STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035143	A. BUILDING _____ B. WING _____	**09/13/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LIFE CARE CENTER OF SCOTTSDALE	**9494 EAST BECKER LANE SCOTTSDALE, AZ 85260**

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

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F 0561 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interviews, the facility failed to ensure follow-up appointments/transportation were scheduled for two residents (#194 & #286). The deficient practice could result in delay of continuity of care. Findings include: -Resident #194 was admitted to the facility on (MONTH) 5, 2019, with [DIAGNOSES REDACTED]. Review of the hospital discharge summary dated (MONTH) 5, 2019, revealed the resident underwent [REDACTED]. Review of the physician's orders [REDACTED]. However, review of the clinical record revealed no documentation the resident had a follow-up appointment with the surgeon. On (MONTH) 11, 2019 at 12:52 p.m., an interview was conducted with a Registered Nurse (RN/staff #61). The RN stated that when admission orders [REDACTED]. The RN said resident #194 stated to her that she had received a call from the physician's office and was told that she was supposed to come in for an appointment today. The RN stated that she notified staff #124 about the call so that staff #124 could review the resident's orders and follow-up on the appointment and reschedule the appointment if needed. An Interview was conducted with the unit clerk (staff #124) on (MONTH) 12, 2019 at 9:22 a.m. Staff #124 stated that when a resident is admitted to the facility, the admission nurse reviews the physician's orders [REDACTED]. She stated that it is her responsibility to review the EHR daily for newly admitted residents to ensure any physician's orders [REDACTED]. She said that the expectation is that she schedule appointments and arrange transportation the same day the orders are put into the EHR. Staff #124 stated that she had made several attempts to schedule an appointment for resident #194 but was unsuccessful. Staff #124 was not able to provide documentation that several attempts had been made to schedule the appointment with the spinal and brain surgeon. During an interview conducted with the Director of Nursing (DON/staff #128) on (MONTH) 12, 2019 at 3:30 p.m., the DON stated that an appointment has been scheduled for (MONTH) 2, 2019.
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, staff interviews, and policy review, the facility failed to ensure the physician's order accurately reflected one resident's (#187) advanced directive. The deficient practice could result in residents receiving emergent services which are not in accordance with their wishes. The resident census was 69. Findings include: Resident #187 was admitted on (MONTH) 8, 2019 with [DIAGNOSES REDACTED]. Review of the clinical record revealed an advanced directive signed by the resident dated (MONTH) 8, 2019 that the resident did not want cardiopulmonary resuscitation (CPR). Continued review of the clinical record revealed an orange Do Not Resuscitate (DNR) form dated (MONTH) 8, 2019 that in the event of cardiac or respiratory arrest, the resident refuses any resuscitation measures. However, review of the physician's order summary report for (MONTH) 2019 revealed an order dated (MONTH) 8, 2019 that the resident was full code status. An interview was conducted with a Registered Nurse (RN/staff #61) on (MONTH) 12, 2019 at 8:37 a.m. The RN stated that the physician order in the electronic record should match the advanced directive forms in the chart. She stated that if the information does not match, there would be a risk the resident's wishes would not be followed. An interview was conducted with the Director of Nursing (DON/staff #128) on (MONTH) 12, 2019 at 11:12 a.m. She stated that a resident has a full code order until the advanced directives are formulated with the resident/family on admission. The DON stated that the advanced directive would be filed in the chart and the full code order would be clarified and changed to match the advance directive. The DON stated that if the signed advanced directive and the physician order do not match, there is a risk the resident's wishes may not be followed. Review of the facility's policy for Advanced Directives revealed residents has the right to self-determination regarding their medical care. This includes the right to direct his or her own medical treatment, including withholding or withdrawing life sustaining treatment. The policy included an advanced directive is defined as a written instruction regarding care and treatment recognized under state law in relation to the provision of such care when the resident is incapacitated.
F 0582 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interviews, the facility failed to provide evidence that they issued the Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) to one resident (#3). The deficient practice could result in residents not being informed of their potential liability for payment. Findings include: Resident #3 was readmitted to the facility on (MONTH) 30, 2019, with [DIAGNOSES REDACTED]. Review of the Admission Record face sheet revealed the resident was her own responsible party. The face sheet also revealed a friend was the resident's Durable POA (Power of Attorney) - Health care. The admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident scored a 13 on the Brief Interview for Mental Status (BIMS) which indicated the resident had intact cognition. A Care Management note dated 8/8/2019 at 3:37 p.m. revealed the Notice of Medicare Non-Coverage (NOMNC) form was discussed and explained to the resident in person and to a family member by phone. The note included the family was informed that

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

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F 0582 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) (MONTH) 11, 2019 was the last Medicare coverage day. The note also included the family elected to have the resident stay at the facility past (MONTH) 11, 2019. Review of the NOMNC form informing the resident the last day of coverage was 8/11/2019, revealed it was signed by the resident however the date was illegible. Review of the SNFABN form informing the resident of care Medicare may not pay beginning 8/12/2019, revealed the form was not signed by the resident or a designee. An interview was conducted with the Case Manager (staff #47) on 9/10/2019 at 2:27 PM. He stated the process for obtaining the beneficiary notice starts with knowing in advance if the resident will require it. Staff #47 stated that he completes the NOMNC form and has it ready for the resident to sign within 48 hour to 72 hours of admission. He stated that if the resident requests to be discharged prior to the date the Medicare coverage will end, he documents a note in the Electronic Medical Record (EMR), obtains a physician's orders [REDACTED]. The Care Manager stated that he obtained the resident's signature on the NOMNC form during the admission process but did not obtain the resident's signature for the SNFABN form. Staff #47 stated that he did not obtain a signature from the resident or a designee. An interview was conducted with Regional Director of Clinical Services (RN/staff #164) on 09/13/19 at 08:08 AM. She stated the facility does not have a specific policy for the NOMNC or SNFABN.
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 observations, staff interviews, clinical record review, and policy review, the facility failed to ensure services provided meet professional standards of quality for two residents (#345 and #36). The deficient practice could result in residents not receiving optimal outcomes related to central venous catheter management and antibiotic use. Findings include: -Resident #345 was readmitted to the facility on (MONTH) 9, 2019, with [DIAGNOSES REDACTED]. Review of the physician's orders [REDACTED]. Review of the clinical record revealed a care plan initiated 9/11/19 that the resident had an implanted port for IV push medications. The goal was the port will have no complications. Interventions included maintenance as ordered. During an observation of resident #345 conducted on 9/11/2019 at 7:54 AM, the Licensed Practical Nurse (LPN/staff #48) was observed to remove the IV medication line and flushed the implanted port with 10 mL of NS. The LPN was not observed to flush the port with a [MEDICATION NAME] solution after the NS flush. An interview was conducted with staff #48 on 9/11/2019 at 12:17 PM. The LPN stated that she did not recall administering [MEDICATION NAME] through resident #345's implanted port as ordered. An interview was conducted with a Registered Nurse (RN/staff #61) on 9/12/19 at 8:51 AM. The RN stated she had not received training on central line access including implanted ports. She stated when a resident has a Peripherally Inserted Central Catheter (PICC) line; she reviews the orders for management of the access device. She stated that usually the order states to flush the line twice a day. The RN stated that it is a pretty standard order to flush with 10 mL of NS and 5 mL of [MEDICATION NAME] after administering a medication. During an interview conducted on 9/12/2019 at 9:27 AM with a LPN (staff #98), he stated he does not know if resident #345 has a valved or non-valved implanted port but that the flushes are the same for both. An interview was conducted with the Regional Director of Clinical Services (RN/staff #164) and the Director of Nursing (RN/staff #128) on 9/12/2019 at 10:42 AM. Staff #164 stated that if the facility does not have any information on the type of implanted port the resident has, the facility treats all implanted ports as non-valved. She stated this practice was deemed best by the pharmacy to ensure that [MEDICATION NAME] and NS would be used to flush the ports. Staff #128 stated that staff development provides the training on IV access. She stated all RNs and LPNs with IV certification are checked off to ensure they remain competent. Review of the facility's policy on Implanted Venous Access Port Flushing and Locking revised 5/1/2016, revealed flushing/locking is performed to ensure and maintain catheter patency and to prevent the mixing of incompatible medications/solutions. If unable to determine if the port is valved or nonvalved, treat the port as nonvalved. Review of the facility's Infusion Maintenance Table revealed that the maintenance for a non-valved implanted venous port is flushing with 10 mL of NS followed by 5 mL of [MEDICATION NAME] and for a valved implanted venous port is flushing only with 10 mL of NS. -Resident #36 was admitted to the facility on (MONTH) 29, 2019 with [DIAGNOSES REDACTED]. Review of a nurse progress note for dated (MONTH) 29, 2019 revealed resident #36 was admitted this afternoon. Review of the physician's orders [REDACTED]. Review of the Medication Administration Record [REDACTED]. Review of an order administration note dated (MONTH) 29, 2019 at 9:00 p.m. revealed Bactrim was pending from the pharmacy. However, review of the facility's Omnicell list of available medications revealed Bactrim/[MEDICATION NAME]-[MEDICATION NAME] was available. The MAR for (MONTH) 2019 revealed the first dose of Bactrim documented as administered to the resident was on (MONTH) 30, 2019 at 8:00 a.m. An interview was conducted with a Registered Nurse (RN/staff #71) on (MONTH) 12, 2019 at 9:45 a.m. She stated that when a resident is admitted , she compares the admission orders [REDACTED]. She stated that if an ordered medication has not arrived from the pharmacy, but is available in the Omnicell, the ordered medication should be taken from the Omnicell and administered to the resident. The RN stated that Bactrim is available in the Omnicell and should have been administered as scheduled. She stated that provider ordered medications should be administered timely and that patient care is a priority. The RN stated that residents should not be missing any doses of an antibiotic medication. An interview was conducted with the Director of Nursing (DON/staff #128) on (MONTH) 12, 2019 at 11:27 a.m. She stated that if a medication has not arrived from the pharmacy and the medication is available in the Omnicell, the medication should be administered as scheduled. She stated that the scheduled antibiotic for resident #36 should have been given as scheduled as it was available in the Omnicell. Review of the facility's policy on Administration of Medications revealed all medications are administered safely and appropriately per physician order [REDACTED]. The policy included medication administration is the responsibility of the nursing professional.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and resident and staff interviews, the facility failed to provide treatment and care in accordance with professional standards of practice for one resident (#337) with low blood sugar levels. The deficient practice could result in residents suffering hypoglycemic events. Findings include: Resident #337 was admitted to the facility on (MONTH) 3, 2019, with [DIAGNOSES REDACTED]. The admission nursing note dated 9/3/2019 revealed the resident was alert and oriented to time, place, person, and situation.Review of the physician orders [REDACTED]. Review of the care plan initiated on 9/3/2019 revealed the resident had diabetes. The goal was that the resident would not have any complications related to diabetes. Interventions included blood sugar checks as ordered and medication as ordered.Review of the blood sugar checks revealed the following: 9/5/2019 at 4:30 AM blood sugar was 59, the resident was asymptomatic, and juice was given 9/6/2019 at 4:44 AM blood sugar was 51 9/7/2019 at 5:06 AM blood sugar was 43 A physician order [REDACTED]. Continued review of the blood sugar checks revealed the following:

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F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) 9/8/2019 at 5:31 AM blood sugar was 46 9/9/2019 at 5:01 AM blood sugar was 50 9/11/2019 at 5:10 AM blood sugar was 39. A physician order [REDACTED]. On 9/12/2019 at 5:06 AM, the resident's blood sugar was 57. Review of the clinical record revealed no evidence that when the resident was having low blood sugar levels in the early mornings, the resident was consistently assessed to be symptomatic or asymptomatic, if interventions were implemented, if the blood sugars were rechecked and/or if the provider was notified. During an interview conducted with resident #337 on 09/09/2019 at 10:57 AM, the resident stated the staff cannot seem to get the insulin dose correct. The resident stated sometimes too much insulin is given which causes a low drop in blood sugars and that it has been that way since admission. An interview was conducted with a Registered Nurse (RN/staff #71) on 09/10/2019 at 3:18 PM. The RN stated that it is the nurses' responsibility to notify the provider for blood sugars that are consistently low even if the resident is asymptomatic. An interview was conducted with the Director of Nursing (DON/staff #128) on 09/11/2019 at 1:12 PM. The DON stated that it is the responsibility of the staff to identify abnormal trends in a resident's blood sugars and report them to the physician. The DON also stated that she reviews the residents' blood sugar reports daily to identify trends as well. During another Interview conducted with resident #337 on 09/12/2019 at 10:34 AM, the resident stated that in the morning when his blood sugar is low, he is drowsy, half drunk, and sweaty. He stated that he reports it to staff and that staff sometimes let him sleep a while before bringing in apple juice and crackers. Another interview was conducted with staff #71 on 09/12/2019 at 1:03 PM who stated that the facility has a standing order for blood sugars less than 70. She stated that a blood sugar below 70 would warrant a call to the provider. Staff #71 stated if a resident was drowsy and sweaty with a low blood sugar she would assess that as hypoglycemic. The RN stated she would administer glucose in some form such as glucose (50-100 grams), orange juice, peanut butter, or a banana. She stated she would monitor the resident during the intervention and recheck the blood sugar in 30 minutes to one hour. The RN stated this would be documented in the progress notes or in the Medication Administration Record. She stated that if she noticed a trend of abnormal blood sugars, she would make a recommendation to the provider to change the long acting insulin. An interview was conducted on 09/13/2019 at 10:18 AM with the Regional Director of Clinical Services (staff #164) and DON (staff #128). The DON stated her expectation is that staff follow physician orders [REDACTED]. The DON stated if the resident was symptomatic, the intervention would depend on the order. She stated if the resident was asymptomatic, the staff would monitor the resident but unless an intervention was ordered, none would be implemented. The DON stated that symptoms of [DIAGNOSES REDACTED] would include dizziness and sweating and that staff would implement an intervention if there was an order. She stated that if the blood sugar was less than 50, her expectation is that staff follow the physician orders [REDACTED]. The DON stated that if the blood sugar is low, staff should recheck the blood sugar.
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, staff interviews, and policy review, the facility failed to provide necessary treatment and services to promote the healing of a pressure ulcer for one resident (#390). The deficient practice could result in delayed healing of pressure ulcers. Findings include: Resident #390 was admitted to the facility on (MONTH) 22, 2019, with [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. Review of the care plan dated (MONTH) 26, 2019 revealed the resident was admitted with breaks in skin integrity and has a deep tissue injury pressure ulcer to the left heel. The goal was to minimize the risk for symptoms of infection. Interventions included skin prep to the bilateral heels every day shift and floating the heels as ordered by the physician.The admission Minimum Data Set assessment dated (MONTH) 29, 2019 revealed the resident was admitted with one unstageable suspected deep tissue injury. The Treatment Administration Record for (MONTH) and (MONTH) of 2019 revealed documentation the resident received skin prep to the bilateral heels and that the resident's heels were floated while in bed every day shift from (MONTH) 23, 2019 to (MONTH) 11, 2019. During observations conducted on (MONTH) 9, 2019 at 10:16 a.m. and at 1:16 p.m., the resident was observed lying in bed on his back with both heels on the mattress. Observations were conducted of the resident on (MONTH) 10, 2019 at 11:24 a.m. and at 12:56 a.m. The resident was observed in bed on his back with a pillow under his lower legs with his heels on the mattress. During an observation conducted on (MONTH) 11, 2019 at 09:08 a.m., the resident was observed lying in bed on his back with two pillows under his lower legs with both heels on the mattress. An observation of wound care to the left heel was conducted on (MONTH) 11, 2019 at 10:21 a.m. with a Registered Nurse (RN/staff #25). The deep tissue injury appeared to flake off when rubbed by the RN, revealing intact pink skin. Redness, approximately the size of a quarter, was observed lateral to the deep tissue injury. Staff #25's thumb sank into the redness. Staff #25 stated that this new redness was blanchable but mushy in feel and that she would not be informing the doctor about this spot as it was not that bad. The RN also stated that the resident's heels should be floated but that the resident's heels were not floated correctly. An interview was conducted on (MONTH) 11, 2019 at 09:00 a.m. with the resident's RN (staff #135). He stated that he would relieve pressure on heels with wounds by floating the heels. The RN stated that the way to float the heels is to elevate the heels with a couple of pillows so that the heels do not touch the mattress. An interview was conducted on (MONTH) 11, 2019 at 09:10 a.m. with the Certified Nursing Assistant (CNA/staff #83) caring for the resident. The CNA stated that floating heels is accomplished by placing pillows under the resident's legs so that the heels are not touching the bed. An interview was conducted with the Director of Nursing (DON/staff #128) and the Regional Director of Clinical Services (staff #164) on (MONTH) 12, 2019 at 01:27 p.m. Staff #164 said that the nurse will obtain orders for deep tissue injury pressure ulcer treatment and will implement the treatment as ordered. Review of the facility's policy for Pressure Ulcer/Injury Prevention and Management revealed that measures to maintain and improve the resident's tissue tolerance to pressure are implemented in the plan of care and included minimizing injury due to shear and friction through proper positioning, transfers, and turning schedules. It also revealed that measures to protect the resident against the adverse effects of external mechanical forces, such as pressure, friction, and shear are implemented in the plan of care and included heel protection/suspension should be implemented while the resident is in bed.
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 observations, staff interviews, and policy review, the facility failed to ensure two residents (#345 and #286) with a central venous catheter device were provided care and services that decrease the risk of infection. The deficient practice could result in residents acquiring catheter related infections. Findings include: -During an observation conducted of resident #345 on 9/11/2019 at 7:54 AM, a Licensed Practical Nurse (LPN/staff #48) was observed to remove IV (intravenous) tubing from the port's extension tubing, lay the extension tubing on the resident's gown, attach a syringe of a normal saline to the extension tubing hub, and flush with normal saline without cleaning the extension tubing hub with alcohol. -An observation was conducted of resident #286 on 9/11/2019 at 8:52 AM. A Registered Nurse (RN/staff #61) was observed to remove IV tubing from the Peripherally Inserted Central Catheter (PICC). The RN then removed the cap from the syringe containing normal saline and dropped the syringe in the resident's bed allowing the syringe tip to come in contact with the bed linen. The RN picked up the syringe and administered the normal saline without cleaning the PICC catheter hub with alcohol.

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) An interview was conducted with the RN (staff #61) on 09/12/19 at 8:51 AM. The RN stated that she had not received training on central venous catheter devices. The RN stated that when she removes the IV tubing from the line or removes the cap from the line, she cleans the hub for 30 seconds with an alcohol wipe and applies a new green cap. During an interview conducted with the Regional Director of Clinical Services (RN/staff #164) and the Director of Nursing (DON/staff #128) on 09/12/19 at 10:42 AM, the DON stated staff development provides IV access training. She also stated RNs and LPNs with IV certification are checked off to ensure they remain competent. Review of the facility's policy on Implanted Venous Access Port Flushing and Locking revealed needless connectors require vigorous cleansing with alcohol prior to accessing to reduce the risk of catheter related bloodstream infection.