STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035133	A. BUILDING _____ B. WING _____	**04/11/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LIFE CARE CENTER OF YUMA	**2450 SOUTH 19TH AVENUE YUMA, AZ 85364**

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 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, interviews and policy review, the facility failed to ensure advanced directive information for 3 of 3 sampled residents (#10, #83 and #105) were accurate. The deficient practice could result in advance directive wishes not being followed, resulting in potential harm. Findings include: -Resident #10 was readmitted to the facility on (MONTH) 2, 2019, with [DIAGNOSES REDACTED]. A Prehospital Medical Care Directive (Do Not Resuscitate) Form dated (MONTH) 15, (YEAR) was located in the resident's clinical record. The Medical Care Directive form was signed by the resident's Power of Attorney (POA). Review of advanced directive statements dated (MONTH) 15, (YEAR) and (MONTH) 6, (YEAR) included revealed In the event I experience [MEDICAL CONDITION] I do not want cardiopulmonary resuscitation measures to be under taken on my behalf. The forms were signed by the resident's POA and a witness. A care plan updated on (MONTH) 19, 2019 included the resident was do not resuscitate (DNR) status. The goal included that advanced directives, care plan directives and physician's orders [REDACTED]. Approaches included the following: reassesses/review advanced directives as needed for any changes or wishes; refer resident to social services as needed; discuss advanced directives on admission and as needed; and to educate resident and/or responsible party regarding DNR verses full code risks and benefits. Despite the above documentation, a physician's orders [REDACTED]. The orders had an original order date of (MONTH) 2, 2019. Review of the (MONTH) and (MONTH) 2019 Medication Administration Record [REDACTED] A quarterly social services note dated (MONTH) 10, 2019 included a quarterly care plan meeting was held on (MONTH) 9, 2019. The documentation included the resident's advanced directive was reviewed and there were no changes at this time, and that the resident will continue under DNR. In an interview with a social service assistant (staff #170) on (MONTH) 11, 2019 at 10:02 a.m., she stated that social services will have a meeting with residents who are readmitted from the hospital and review the care plan with them to make sure nothing has changed, and that advanced directives are also discussed. She stated if the resident changes their advanced directive status, then social services will let the nurse know. She also stated advanced directives are reviewed at each care plan meeting. -Resident #83 was admitted to the facility on (MONTH) 29, 2019, with [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. An advanced directive care plan dated (MONTH) 29, 2019 included the resident was a full code, per the advanced directive. The goal was that the advanced directives, care plan directives and physician orders [REDACTED]. Approaches included reassesses/review advanced directives as needed for any changes; refer resident to social services as needed; discuss advanced directives on admission and as needed; and to educate resident and/or responsible party regarding DNR verses full code risks and benefits. Review of physician orders [REDACTED]. However, a history and physical dated (MONTH) 4, 2019 included the resident's code status was DNR/DNH (Do not hospitalize). A physician's orders [REDACTED]. Nursing notes indicated the resident was sent to the hospital and returned on (MONTH) 7, 2019. Review of a social services admission note dated (MONTH) 26, 2019 included the resident was full code status. A physician's orders [REDACTED]. A physician's progress note dated (MONTH) 8, 2019 included the resident was a DNR/DNH. Review of the physician's orders [REDACTED]. Despite conflicting documentation regarding the resident's code status, there was no evidence that an Advanced Directive Statement form had been completed by the resident or the resident's representative, indicating their code status choices. During an interview with a registered nurse (RN/staff #179) on (MONTH) 11, 2019 at 12:29 p.m., he reviewed resident #83's chart and stated that normally there is a paper in the chart with the resident's code status. He was unable to locate this in the resident's chart. In an interview with the Director of Nursing (DON/staff #83) on (MONTH) 11, 2019 at 1:23 p.m., she stated that advanced directives are reviewed by the nurses every time a resident comes back from the hospital. She stated resident #83 had just recently been in the hospital and the physician was in to see her on (MONTH) 9. She stated when the physician comes to visit, he asks for a copy of the resident's advanced directive information. She stated she believes that paper was misplaced after making a copy for the physician. Another interview with staff #83 was conducted on (MONTH) 11, 2019 at 3:55 p.m. She stated the advanced directive information for resident #83 had not been located. -Resident #105 was admitted to the facility on (MONTH) 19, 1996 and was readmitted (MONTH) 29, (YEAR), with [DIAGNOSES REDACTED]. Review of the clinical record revealed documentation that on (MONTH) 30, 2012, the county court appointed the resident a public fiduciary. Review of the advance directive statement dated (MONTH) 9, (YEAR) revealed the resident's guardian had initialed next to the these statements: I do not want cardiopulmonary resuscitation; I do not want defibrillation performed; and next to I do not want life support. The advance directive statement was signed by the guardian and a witness. Review of a State of Arizona Do Not Resuscitate (DNR) form indicated that in the event of cardiac or respiratory arrest, the guardian refuses resuscitation measures, including cardiac compression, endotracheal intubation and other advanced airway management, artificial ventilation, defibrillation, administration of advance cardiac life support drugs and related emergency medical procedures. This form was signed by the guardian on (MONTH) 13, (YEAR). Review of the physician orders [REDACTED]. Despite advance directive documentation that the resident was a DNR status, there was still an active order for a full code status. An interview was conducted on (MONTH) 10, 2019 at 2:19 p.m. with a licensed practical nurse (LPN/staff #69). At this time, staff #60 reviewed the clinical record and stated that if the advance directives are updated by a guardian, then provider

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) is notified and an order matching the advance directive is obtained. Staff #69 stated the most recent advance directive for the resident reflects a DNR status, however, the physician orders [REDACTED]. In a later interview at 2:51 p.m. staff #69 stated the provider was notified and a new order reflecting the DNR was obtained. An interview was conducted on (MONTH) 11, 2019 at 9:15 a.m. with the Director of Nursing (DON/staff #83). At this time, staff #83 reviewed the clinical record and stated the public fiduciary had completed the advance directive for the DNR in (YEAR) and an order was obtained, however, there was an error with the order being transcribed and the current order reflects a full code. Review of the facility's policy titled, Advance Directives revised in (MONTH) (YEAR), revealed a physician's orders [REDACTED]. The policy included that the DNR order should be flagged appropriately on the resident's chart to alert staff as to the resident's advance directive status.
F 0636 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews and the Resident Assessment Instrument (RAI) manual, the facility failed to ensure a death in facility tracking Minimum Data Set (MDS) record was completed for one resident (#1). The deficient practice results in a lack of gathering important quality data and quality monitoring. Findings include: Resident #1 was admitted to the facility on (MONTH) 27, (YEAR), with [DIAGNOSES REDACTED]. A nursing note dated (MONTH) 27, (YEAR) included the resident expired in the facility at 5:20 a.m. Two licensed practical nurses (LPN) verified absence of vital signs. The family and physician were notified and post mortem care was done. A Human Remains Release Form and Mortician's receipt were signed on (MONTH) 27, (YEAR). A Discharge Summary Form signed by the physician on (MONTH) 28, (YEAR) included the reason for discharge was the patient expired. However, there was no evidence a death in facility tracking MDS record was completed and transmitted to the Centers for Medicare and Medicaid Services (CMS) system. In an interview with the MDS coordinator (staff #9) on (MONTH) 10, 2019 at 1:20 p.m., she stated she gets a copy of the census every day to see if there are residents who have discharged and then she schedules a discharge MDS right away. Staff #9 said that if a resident has expired in the facility, she schedules a death in facility MDS assessment. She stated this resident was missing a death in facility MDS assessment and did not know how it got missed. A death in facility tracking MDS record was completed on (MONTH) 12, 2019. An interview was conducted with the Director of Nursing (DON/staff #83) on (MONTH) 11, 2019 at 9:47 a.m. She stated the facility did not have a specific policy related to MDS assessments, as they follow the RAI manual. In a later interview with staff #83 on the same date, she stated her expectation is that there should be a discharge MDS assessment completed for every discharged resident. The RAI manual included Death in the Facility refers to when a resident dies in the facility, the facility must complete a Death in Facility tracking record. The RAI manual also included that a Death in Facility tracing record must be completed no later than 7 calendar days after the discharge (death) date, and must be transmitted no later than 14 calendar days after the discharge (death) date.
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, facility documentation and policy review, the facility failed to ensure 2 of 24 (#70 and #100) sampled residents were administered medications as ordered and failed to ensure the physician was notified regarding the refusal of treatments for 1 of 24 sampled residents (#37). The deficient practice could result in potential medical complications [REDACTED]. Findings include -Resident #70 was admitted on (MONTH) 7, (YEAR), with [DIAGNOSES REDACTED]. Review of the significant change Minimum Data Set (MDS) assessment dated (MONTH) 13, (YEAR) revealed the resident scored a one on the Brief Interview for Mental Status (BIMS), indicating the resident had severe cognitive impairment. Further review revealed the resident did not have hallucinations, delusions, behavioral symptoms or refused care. The MDS included the resident received antipsychotic and antianxiety medications during the last 7 days of the assessment and that a gradual dose reduction (GDR) had not been attempted and the GDR was not clinically contraindicated. Review of the physician orders [REDACTED]. Physician orders [REDACTED]. Review of the annual MDS assessment dated (MONTH) 17, 2019, revealed the resident scored a zero on the BIMS, indicating the resident had severe cognitive impairment. The MDS included the resident did not have hallucinations, delusions or behavioral symptoms, and received antipsychotic and anti-anxiety medications during the last 7 days. Per the MDS, a GDR had not been attempted and was not clinically contraindicated. Review of the medication administration record (MAR) for (MONTH) 2019, revealed there were approximately 32 occasions when [MEDICATION NAME] was circled on the MAR, and there were approximately 16 occasions when [MEDICATION NAME] was circled, indicating the medications were not administered. The MAR notes indicated that the medications were not administered, due to unavailability. -Resident #100 was admitted on (MONTH) 16, 2019, with [DIAGNOSES REDACTED]. Review of the physician orders [REDACTED]. According to the (MONTH) 2019 MAR from (MONTH) 17 through the 27, there were more than 12 doses of [MEDICATION NAME] which were circled and more than 3 doses which were blank, indicating the medication was not administered. The MAR notes included that on a couple of days the medication was not administered, as the medication was unavailable from the pharmacy. An admission MDS assessment dated (MONTH) 29, 2019, revealed the resident scored a 14 on the Brief Interview for Mental Status (BIMS), indicating the resident was cognitively intact. The MDS included the resident was on a pain management program and received opioids. Further review of the clinical record revealed no evidence that the medication was administered as ordered, and there was no documentation the physician was notified regarding the medication not being administered, due to unavailability. An interview was conducted on (MONTH) 9, 2019 at 1:54 p.m. with a registered nurse (RN/staff #73). The RN stated that medications are to be administered and documented on the MAR. The RN stated if the medication is not administered it is indicated by a circle and on the MAR nursing notes the nurse is to document why the medication was not administered. An interview was conducted on (MONTH) 11, 2019 at 8:52 a.m. with the Assistance Director of Nursing (ADON/staff #18 and the Director of Nursing (DON/staff #83). The DON stated the administration of medications are documented on the MAR, as indicated by a nurse's initials. The DON stated if the medication is not administered, the nurses' initials would be circled and if the documentation is blank it indicates the medication was not administered. The DON stated if the initials are circled the reason for the medication not being administered is to be documented on the MAR. The DON stated if the medication was not given due to unavailability or the resident's refusal, after 3 days the nurse is to notify the physician and continuously follow up with the pharmacy to determine why the medication is not available. -Resident #37 was admitted to the facility on (MONTH) 5, (YEAR), with [DIAGNOSES REDACTED]. Review of a care plan dated (MONTH) 18, (YEAR), revealed the resident had a stage 2 bunion on the right foot. An intervention included offloading with wedge right foot at all times. A physician's orders [REDACTED]. Review of the nurses progress notes for (MONTH) 20 and 30, (YEAR), (MONTH) 6, 13, 20 and 25, (YEAR) and (MONTH) 4, 2019, revealed the resident was compliant with the wedge and is in place at all times. Review of the clinical record revealed there were no additional progress notes regarding the use of the wedge to offload the right foot or that the resident was refusing the wedge from (MONTH) 5, 2019 through (MONTH) 9, 2019.

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F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) Further review of the care plan revealed no documentation that indicated the resident was refusing the wedge. An observation of the resident was conducted on (MONTH) 8, 2019 at 3:10 p.m. Resident #37 was laying in bed, with no wedge to the right foot. An interview was conducted with a Licensed Practical Nurse (LPN/staff #138) on (MONTH) 9, 2019 at 11:44 a.m. She stated the resident refuses to have the wedge under her right foot and this has been going on for a long time. At this time, the nurse offered to put the wedge in place and the resident refused stating that it hurts her hips. Another observation was conducted on (MONTH) 9, 2019 at 2:47 p.m. and the resident was sleeping in bed on her left side with legs pulled up and no wedge in place to the right foot. Additional observations were conducted on (MONTH) 9, 2019, and the resident was observed laying in bed, with no wedge in place. Multiple observations were conducted on (MONTH) 10, 2019 and resident was observed laying in bed, with no wedge in use for the right foot. Review of a nurses progress note dated (MONTH) 10, 2019, revealed a late entry for (MONTH) 9, and a note on (MONTH) 10, which now included the resident refused to have the wedge under right her foot to offload. In addition, there was no documentation that the care plan was updated to reflect the resident's refusal of the wedge. There was also no clinical record documentation that the physician was notified of the resident's refusal of the wedge for the right foot when in bed. An interview was conducted with the Director of Nursing (DON/staff #83) on (MONTH) 11. 2019 at 2:07 p.m. When asked about resident #37 refusing the wedge which was ordered to be on at all times when in bed, the DON stated that she would discuss the risk and benefits of not having the wedge on with the resident and family. She said that she would expect the staff to notify the physician and family about the refusal. Review of the facility's policy regarding changes in the resident's condition or status revealed the facility will notify the resident's primary care provider and representative of changes in the resident's condition or status. The policy also stated that notification of changes may also include a need to alter treatment or to discontinue an existing form of treatment.
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 review, staff interviews and policy review, the facility failed to ensure one of five sampled residents (#70) receiving [MEDICAL CONDITION] medications had adequate indications for their use, and that gradual dose reductions (GDR) were attempted or documentation that they were clinically contraindicated. The deficient practice could result in residents receiving [MEDICAL CONDITION] medications which are unnecessary, and could result in residents experiencing possible adverse consequences. Findings include: Resident #70 was admitted on (MONTH) 7, (YEAR), with [DIAGNOSES REDACTED]. Regarding [MEDICATION NAME]: Review of the physician's orders [REDACTED]. These orders had an original order date of (MONTH) 10, (YEAR). Review of the clinical record from (MONTH) 1, (YEAR) to (MONTH) 30, (YEAR) revealed no documentation that the resident had displayed any combative behaviors with care. In addition, there was clinical record documentation that the resident's medications had been reviewed, however, there were no changes made. A significant change Minimum Data Set (MDS) assessment dated (MONTH) 13, (YEAR), revealed the resident scored a one on the Brief Interview for Mental Status (BIMS), indicating the resident had severe cognitive impairment. Per the MDS, the resident did not have hallucinations, delusions, behavioral symptoms or rejected care. The MDS also included the resident received antipsychotic medications during the last 7 days of the assessment and that a gradual dose reduction (GDR) had not been attempted and was not documented by the physician as clinically contraindicated. The physician orders [REDACTED]. During this time frame, there was no clinical record documentation that the resident displayed any combative behaviors with care. Per the documentation, the resident's medications were reviewed and no changes were made. Review of the monthly behavior flowsheet record for (MONTH) (YEAR), revealed the resident had no episodes of combative behaviors with care. A physician's progress note dated (MONTH) 19, (YEAR), revealed no recommendations to reduce or discontinue the [MEDICATION NAME] due to a lack of behaviors. The monthly pharmacy reviews completed from (MONTH) (YEAR) to (MONTH) (YEAR) were requested, however, the facility was unable to provide the documents. A quarterly MDS assessment dated (MONTH) 23, (YEAR), revealed the resident had severe cognitive impairment and did not have hallucinations, delusions, behavioral symptoms or rejected care. The MDS included the resident received antipsychotic medications during the last 7 days and that a GDR had not been attempted and was not clinically contraindicated. The physician orders [REDACTED]. The clinical record documentation included that the [MEDICATION NAME] was reviewed and there were no changes made. The documentation also included for social services to monitor the resident's behaviors and mood. Review of the monthly behavior flowsheet records from (MONTH) 1, (YEAR) to (MONTH) 25, (YEAR), revealed no evidence that the resident had any episodes of combative behaviors with care. In addition, there was no clinical record documentation of any attempts for a GDR for the [MEDICATION NAME] from (MONTH) (YEAR) to (MONTH) 25, (YEAR). Review of the pharmacy consultation report dated (MONTH) 26, (YEAR) revealed the resident was receiving [MEDICATION NAME] 50 mg twice a day and 150 mg at bedtime for impulse control disorder since (MONTH) 10, (YEAR). Per the report, the pharmacist recommended a gradual dose reduction as follows: [MEDICATION NAME] 50 mg twice a day and 125 mg at bedtime, with the end goal of discontinuation while monitoring for re-emergence of target behaviors and withdrawal symptoms. The report included it is recommended for the prescriber to document the assessment of the risk verse benefits, indicating that the antipsychotic therapy continued to be a valid therapeutic intervention; ongoing monitoring of specific target behaviors and evaluation for potentially reversible causes of behavioral symptoms; and assessment of alternative interventions. Per the report, the provider agreed. Physician orders [REDACTED]. Despite the pharmacy recommendation, there was no evidence in the clinical record that the physician documented the clinical rationale for the continued use of [MEDICATION NAME]. The pharmacy review for (MONTH) 2019 included that [MEDICATION NAME] was started in (MONTH) of (YEAR) and the last gradual dose reduction was attempted in (MONTH) 2019, and the next reduction will be in (MONTH) 2020. Review of the monthly behavior flowsheet records from (MONTH) 1, 2019 to (MONTH) 28, 2019, revealed the resident had no episodes of combative behaviors with care. Further review of the clinical record from (MONTH) 1, 2019 to (MONTH) 28, 2019, revealed the [MEDICATION NAME] was reviewed and there were no changes made, and for social services to monitor the resident's behaviors and mood. The (MONTH) 2019 recapitulation of physician orders [REDACTED]. Review of the pharmacy review for (MONTH) and (MONTH) 2019, revealed no recommendations to decrease or discontinue the [MEDICATION NAME], despite the lack of behaviors. An annual MDS assessment dated (MONTH) 17, 2019 revealed the resident scored a zero on the BIMS, indicating the resident has severe cognitive impairment. Per the MDS, the resident did not have hallucinations, delusions or behavioral symptoms. The

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F 0758

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

(continued... from page 3)

MDS also included the resident received antipsychotic medications during the last 7 days and that a GDR had not been attempted and the GDR was not documented by the physician as clinically contraindicated.
Review of a care plan dated (MONTH) 17, 2019 revealed the resident is receiving [MEDICATION NAME] for [MEDICAL CONDITION] as evidenced by combative with care. Interventions included to monitor and document behavior at least every shift and report any abnormal observation to MD and evaluate the possibility of medication drug reduction at least quarterly.
Review of the monthly behavior flowsheet record (MONTH) 2019, revealed on (MONTH) 15, 22 and 26, the resident was combative with care. The documentation included that non pharmacological interventions and medications were provided, which resulted in positive results. There was no additional description of the events.
The clinical record documentation included that [MEDICATION NAME] was reviewed in (MONTH) 2019 and there were no changes made and for social services to monitor the resident's behaviors and mood.
Despite documentation of only three episodes of the resident being combative with care from (MONTH) 1, (YEAR) through (MONTH) 31, 2019, a physician's orders [REDACTED].
In addition, there was no evidence found in the clinical record that the physician was notified of the lack of behaviors.
Regarding [MEDICATION NAME]:
A physician's orders [REDACTED].
A physician's orders [REDACTED].
Review of the clinical record from (MONTH) (YEAR) through (MONTH) 31, (YEAR) revealed no documentation that the resident was striking out at others during this period.
Review of the monthly behavior flowsheets from (MONTH) 1, (YEAR) through (MONTH) 30, (YEAR), revealed no evidence of the resident striking out at others.
Documentation of the monthly pharmacy reviews from (MONTH) (YEAR) through (MONTH) (YEAR) were requested, however, the facility was unable to provide these documents.
Review of the monthly behavior flowsheet for (MONTH) (YEAR) revealed that on (MONTH) 24, the resident exhibited an episode of striking out and was provided redirection with a positive outcome. There was no additional description of the event.
Review of the physician's progress note dated (MONTH) 14, 2019 revealed the resident had a [DIAGNOSES REDACTED].
The pharmacy review for (MONTH) 2019 included that [MEDICATION NAME] was started in (YEAR) and that the last GDR was attempted in (MONTH) (YEAR), and the next reduction will be in (MONTH) 2019. Per the report, a GDR was clinically contraindicated in (MONTH) (YEAR).
Review of the clinical record from (MONTH) 1, 2019 through (MONTH) 31, 2019, revealed the [MEDICATION NAME] was periodically reviewed and there were no changes made. The documentation also included for social services to monitor the resident's behaviors and mood. Further, there was no evidence that the resident was striking out at others.
Review of the monthly behavior flowsheets from (MONTH) 1, 2019 through (MONTH) 31, 2019, revealed no evidence the resident exhibited episodes of striking out at others.
Review of a care plan dated (MONTH) 17, 2019 revealed the resident is receiving [MEDICATION NAME] for [MEDICAL CONDITION] as evidenced by striking out at others. Interventions included to monitor and document behavior at least every shift and report any abnormal observation to MD and evaluate the possibility of medication drug reduction at least quarterly.
Despite documentation of only one episode of striking out from (MONTH) 1, 2019 through (MONTH) 31, 2019, the resident continued to receive [MEDICATION NAME], and there was no evidence that the physician was notified of the lack of behaviors.
Review of the pharmacy reviews for (MONTH) 2019 and (MONTH) 2019 revealed no recommendations to decrease or discontinue [MEDICATION NAME], despite the lack of behaviors.
Regarding [MEDICATION NAME]:
Review of the physician orders [REDACTED]. The orders had an original order date of (MONTH) 22, (YEAR).
Review of the clinical record from (MONTH) 1, (YEAR) to (MONTH) 30, (YEAR), revealed the [MEDICATION NAME] was reviewed and there were no changes made. Further, there was no evidence that the resident had any episodes of restlessness distressing to the resident, during this timeframe.
A significant change MDS assessment dated (MONTH) 13, (YEAR) included the resident received antianxiety medications during the last 7 days of the assessment and that a GDR had not been attempted and was not documented by the physician as clinically contraindicated.
Review of the clinical record from (MONTH) 1, (YEAR), (YEAR) to (MONTH) 30, (YEAR) revealed the [MEDICATION NAME] was reviewed and there were no changes made. Further, there was no evidence the resident had episodes of restlessness distressing to the resident. The documentation also included for social services to monitor the resident's behavior and mood.
Review of the monthly behavior flowsheet record for (MONTH) (YEAR) revealed no episodes of restlessness.
Documentation on the monthly pharmacy reviews completed from (MONTH) (YEAR) to (MONTH) (YEAR) were requested, however, the facility was unable to provide these documents.
Review of the pharmacy consultation report dated (MONTH) 29, (YEAR) revealed a recommendation for a gradual dose reduction for [MEDICATION NAME], which included for [MEDICATION NAME] 0.5 mg twice a day and 0.25 mg at noon daily, with the eventual goal of discontinuation while concurrently monitoring for reemergence of target behaviors and withdrawal symptoms. Per the report, the provider agreed with the recommendation and the previous [MEDICATION NAME] order was discontinued and new orders were obtained.
Physician orders [REDACTED].
A physician's progress note dated (MONTH) 19, (YEAR) included documentation to taper the [MEDICATION NAME]. Despite this recommendation, there were no new physician orders [REDACTED].
Review of the clinical record for (MONTH) (YEAR) revealed there was no evidence the resident had any episodes of restlessness distressing to the resident.
A nursing note dated (MONTH) 18, (YEAR) and a social services note dated (MONTH) 19, 2019, included the resident would get scared and agitated in the past, due to his medical condition.
Review of the physician's progress note dated (MONTH) 14, 2019 revealed the resident had anxiety and the medications were reviewed and updated.
The monthly behavior flowsheets from (MONTH) (YEAR) through (MONTH) 2019 revealed there was no evidence that the resident experienced episodes of restlessness.
The pharmacy reviews for (MONTH) 2019 and (MONTH) 2019 revealed no recommendations to decreased or discontinue [MEDICATION NAME], despite the lack of behaviors.
Review of the physician's progress note dated (MONTH) 1, 2019 revealed the resident was in no apparent distress and the medications were reviewed and updated.
Review of the annual MDS assessment dated (MONTH) 17, 2019, revealed the resident did not have hallucinations, delusions or behavioral symptoms and received anti-anxiety medications during the last 7 days. The MDS included that a GDR had not been attempted and the GDR was not documented by the physician as clinically contraindicated.
Review of the monthly behavior flowsheet revealed that on (MONTH) 22, 2019, the resident experienced an episode of restlessness and non-pharmacological interventions and medications were provided, which resulted in a positive outcome.
Despite documentation of only one episode of restlessness from (MONTH) 2019 through (MONTH) 2019, the resident continued to receive [MEDICATION NAME]. There was also no clinical record documentation that the physician was notified of the lack of behaviors.
An observation of the resident was conducted on (MONTH) 9, 2019 at 11:35 a.m. The resident was in bed and appeared to be calm and was pleasant, with no signs of distress.
An interview was conducted on (MONTH) 11, 2019 at 12:58 pm., with a certified nursing assistant (CNA/staff #84). Staff #84 stated the resident is not very physically aggressive and that his restlessness has improved since admission.
An interview was conducted on (MONTH) 11, 2019 at 1:06 p.m., with a licensed practical nurse (LPN/staff #145). Staff #145 stated a resident receiving an [MEDICAL CONDITION] medication will be monitored for behaviors such as crying, kicking or aggression and the behaviors must be documented. Staff #145 stated once the behaviors have improved, the provider is notified and the medication is titrated. Staff #145 stated the resident is currently receiving [MEDICATION NAME] and [MEDICATION NAME]. Staff #145 stated on admission the resident was resistive to care, was crying and was a danger to self, however, the resident has improved overtime.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035133	A. BUILDING _____ B. WING _____	**04/11/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LIFE CARE CENTER OF YUMA	**2450 SOUTH 19TH AVENUE YUMA, AZ 85364**

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 0758 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 4) An interview was conducted on (MONTH) 11, 2019 at 1:42 p.m., with the Director of Nursing (DON/staff # 83). The DON stated the physician is managing the resident's [MEDICAL CONDITION] medications, as it is difficult to get a psych evaluation in the area. The DON stated the resident came from a psychiatric facility and was receiving multiple [MEDICAL CONDITION] medications on admission. The DON stated the physician did not want to taper the [MEDICATION NAME] and [MEDICATION NAME] at the same time, and that gradual dose reductions have been attempted over the past two years. Review of a policy titled, Psychopharmacological Medication Management dated (MONTH) (YEAR), revealed the purpose was to support utilization of psychopharmacological medications in the appropriate treatment of [REDACTED]. The policy included that each resident's drug regimen must be free from unnecessary drugs. An necessary drug is any drug used in excessive dose including duplicate therapy, excessive duration, and without adequate indication for use. The policy also included the focus is on treating the resident's behavior indicators, with the most appropriate medication at the lowest dose and duration possible, which results in a decrease in behavior indicators that are new, unsafe, disruptive or threatening to the resident or others. The policy further stated the attending physician must document in the resident's medical record that identified irregularities have been reviewed and what, if any action has been taken to address it. If there is no change in the medication, the attending physician should document his or her rationale in the resident's medical record.