not have any [DIAGNOSES REDACTED]. Per the documentation, the resident had a primary [DIAGNOSES REDACTED]. A nursing admission assessment dated (MONTH) 11, (YEAR) revealed the resident was alert and oriented to person, place and situation and can communicate needs. Per the documentation, the resident did not have any behaviors. A physician's progress note dated (MONTH) 11, (YEAR) included the resident was very pleasant, but had significant agitation at the hospital requiring admission to the ICU (Intensive Care Unit), and had a psychiatric evaluation. Physical examination included the resident was alert and oriented x 4. The note included the resident had severe agitation. The admission MDS (Minimum Data Set) assessment dated (MONTH) 17, (YEAR) included a BIMS (Brief Interview for Mental Status) score of 15, indicating the resident had intact cognition and had no mood disorders or any physical or verbal behaviors. The MDS assessment also included the resident did not have [DIAGNOSES REDACTED]. The Behavior/Intervention Monthly Flow Record from (MONTH) 11 through (MONTH) 20, (YEAR) revealed no documentation that the resident experienced increased agitation/anxiety. A psychosocial note dated (MONTH) 21, (YEAR) included the resident was yelling out throughout the whole shift and was unable to identify needs. Per the note, the resident was reminded to use the call light system, but was ineffective and continued to yell out for help. Review of the behavior monitoring sheet for (MONTH) 21, (YEAR) revealed the resident had behaviors marked as C, indicating behaviors were continuous during the day shift. Non pharmacological interventions included redirection and 1:1. The number of episodes were not documented by the night shift. A nurse practitioner (NP) note dated (MONTH) 22, (YEAR) included the resident was alert and oriented x 3, and that nursing staff reported the resident was agitated and yelling at times. The note included the resident had anxiety and the plan included that [MEDICATION NAME] ([MEDICATION NAME]/anxiolytic) was added on a PRN basis for agitation and yelling by the physician. Review of the physician's note dated (MONTH) 22, (YEAR) revealed that staff reported the resident has been having increased agitation. A physician's orders [REDACTED]. The order did not include the duration of its use.

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F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 8) Review of the psychoactive medication informed consent for the use of [MEDICATION NAME] dated (MONTH) 24, (YEAR), revealed the medication was being used for increased yelling out. The NP note dated (MONTH) 25, (YEAR) included the resident was awake, alert and oriented x 2 and was cooperative. Per the note, the resident had unspecified dementia with behavioral disturbance and that the [MEDICATION NAME] was on hold for episode of difficulty arousing the resident. Review of the MAR (medication administration record) for (MONTH) (YEAR), revealed the order for [MEDICATION NAME] ([MEDICATION NAME]) 0.5 mg give 1 tablet by mouth every 8 hours as needed for anxiety, as evidenced by yelling out. The MAR indicated [REDACTED] However, there was no evidence found in the clinical record that the resident was anxious or was yelling out on (MONTH) 28. There was also no clinical record documentation that the resident was monitored for behaviors from (MONTH) 23-29, (YEAR), or that the resident was being monitored for possible side effects associated with the use of [MEDICATION NAME] from (MONTH) 23-29. An interview with a licensed practical nurse (LPN/staff #82) was conducted on (MONTH) 1, (YEAR) at 1:08 p.m. Staff #82 stated that when a resident is on psychoactive medication, she ensures the physician's orders [REDACTED]. She said the order will be transcribed in the clinical record and the target behavior will be transcribed onto the behavior flow sheet. She said the number of episodes will be monitored by the nurses and the CNAs (certified nursing assistant) for the duration of the shift and should be documented on the behavior sheet. During an interview with the Director of Nursing (DON/staff #95) conducted on (MONTH) 2, (YEAR) at 3:02 p.m., she stated there are some pharmacists who tell them that it is okay to have PRN [MEDICAL CONDITION] medications like anxiolytics to have no stop dates. During an interview with a CNA (staff #103) conducted on (MONTH) 5, (YEAR) at 2:11 p.m., she stated the resident is alert and oriented and can tell staff her needs and wants. She also stated the resident has periods of confusion and starts screaming especially after meals. An interview with a LPN (staff #51) was conducted on (MONTH) 5, (YEAR) at 2:31 p.m. Staff #51 stated that resident is alert and oriented and able to verbalize needs. She said the resident has a behavior of yelling. She said the resident usually yells when she cannot find her call light, and does not know of any other behaviors the resident exhibits. -Resident #102 was admitted to the facility on (MONTH) 2, (YEAR), and readmitted on (MONTH) 17, (YEAR), with [DIAGNOSES REDACTED]. Review of the admission MDS assessment dated (MONTH) 9, (YEAR), revealed the resident scored a 14 on the BIMS, which indicated the resident was cognitively intact. The MDS also included that the resident had not received antianxiety medication during the look back period. A physician's orders [REDACTED]. The order did not include a stop date. A care plan identified that the resident was receiving antianxiety medication for feelings of panic. The goals were for an improvement in behaviors and would have no adverse side effects from the medication. Interventions listed were to encourage out of room activities and attend facility social activities, provide positive feedback, validate the resident's feelings, provide in room activities such as television, books and music, and to offer food or fluids. A physician's orders [REDACTED]. On (MONTH) 5, (YEAR) all narcotic orders were discontinued. On (MONTH) 26, (YEAR), a physician's orders [REDACTED]. The order did not include a stop date. This order was renewed on (MONTH) 26, (YEAR) and did not include an end date. Review of the clinical record including the physician's progress notes from (MONTH) through (MONTH) (YEAR) revealed no rationale for extending the use of [MEDICATION NAME]. Review of nursing progress notes from (MONTH) through (MONTH) (YEAR) revealed no documentation of the resident exhibiting signs or symptoms of anxiety, as evidenced by feelings of panic. According to the nursing behavior/intervention flow records from (MONTH) through (MONTH) (YEAR) revealed that resident #102 was not being monitored for anxiety, as evidenced by feelings of panic. Review of the MARs from (MONTH) 17 through (MONTH) 31, (YEAR) revealed that [MEDICATION NAME] was administered to the resident multiple times. An interview was conducted on (MONTH) 2, (YEAR) at 1:48 p.m. with a LPN (staff #192), who stated that if a resident is prescribed any [MEDICAL CONDITION] medications, target behaviors should be written in the order as evidenced by. Staff #192 said that target behaviors and side effects should be monitored and documented in the nurses notes, the MAR, and the behavior monitoring flowsheets. She also stated that target behaviors and side effects are monitored for the entire shift. The policy on Psychopharmacological Medication Management stated each residents drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used for excessive duration, without adequate monitoring and without adequate indication for its use. The policy further included the facility must ensure to limit PRN [MEDICAL CONDITION] drug orders to fourteen (14) days. If an extension is needed, the attending physician or prescribing practitioner documents the rational in the medical record and indicates the duration of the PRN order.
F 0760 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interviews, the facility failed to ensure one resident (#71) was free from a significant medication error. Findings include: Resident #71 was admitted to the facility on (MONTH) 11, 2008, with [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. On an infusion Medication Administration Record [REDACTED]. There was also a section on the infusion MAR for licensed staff to initial that the IV medication had been administered. However, there was no documentation that [MEDICATION NAME] IV had been administered on (MONTH) 23. An interview was conducted with a Licensed Practical Nurse (staff #29) on (MONTH) 2, (YEAR) at 2:39 p.m. She stated that any physician's orders [REDACTED]. She further stated that if a medication is not administered for some reason, the physician must be notified. An interview was conducted with the Director of Nursing (staff #95) on (MONTH) 2, (YEAR) at 3:15 p.m. She stated it is standard nursing practice that all nurses follow physician's orders [REDACTED].
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 that expired medications were discarded and not available for resident use. Findings include: A medication storage observation of the Station 2 front hall medication room was conducted on (MONTH) 30, (YEAR) at 11:07 a.m., with a licensed practical nurse (LPN/staff #62) and the following was observed: there were 2 liter bags of Intravenous fluids 5% [MEDICATION NAME] in 0.2% normal saline which had expiration dates of (MONTH) (YEAR). Another medication storage observation was conducted on (MONTH) 31, (YEAR) at 8:13 a.m., with a LPN (staff #80) of the Station 3 medication room and the following was observed: there was one bottle of aspirin 325 mg, with an expiration date of (MONTH) (YEAR) and 1 bottle of aspirin 325 mg [MEDICATION NAME] coated with an expiration date of (MONTH) (YEAR). During the observation, an interview was conducted with staff #80 who stated that the nurses are responsible to check the medication cart and medication room for expired meds.

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F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 9) An interview was conducted with Director of Nursing (DON/staff #95) on (MONTH) 2, (YEAR) at 12:40 p.m. She stated that floor nurses should be checking the medication carts every shift, every day for expired medications. She stated that the medication rooms should be checked by the nurses and the unit manager and that they should be checking them at least once a week. She stated that expired medications should not be present in the medication cart or the medication rooms. A policy regarding the Storage and Expiration of Medications revealed that the facility should ensure that medications including IV fluids and biologicals are destroyed or returned to pharmacy when expired.
F 0770 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide timely, quality laboratory services/tests to meet the needs of residents.** Based on observations, facility documentation, staff interviews and policy review, the facility failed to ensure that quality control testing was performed on two glucometers per their policy. Finding includes: During a medication storage observation conducted on (MONTH) 31, (YEAR) at 8:36 a.m. with Licensed practical nurse (LPN/staff #80) on Station 3 medication cart, review of the quality control results log for the glucometers was reviewed. The log contained spaces to document the date, the test strip lot number, the low and high control results, any corrective action taken and the nurse's name. However, there was no documentation that the glucometer was tested on the following days in (MONTH) (YEAR): (MONTH) 7, 14, 15, 21, 22, 26 and 28 At this time, an interview was conducted with staff #80 who stated that the glucometer quality control testing is done daily by the night shift and is supposed to be documented on the quality control results log. A medication storage observation was conducted on (MONTH) 31, (YEAR) at 8: 45 a.m., with a LPN (staff #91) on the front medication cart on Station 4. According to the quality control results log for the glucometers revealed there was missing documentation that the glucometer was tested on (MONTH) 29 and 30. An interview was conducted on (MONTH) 31, (YEAR) at 8:50 a.m. with the Assistant Director of Nursing (ADON/staff #37). Staff #37 said that the glucometer quality control testing is done by the night shift nurses daily and documented in the log book.During an interview conducted on (MONTH) 31, (YEAR) at 11:09 a.m. with a LPN (staff #182), staff #182 stated that the glucometer quality control testing is done every night shift and the results are logged in the quality control log book. She stated that the glucometer quality control testing is done to ensure that the blood sugar readings on the glucometers are accurate, and if the testing is not done, the blood sugar readings could be off. She stated that the testing has to be done daily to make sure that the glucometers are working correctly. During an interview conducted on (MONTH) 31, (YEAR) at 11:28 a.m. with a LPN (staff #200), she stated that they do the quality control testing to make sure that the glucometers are reading the blood sugars accurately. She said if you don't do the testing, the blood sugar readings may not be accurate. She stated that during the quality control testing if the glucometer reading is out of the listed range, that means the glucometer is not working correctly and they can replace it. During an interview conducted on (MONTH) 2, (YEAR) at 12:40 p.m. with the Director of Nursing, (DON/staff #95), staff #95 stated that she expects her staff to do the glucometer quality control testing every night on the night shift. She said when performing the quality control testing, they are checking the high and low solutions, which makes sure that the glucometer machines are reading the blood sugars correctly. Review of the facility policy for Glucose Control Testing revealed that quality control testing must be performed a minimum of once every 24 hours, and with each new box of test strips and whenever the test results are questionable.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** Based on observation, staff interviews and policy review, the facility failed to ensure that a glucometer was disinfected following the testing of a resident's blood glucose level. Findings include: An observation was conducted on (MONTH) 31, (YEAR) at 11:09 a.m. of a licensed practical nurse (LPN/staff #182) performing a blood glucose test on a resident using a glucometer. Following the test, staff #812 placed the glucometer back in the medication cart, without cleaning/ disinfecting the glucometer. An interview with staff #182 was conducted immediately after the observation. Staff #182 stated the glucometer was not specifically for this resident's use. She stated that she forgot to cleanse the glucometer after using it and prior to putting it back in the medication cart. An interview was conducted on (MONTH) 31, (YEAR) at 11:28 a.m. with a LPN (staff #200). She stated that the glucometers are to be cleansed with Clorox wipes between patients. An interview was conducted with the Director of Nursing (DON/staff #95) on (MONTH) 2, (YEAR) at 12:40 p.m. Staff #95 stated that the nurses are expected to cleanse the glucometers with Clorox bleach wipes after use on a resident. Review of a policy regarding the Cleaning and Disinfection of non-critical patient care equipment revealed that reusable patient care equipment is cleansed daily before and after use to prevent infections. The policy included that equipment will be cleansed and disinfected prior to storage.