STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035136	A. BUILDING _____ B. WING _____	**02/07/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LIFE CARE CENTER OF SIERRA VISTA	**2305 EAST WILCOX DRIVE SIERRA VISTA, AZ 85635**

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 0623 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview, and policy review, the facility failed to notify the Office of the State Long Term Care Ombudsman when one resident (#95) was discharged to the hospital. Findings include: Resident #95 was readmitted to the facility on (MONTH) 7, (YEAR) with [DIAGNOSES REDACTED]. The resident was discharged (MONTH) 11, (YEAR). Review of a Nursing Progress Note dated (MONTH) 11, (YEAR) revealed Upon checking resident fingerstick, noted that skin was hot to touch. Vital signs checked and temperature was 103.8. Blood sugar checked and was 355. Resident coughing, lungs crackles. Pulse 126 .Paramedics called and arrived and transported resident to hospital . Further review of the clinical record revealed no evidence that the Office of the State Long Term Care Ombudsman was notified of the resident's discharge to the hospital. An interview was conducted with a Registered Nurse case manager(staff #113) on (MONTH) 6, 2019 at 12:57 p.m. Staff #113 stated that she notifies the ombudsman weekly of residents who are discharged to the hospital. Staff #113 stated that she retains copies of weekly ombudsman notifications but was unable to locate the week this resident was discharged to the hospital. Review of the facility's policy Transfers and Discharges revealed .A copy of the notice of transfer/discharge will be sent to a representative of the Office of the State Long Term Care Ombudsman for all facility-initiated transfers or discharges .
F 0645 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**PASARR screening for Mental disorders or Intellectual Disabilities** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview, and policy review, the facility failed to ensure two residents (#45 and #66) had a Pre-admission Screening and Resident Review (PASARR) Level I completed. Findings include: -Resident #45 was admitted to the facility from another nursing facility on (MONTH) 4, (YEAR), with [DIAGNOSES REDACTED]. Review of the quarterly Minimum Data Set (MDS) assessment dated (MONTH) 12, (YEAR) revealed a Brief Interview for Mental Status (BIMS) score of 4 which indicated the resident was cognitively impaired. -Resident #66 was admitted to the facility on (MONTH) 4, (YEAR) from an acute hospital, with [DIAGNOSES REDACTED]. The quarterly MDS assessment dated (MONTH) 11, (YEAR) revealed a BIMS score of 6 which indicated the resident was cognitively impaired. Review of the clinical record did not reveal any documentation that a PASARR Level I had been conducted for either resident. An interview was conducted on (MONTH) 7, 2019 at 10:15 a.m. with the Director of Nursing (DON/staff #42). She stated that a PASARR Level I is usually completed prior to the resident admitting to the facility. The DON stated that when a resident is admitted from a hospital or another skilled nursing facility a PASARR Level I should be completed. She stated that if a resident is admitted to the facility without a PASARR Level I, they are obligated to ensure it is completed. The DON stated that regarding resident #45 and #66, she did not know why the PASARR level I was not completed for them. The facility's policy titled Pre-admission Screening revealed PASRR is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care. The PASARR requires that 1) all applicants to a Medicaid-certified nursing facility be evaluated for serious mental illness 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 setting); and receive the services they need in those settings. The policy also included the facility is to ensure a Level I PASARR screening is completed on all potential admissions.
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 closed clinical record review, staff interviews, and review of policies, the facility failed to ensure treatments were provided as ordered for surgical wounds for one resident (#294). Findings include: Resident #294 was admitted to the facility (MONTH) 7, (YEAR) with [DIAGNOSES REDACTED]. The resident was discharged (MONTH) 11, (YEAR). Review of the care plan initiated (MONTH) 7, (YEAR) revealed that the resident had a break in skin integrity. Interventions included skin treatment as ordered. -Regarding the Left index finger amputation site: Review of a physician's orders [REDACTED]. Review of the Treatment Assessment Record (TAR) for (MONTH) (YEAR) revealed no documentation that the dressing to the amputation site on the left index finger was completed or checked on (MONTH) 10, (YEAR). The TAR also revealed no documentation that the treatment or dressing checks to the amputation site was provided after (MONTH) 12, (YEAR). The TAR included documentation that the wound was left open to air (OTA) on (MONTH) 13 and 14, (YEAR). Review of the admission Minimum Data Set (MDS) assessment dated (MONTH) 14, (YEAR) revealed a BIMS score of 15 which indicated the resident had intact cognition and included the resident had surgical wound(s). Review of the clinical record did not reveal a discontinuation of the treatment order or an order to leave the site open to air. The recapitulation of physician's orders [REDACTED]. -Regarding the left foot wound located on the plantar aspect of the first metatarsal: A physician's orders [REDACTED]. Review of the TAR for (MONTH) (YEAR) and (MONTH) (YEAR) revealed no documentation that the treatment to the left foot wound was provided on (MONTH) 18, 21, 25, and 26, (YEAR) and (MONTH) 4 and 11, (YEAR). A physician's orders [REDACTED]. The order also included to check the dressing to the bottom of the left foot each shift. The physician's orders [REDACTED]. Review of the (MONTH) (YEAR) TAR revealed no documentation that the treatment to the left foot wound was provided on (MONTH)

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 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) 23, (YEAR) and no documentation that the dressing was checked on (MONTH) 29, (YEAR). The TAR for (MONTH) (YEAR) revealed documentation that the treatment to the left foot was provided on (MONTH) 3, (YEAR) and not again until (MONTH) 6, (YEAR), and then not again until (MONTH) 10, (YEAR). The TAR did not reveal documentation that the placement of the left foot dressing was checked on (MONTH) 5, (YEAR) on the 6 a.m. to 6 p.m. shift. An interview was conducted with a Licensed Practical Nurse (LPN/staff#144) on (MONTH) 7, 2019 at 2:56 p.m. He stated that the staff provides treatment to a resident's wounds as ordered by the doctor and documents it on the TAR. The LPN stated that if there is no documentation on the TAR that the treatment was done, it would mean the treatment was not provided. He stated that the expectation is that the TAR should be free of holes. The LPN also stated that if wound treatments were not provided, it could cause infection and decline in wound healing. An interview was conducted with a Registered Nurse (RN/staff #29) on (MONTH) 7, 2019 at 2:32 p.m. She stated that when a resident is admitted with a surgical wound that staff would watch for signs and symptoms of infection, make sure the dressing was in place, and re-enforce the dressing as needed. The RN stated that if the TAR does not contained documentation that the treatment was provided, then the nurse would not be able to prove that the treatment was done. She stated that if the wound treatment was not done, it could increase the risk for infection and decline in the wound. The RN stated that the expectation is that the nurse would document on the TAR right after the treatment was provided. During an interview conducted with the Director of Nursing (DON/staff #41) on (MONTH) 7, 2019 at 3:17 p.m., she stated that the nurses are expected to change dressings to surgical wounds according to the physician's orders [REDACTED]. The DON stated that if the nurse does not document that the treatment was provided, she would be unable to prove that the care was given. She also stated that the resident would be at risk for infection or wound deterioration if the treatments were not provided as ordered. The facility's policy titled treatment of [REDACTED]. The facility's policy regarding Resident Rights revealed the resident has the right to receive the services included in the plan of care.
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 closed clinical record review, staff interviews, and review of policies, the facility failed to ensure treatment and services were provided to prevent and treat pressure ulcers for one resident (#294). Findings include: Resident #294 was admitted to the facility on (MONTH) 7, (YEAR) with [DIAGNOSES REDACTED]. The resident was discharged (MONTH) 11, (YEAR). Review of the care plan initiated (MONTH) 7, (YEAR) revealed that the resident had a break in skin integrity. Interventions included skin treatment as ordered and moon boots to the bilateral lower extremities. A Braden Scale assessment dated (MONTH) 7, (YEAR) revealed a risk score of 15 which indicated the resident was at mild risk of developing a pressure ulcer. The admission Minimum Data Set (MDS) assessment dated (MONTH) 14, (YEAR) revealed a BIMS score of 15 which indicated that the resident had intact cognition. The assessment included the resident had 2 unstageable deep tissue injuries and a pressure reducing device on the bed. Review of the physician's orders [REDACTED]. -an order for [REDACTED]. -an order for [REDACTED]. -an order to clean the deep tissue injury to the right and left heel with normal saline, pat dry, cover with a border foam and change every other day and as needed and to check the dressing each shift dated (MONTH) 17, (YEAR). Review of the Treatment Administration Record (TAR) for (MONTH) (YEAR) revealed the dressing changes were provided on (MONTH) 17, (YEAR) and not again until (MONTH) 20, (YEAR) and revealed the dressings were done (MONTH) 22, (YEAR) and not again until (MONTH) 26, (YEAR). There was no documentation that the dressings to the right and left heel were checked on the 6 p.m. to 6 a.m. shift on (MONTH) 24, (YEAR). A physician's orders [REDACTED]. The physician's orders [REDACTED]. Review of the TAR for (MONTH) (YEAR) revealed the following: -no documentation that the moon boots were checked for placement on (MONTH) 16, (YEAR). -no documentation that the bilateral heel protectors were on and checked for placement on the 6 p.m. to 6 a.m. shift on (MONTH) 1, 2, 28, and 29, (YEAR). -no documentation that the heels were kept offloaded at all times on (MONTH) 29, (YEAR). -documentation that the treatment was done to the left and right heels on (MONTH) 3, (YEAR) and not again until (MONTH) 7, (YEAR) and documentation that the treatment was provided on (MONTH) 21, (YEAR) and not again until (MONTH) 23, (YEAR). -no documentation that the heel dressings were checked on (MONTH) 29, (YEAR). Review of the TAR for (MONTH) (YEAR) revealed the following: -no documentation that the bilateral heel protectors were on or the placement was checked on the 6 p.m. to 6 a.m. shift on (MONTH) 10, (YEAR). -documentation that the left and right heel treatment was provided on (MONTH) 3, (YEAR) and not again until (MONTH) 6, (YEAR) and then not again until (MONTH) 10. (YEAR). -no documentation that the dressings were checked on (MONTH) 5, (YEAR) on the 6 a.m. to 6 p.m. shift. An interview was conducted with a Licensed Practical Nurse (LPN/staff#144) on (MONTH) 7, 2019 at 2:56 p.m. He stated that the staff provides treatment to a resident's wounds as ordered by the doctor and documents it on the TAR. The LPN stated that if there is no documentation on the TAR that the treatment was done, it would mean the treatment was not provided. He stated that the expectation is that the TAR should be free of holes. The LPN also stated that if wound treatments were not provided, it could cause infection and decline in wound healing. He stated that if heel protection was not in place, it could cause a pressure ulcer or worsening of an existing pressure ulcer. During an interview conducted with a Registered Nurse (RN/staff #29) on (MONTH) 7, 2019 at 2:32 p.m., she stated that the wound nurse is responsible for staging wounds. The RN stated that if the TAR does not contained documentation that a treatment was provided to a wound, then the nurse would not be able to prove that the treatment was done. She stated that if the treatment was not done, it could increase the risk for infection and decline in the wound. The RN stated that the expectation is that the nurse would document on the TAR right after the treatment was provided. An interview was conducted with the Director of Nursing (DON/staff #41) on (MONTH) 7, 2019 at 3:17 p.m. She stated that the wound nurse assess pressure ulcers, obtain physician orders [REDACTED]. The DON stated that her expectation is that the nurses follow the physician's orders [REDACTED]. The DON stated that if the nurse does not document that the treatment was provided, she would be unable to prove that the care was given. She also stated that the resident would be at risk for infection or wound deterioration if the treatments were not provided as ordered. The DON stated that if heel protection was not implemented as ordered the pressure ulcer risk would increase for the resident. The facility's policy titled treatment of [REDACTED]. Review of the facility's policy for Pressure Ulcer/Injury Prevention and Management revealed measures to protect the resident against the adverse effects of external mechanical forces, such as pressure, friction, and shear are to be implemented and included heel protection/suspension while the resident is in bed. The facility's policy regarding Resident Rights revealed the resident has the right to receive the services included in the plan of care.
F 0757 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed clinical record review, staff interviews, and policy review, the facility failed to ensure that medication was administered as ordered for one resident (#294). Findings include: Resident #294 was admitted to the facility on (MONTH) 7, (YEAR) with [DIAGNOSES REDACTED]. The resident was discharged

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F 0757 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) (MONTH) 11, (YEAR). Review of the admission Minimum Data Set (MDS) assessment dated (MONTH) 14, (YEAR) revealed a BIMS score of 15 which indicated the resident had intact cognition. A physician's orders [REDACTED]. Review of the Medication Administration Record (MAR) for (MONTH) (YEAR) revealed no documentation the patch was removed on (MONTH) 30 and 31, (YEAR). Review of the MAR dated (MONTH) (YEAR) revealed no documentation that the patch was removed as ordered on (MONTH) 6 and 27, (YEAR). An interview was conducted with a Registered Nurse (RN/staff #29) on (MONTH) 7, 2019 at 2:32 p.m. She stated that if the [MEDICATION NAME] was not removed the resident could receive too much of the medication, experience adverse side effects from the medication, and could experience skin breakdown at the site. She stated that the expectation is that the nurse document on the MAR as soon as the care is administered. The RN stated that if the documentation is not on the MAR, the nurse is unable to prove the care was provided. During an interview conducted with a Licensed Practical Nurse (LPN/staff #144) on (MONTH) 7, 2019 at 2:56 p.m., he stated that if the MAR is not signed off it would mean that the care was not provided. The LPN stated that if the nurse did not sign for the removal of the [MEDICATION NAME], it would mean the patch was not removed. He stated that the expectation is that there will be no holes on the MAR. An interview was conducted with the Director of Nursing (DON/staff#41) on (MONTH) 7, 2019 at 3:17 p.m. She stated that the expectation is that staff follow physician's orders [REDACTED]. She stated that the expectation is that there should be no holes on the MAR. The DON stated that if the [MEDICATION NAME] was not removed the resident could absorb more than the intended dose and it could lead to [MEDICAL CONDITION]. The facility's policy on Physician order [REDACTED]. follow physician orders [REDACTED].