STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035247	A. BUILDING _____ B. WING _____	**10/24/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MARYLAND GARDENS CARE CENTER	**31 WEST MARYLAND AVENUE PHOENIX, AZ 85013**

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 0561 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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, observations, resident and staff interviews, and facility documentation and policy, the facility failed to promote and facilitate resident self-determination through the support of resident choice for eight residents (#s 293, 1, 25, 31, 33, 3, 34, and 29), by failing to provide the residents with the option to receive meals in their rooms. The facility census was 43 residents. The deficient practice could result in residents not having the choice about aspects of their life that are significant to them. Findings include: -Resident #293 was readmitted to the facility on (MONTH) 13, 2019 with [DIAGNOSES REDACTED]. Review of an annual Minimum Data Set (MDS) assessment dated (MONTH) 29, 2019 revealed that the resident scored a 15 on the Brief Interview for Mental Status (BIMS) indicating that she was cognitively intact. A physician's order dated (MONTH) 16, 2019 revealed an order for [REDACTED]. A physician order dated (MONTH) 9, 2019 revealed an order for [REDACTED]. Review of the nutrition care plan, revised on (MONTH) 18, 2019, revealed that the resident had nutrition risk secondary to variable oral intakes due to conditions associated with [MEDICAL CONDITION]. The care plan indicated that the resident had significant weight loss in the last 6 months. The resident was noted to refuse meals and supplements. An intervention indicated to offer the resident a health shake at lunch and dinner on her meal tray. Further interventions included to assist the resident with meals as needed, encourage her to eat, offer alternatives if she refuses, and honor food preferences. During an interview on (MONTH) 21, 2019 at 10:16 a.m., resident #293 stated that the residents in the facility have to go to the dining room for meals and if they don't want to go then they miss their meals as no meals are delivered to the rooms. She stated that one day she was sick and did not get lunch or dinner that day and this has happened on multiple occasions. A lunch meal observation was conducted on (MONTH) 21, 2019 at 12:43 p.m. Resident #293 was observed in her room as she did not go to the dining room for lunch. When asked why, she said that she did not feel like going down to the dining room. She also stated that if the staff brought her a room tray she would try eating her lunch. No room trays were delivered to any residents in the facility during the lunch meal. During an observation on (MONTH) 22, 2019 at 7:30 a.m., resident #293 was in her room during breakfast time. She stated that she did not want to go to the dining room. No room tray was observed to be delivered to the resident. An interview was conducted with resident #293 on (MONTH) 22, 2019 at 2:00 p.m. She stated she missed her lunch on this date as she just came back from a doctor's appointment. She also stated that she missed breakfast on this date because the staff woke her up right at breakfast time and she needed some time to get ready. She said that since she did not go to the dining room, she did not get breakfast. She stated that no lunch meal tray was brought to her on this date. She also stated that she did not eat lunch on (MONTH) 21, 2019 either. However, review of resident #293's documented meal intakes revealed that she was coded as eating 76-100% for lunch on (MONTH) 21, 2019 and for breakfast on (MONTH) 22, 2019. The resident was coded as consuming 0% of her lunch on (MONTH) 22, 2019. An interview was conducted on (MONTH) 22, 2019 at 1:21 p.m. with a Certified Nursing Assistant (CNA/staff #10). Staff #10 stated that the CNAs help residents to the dining room for meals and when the residents are done eating, they observe the amount they have eaten on their tray and it is documented in the electronic medical record. Staff #10 stated that she remembers resident #293 sitting in the dining room for breakfast and lunch on this date and that resident eats 76-100%. She stated that sometimes the resident's intakes are logged on a paper by the CNA who is assigned to the dining room and then she will input the information into the electronic medical record. She stated that when a resident says that they don't want to go to the dining room she was told to give them a shake and she would notify the nurse. She also stated that she would bring a shake for a resident who is not feeling well and does not want to do to the dining room to eat meals. She said she would then document it as a refused meal and the shake is documented as fluid intake. During an interview with the Registered Dietitian (RD/staff#85) on (MONTH) 23 at 9:24 a.m., she stated that she expects the staff to encourage residents to eat their meals and offer meals several times before they put down a refusal. She stated that even after encouragement they don't want to eat the meals offered she expects staff to offer them alternatives like sandwiches, salads, and burgers. She stated that resident #293 has a 7 pound weight loss and she is on weekly weights and weekly monitoring. She said resident #293 is considered as one of her high-risk residents. -Resident #1 was admitted to the facility on (MONTH) 12, (YEAR) with [DIAGNOSES REDACTED]. Review of the quarterly MDS assessment dated (MONTH) 13, 2019 included a BIMS score of 15, which indicated the resident was cognitively intact. An observation of the resident was conducted on (MONTH) 21, 2019 at 12:00 p.m. The resident was in her bed when lunch was being served in the dining room. The resident was not served a tray or meal of any type. An interview was conducted on (MONTH) 21, 2019 at 12:47 p.m. with resident #1. She stated she does not like to go to the dining room because it is too noisy. She stated that she would eat lunch if a tray was bought to her room. During another interview conducted with resident #1 on (MONTH) 24, 2019 at 9:55 a.m., she stated that staff will insist that she go to the dining room and if she does not, the staff will take away all her privileges such as smoking and attending activities. She said that when she stays in her room during a meal, the staff will not offer her a room tray; instead they will give her a shake. -Resident #25 was admitted to the facility on (MONTH) 2, 2019 with [DIAGNOSES REDACTED]. Review of the quarterly MDS assessment dated (MONTH) 29, 2019 included a BIMS score of 15, which indicated the resident was cognitively intact. An interview was conducted on (MONTH) 21, 2019, at 10:09 a.m. with resident #2 who stated that if the residents don't go down to the dining room, then they don't get any meals and instead are given a 4 ounce shake. She stated that she requires a mechanical lift to get out of bed and is sometimes too tired to get up for breakfast and that instead of being offered a room tray, she is given a shake. During the interview, the resident retrieved an empty carton of shake from the trash bin. She indicated that this was the shake she was given and that this has happened on many occasions. During another interview conducted with resident #2 on (MONTH) 23, 2019 at 9:15 a.m., she stated that if she refuses to go to the dining room, she doesn't get any food. She said she only gets a shake. She said that this is hard for her because she has diabetes and the shake isn't enough to manager her blood sugar. She also said that the shake does not fill her up

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 0561 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) and she ends up going hungry. -Resident #31 was admitted to the facility on (MONTH) 6, (YEAR) with [DIAGNOSES REDACTED]. Review of the quarterly MDS assessment dated (MONTH) 12, 2019 included a BIMS score of 15, which indicated that the resident is cognitively intact. An interview was conducted on (MONTH) 21, 2019 at 10:38 a.m. with the resident who stated that if the residents don't go down to the dining room, they don't get any meals as the facility does not deliver meal trays to the rooms. She said that if she does not wake up and go to the dining room, she ends up missing the meal as staff does not offer her any food. -Resident #33 was admitted to the facility on (MONTH) 3, 2011 with [DIAGNOSES REDACTED]. A review of the annual MDS assessment dated (MONTH) 5, 2019 included a BIMS score of 15, which indicated the resident is cognitively intact. During a resident council meeting conducted on (MONTH) 23, 2019 at 10:19 a.m., resident #33 stated that the residents cannot eat meals in their rooms because the facility staff told them that it attracts insects. He said that residents have to go to the dining room to eat their meals. -Resident #3 was admitted to the facility on (MONTH) 3, 2019 with [DIAGNOSES REDACTED]. A review of the quarterly MDS assessment dated (MONTH) 8, 2019 included a BIMS score of 15, which indicated the resident was cognitively intact. During a resident council meeting conducted on (MONTH) 23, 2019, at 10:19 a.m., resident #33 stated that the residents cannot eat meals in their rooms because the facility staff told them that it attracts insects. He said that residents have to go to the dining room to eat their meals. -Resident #34 was admitted to the facility on (MONTH) 5, 2019 with [DIAGNOSES REDACTED]. Review of the quarterly MDS assessment dated (MONTH) 12, 2019 included a Brief Interview for BIMS score of 15, which indicated the resident is cognitively intact. During a resident council meeting conducted on (MONTH) 23, 2019 at 10:19 a.m., the resident stated the only way residents will get meals in their rooms is if they are sick. She stated that the facility has said this is because eating meals in the room attracts insects. An interview with a Registered Nurse (RN/staff #53) was conducted on (MONTH) 21, 2019 at 12:57 p.m. Staff #53 stated that if a resident refuses meals staff give them a shake but for residents who are not feeling well and who don't want to go to the dining room, the kitchen will send trays down to their rooms. However multiple observations were made during meal times and no tray was delivered to any of the residents who did not go to the dining room. An interview was conducted on (MONTH) 22, 2019 at 12:42 p.m. with a Licensed Practical Nurse (LPN/staff #65). She stated that if any residents refuse to go to the dining room because they are tired, the staff will wake them up and tell them that it is meal time. She said that if they refuse, staff offers the resident a shake. Staff #65 said if residents say that they don't want to go to the dining room then they get a tray, she said they don't have to go to the dining room to eat they have the right to eat in the room if they choose. -Resident #29 was readmitted to the facility on (MONTH) 10, 2019 with [DIAGNOSES REDACTED]. Review of the quarterly MDS assessment dated (MONTH) 3, 2019 revealed the resident had a BIMS score of 15, which indicated the resident was cognitively intact. The review also revealed the resident required extensive assistance for bed mobility, was dependent on staff for transfers, and that she required extensive assistance with locomotion using a wheelchair. Review of the resident's nutrition care plan, revised (MONTH) 9, 2019, revealed the resident was at nutrition risk due to obesity, [MEDICAL CONDITION] disorder, anxiety, type 2 diabetes mellitus, depression, ulcerative [MEDICAL CONDITIONS], dysphagia, [MEDICAL CONDITION], and swallowing difficulty due to dysphagia. The resident was noted to be on a mechanically altered diet. The goal for the care plan included the resident would consume at least 55% of meals through the next review. Interventions included to provide the diet as ordered, assist with meals as needed, and document meal intakes. Review of resident #29's behavior care plan revealed if the resident was yelling out disruptively in common areas, staff were to return the resident to her room. There were no interventions regarding where the resident would eat meals. Review of the (MONTH) 2019 Physician's Orders for resident #29 revealed a diet order for a regular diet, with diet condiments and diet desserts, mechanical soft texture, and thin liquid consistency. The orders also specified the resident may have salads and to provide condiments and gravy for mechanical meats, as available. There were no physician orders regarding where the resident would eat meals. An observation on (MONTH) 21, 2019 from 12:15 p.m. until 1:00 p.m., revealed that resident #29 was observed in bed sleeping. The resident never received a meal or a supplement during the meal time. A second observation was conducted on (MONTH) 22, 2019 from 12:10 p.m. until 1:15 p.m., resident #29 was observed in bed sleeping. The resident never received a meal or a supplement during the meal time. A review of resident #29's meal intakes revealed the resident refused meals on (MONTH) 21, 2019 at 9:00 a.m. and at 1:00 p.m., and on (MONTH) 22, 2019 at 1:00 p.m. During an interview with resident #29 on (MONTH) 23, 2019 at 8:30 a.m., the resident stated that she had not been feeling well the past couple of days. She stated that she refused lunch on (MONTH) 22, 2019 and breakfast and lunch on (MONTH) 21, 2019 because she didn't want to go to the dining room. She explained that she didn't ask for a room tray because it is against the facility rules to provide room trays. She stated that sometimes they bring her a tray, but usually she would have to go to the dining room if she wanted a meal. During an interview with the Director of Nursing (DON/staff #44) and the Resource Nurse (staff #86), conducted on (MONTH) 24, 2019 at 11:05 a.m., the DON stated the residents are encouraged to go to the dining room for meals but that if they refuse to go to the dining room they will receive a meal tray in their room. The DON said that she expects the staff to encourage residents to eat by sitting down with them, assist them if needed, and to offer alternatives if they do not like what is being served. She said that if the resident still does not want to eat, she expects that staff would involve the dietitian as well as the provider. Staff #86 stated that it is expected that the residents will go to the dining room as it is a behavioral facility. She stated that this is the expectation, but that it is not required and residents are not forced to go to the dining room. In an interview with the administrator (staff #15) conducted on (MONTH) 24, 2019 at 11:25 a.m., she stated that residents are not required to come to the dining room and that if a resident is ill or refusing to go to the dining room, the facility would send them a room tray. She also stated that a staff member would have to stay with the resident eating in their room because the facility would have no other way to monitor the residents' safety. She stated that since (MONTH) 2019, the facility highly encourages residents to go to the dining room. She said that the admission agreement notes that residents are required to go the dining room, but that this is not technically true, and instead, the residents are highly encouraged to go the dining room. She stated the resident still has a right to choose, and the facility would make sure the resident received something to eat. She also stated that if a resident does not want to come to the dining room, staff do not take their other privileges away. Review of the facility policy titled Resident Care Routine, revised (MONTH) 2012, includes each resident shall be out of bed daily unless the resident refuses or prefers to stay in bed. The policy also includes the staff to encourage residents to take meals in the dining room. Review of the facility admission agreement revealed that residents are required to eat in the dining room due to safety monitoring.
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, policy review, and the Resident Assessment Instrument (RAI) manual, the facility failed to ensure an admission Minimum Data Set (MDS) assessment was completed within the specified 14-day timeframe for one resident (#293). The census was 43 residents. The deficient practice can result in a lack of gathering important quality data and quality monitoring.

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F 0636 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) Findings include: Resident #293 was readmitted to the facility on (MONTH) 13, 2019 with [DIAGNOSES REDACTED]. Review of the resident's MDS assessments revealed that an entry MDS dated (MONTH) 13, 2019 was completed, but there was no evidence that an admission MDS assessment was initiated or completed. An interview was conducted on (MONTH) 24, 2019 at 12:20 p.m. with a MDS nurse (staff #87). Staff #87 stated the timeframe for the completion of the admission MDS assessment is within 14 days of admission. Staff #87 further stated that an admission MDS assessment should have been completed by (MONTH) 26, 2019 for this resident. Staff #87 stated she works full time at a sister facility and was helping this facility since they did not have a MDS nurse. She stated that the regional MDS nurse (staff #88) was also helping and was responsible for scheduling and keeping track of the MDS assessments. An interview was conducted on (MONTH) 24, 2019 at 12:40 p.m. with a regional MDS nurse (staff #88). Staff #88 stated she is responsible to ensure that MDS assessments are opened and staff #87 is responsible for completing them. She said staff #87 comes here from a sister facility to do the MDS and it is kind of a fractured stop-gap system. Staff #88 said when a resident comes in she opens the entry, admission, and 5-day (if needed) MDS assessments on the same day. She said the admission assessment has to be completed by day 14, but that this is not always happening because the facility does not have a full-time MDS nurse at this time. Staff #88 stated that for this resident, they should have completed an admission assessment and that she would open one on this date, but it will be completed late. Review of the facility's RAI and MDS policy revealed that the MDS will be completed timely and accurately per federal guidelines and will serve as a foundation for the comprehensive care planning process. The policy included that the completed MDS will be electronically transmitted to the state per federal and state guidelines. The policy noted that to avoid late transmittal, it is recommended that a weekly schedule of transmission be kept by the facility. The RAI manual notes that the admission MDS assessment is a comprehensive assessment and must be completed by the end of day 14. The manual includes that federal statute and regulations require that residents are assessed promptly upon admission, but no later than 14 days after admission, and the results are used in planning and providing appropriate care to attain or maintain the highest practicable well-being.
F 0638 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Assure that each resident's assessment is updated at least once every 3 months.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, interviews, policy review and the Resident Assessment Instrument (RAI) manual, the facility failed to ensure quarterly Minimum Data Set (MDS) assessments were completed timely for 7 out of 10 sampled residents (#11, #17, #19, #22, #25, #33 and #39). The census was 43 residents. The deficient practice could result in a lack of monitoring for critical indicators of change in a resident's status. Findings include: -Resident #11 was admitted to the facility on (MONTH) 2, 2004 with [DIAGNOSES REDACTED]. A quarterly MDS assessment dated (MONTH) 10, 2019 included a completion date of (MONTH) 26, 2019. Review of the MDS Final Validation Report revealed the assessment was completed late, more than 14 days after the ARD (Assessment Reference Date). -Resident #17 was admitted to the facility on (MONTH) 5, (YEAR) with [DIAGNOSES REDACTED]. A quarterly MDS assessment dated (MONTH) 9, 2019 included a completion date of (MONTH) 28, 2019. Review of the MDS Final Validation Report revealed the assessment was completed late, more than 14 days after the ARD (Assessment Reference Date). -Resident #19 was admitted to the facility on (MONTH) 23, 2006 with [DIAGNOSES REDACTED]. A quarterly MDS assessment dated (MONTH) 4, 2019 included a completion date of (MONTH) 23, 2019. Review of the MDS Final Validation Report revealed the assessment was completed late, more than 14 days after the ARD. -Resident #22 was admitted to the facility on (MONTH) 20, 2007 with [DIAGNOSES REDACTED]. A quarterly MDS assessment dated (MONTH) 26, 2019 included a completion date of (MONTH) 16, 2019. Review of the MDS Final Validation Report revealed the assessment was completed late, more than 14 days after the ARD. -Resident #25 was admitted to the facility on (MONTH) 21, 2019 with [DIAGNOSES REDACTED]. A quarterly MDS assessment dated (MONTH) 27, 2019 included a completion date of (MONTH) 17, 2019. Review of the MDS Final Validation Report revealed the assessment was completed late, more than 14 days after the ARD. -Resident #33 was admitted to the facility on (MONTH) 6, (YEAR) with [DIAGNOSES REDACTED]. A quarterly MDS assessment dated (MONTH) 12, 2019 included a completion date of (MONTH) 29, 2019. Review of the MDS Final Validation Report revealed the assessment was completed late, more than 14 days after the ARD. -Resident #39 was admitted to the facility on (MONTH) 26, (YEAR) with [DIAGNOSES REDACTED]. A quarterly MDS assessment dated (MONTH) 2, 2019 included a completion date of (MONTH) 17, 2019. Review of the MDS Final Validation Report revealed the assessment was completed late, more than 14 days after the ARD. In an interview with a MDS nurse (staff #87) on (MONTH) 24, 2019 at 12:30 p.m., she stated that she currently worked at a sister facility and has been helping out at this facility with MDS assessments. She stated MDS assessments should be completed 14 days after the ARD. She also stated the assessment should then be transmitted to CMS 14 days after the assessment is complete. She stated she did not have access to transmit MDS assessments until recently. She was unsure why the assessments would not have been transmitted timely. In an interview with the Director of Nursing (DON/staff #44) on (MONTH) 24, 2019 at 1:19 p.m., she sated the expectation is that MDS assessments should be completed and transmitted in a timely matter. A facility policy titled, Resident Assessment Instrument (RAI/MDS) dated (MONTH) 2011 included, The Resident Assessment Instrument (RAI) will be completed timely and accurately, per Federal Guidelines, and will serve as a foundation for the comprehensive care planning process. Further, The completed MDS will be electronically transmitted to the State per policy of the Federal and state guidelines. Review of the RAI manual revealed that the MDS assessment should be completed and signed by each person completing a section or portion of a section no later than 14 days after the ARD date. The manual also included that the quarterly assessment is used to track a resident's status between comprehensive assessments to ensure critical indicators of gradual change in a resident's status are monitored.
F 0640 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, interviews, review of facility policy, and the Resident Assessment Instrument (RAI) manual, the facility failed to ensure Minimum Data Set (MDS) assessments were transmitted to the Centers for Medicare and Medicaid (CMS) system timely for 10 out of 10 sampled residents (#9, #11, #17, #19, #22, #25, #27, #33, #37 and #39). The facility census was 42 residents. The deficient practice could result in delays in receiving resident specific information related to quality measure purposes Findings include: -Resident #9 was admitted to the facility on (MONTH) 14, (YEAR) with [DIAGNOSES REDACTED]. A quarterly MDS assessment dated (MONTH) 18, 2019 included a completion date of (MONTH) 2, 2019. Review of the MDS Final Validation Report revealed the assessment was transmitted and accepted by CMS on (MONTH) 21, 2019, and the submission date was more than 14 days after the assessment completion date. -Resident #11 was admitted to the facility on (MONTH) 2, 2004 with [DIAGNOSES REDACTED]. A quarterly MDS assessment dated (MONTH) 10, 2019 included a completion date of (MONTH) 26, 2019. Review of the MDS Final Validation Report revealed the assessment was transmitted and accepted by CMS on (MONTH) 21, 2019, and the submission date was more than 14 days after the assessment completion date. -Resident #17 was admitted to the facility on (MONTH) 5, (YEAR) with [DIAGNOSES REDACTED]. A quarterly MDS assessment dated (MONTH) 9, 2019 included a completion date (MONTH) 28, 2019. Review of the MDS Final Validation Report revealed the assessment was transmitted and accepted by CMS on (MONTH) 21, 2019,

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F 0640 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) and the submission date was more than 14 days after the assessment completion date. -Resident #19 was admitted to the facility on (MONTH) 23, 2006 with [DIAGNOSES REDACTED]. A quarterly MDS assessment dated (MONTH) 4, 2019 included a completion date of (MONTH) 23, 2019. Review of the MDS Final Validation Report revealed the assessment was transmitted and accepted by CMS on (MONTH) 21, 2019, and the submission date was more than 14 days after the assessment completion date. -Resident #22 was admitted to the facility on (MONTH) 20, 2007 with [DIAGNOSES REDACTED]. A quarterly MDS assessment dated (MONTH) 26, 2019 included a completion date of (MONTH) 16, 2019. Review of the MDS Final Validation Report revealed the assessment was transmitted and accepted by CMS on (MONTH) 21, 2019, and the submission date was more than 14 days after the assessment completion date. -Resident #25 was admitted to the facility on (MONTH) 21, 2019 with [DIAGNOSES REDACTED]. A quarterly MDS assessment dated (MONTH) 27, 2019 included a completion date of (MONTH) 17, 2019. Review of the MDS Final Validation Report revealed the assessment was transmitted and accepted by CMS on (MONTH) 21, 2019, and the submission date was more than 14 days after the assessment completion date. -Resident #27 was admitted to the facility originally (MONTH) 18, 2010 with [DIAGNOSES REDACTED]. A quarterly MDS assessment dated (MONTH) 16, 2019 included a completion date of (MONTH) 29, 2019. Review of the MDS Final Validation Report revealed the assessment was transmitted and accepted by CMS on (MONTH) 21, 2019, and the submission date was more than 14 days after the assessment completion date. -Resident #33 was admitted to the facility on (MONTH) 6, (YEAR) with [DIAGNOSES REDACTED]. A quarterly MDS assessment dated (MONTH) 12, 2019 included a completion date of (MONTH) 29, 2019. Review of the MDS Final Validation Report revealed the assessment was transmitted and accepted by CMS on (MONTH) 21, 2019, and the submission date was more than 14 days after the assessment completion date. -Resident #37 was admitted to the facility on (MONTH) 10, 2019 with [DIAGNOSES REDACTED]. A quarterly MDS assessment dated (MONTH) 17, 2019 included a completion date of (MONTH) 29, 2019. Review of the MDS Final Validation Report revealed the assessment was transmitted and accepted by CMS on (MONTH) 21, 2019, and the submission date was more than 14 days after the assessment completion date. -Resident #39 was admitted to the facility on (MONTH) 26, (YEAR) with [DIAGNOSES REDACTED]. A quarterly MDS assessment dated (MONTH) 2, 2019 included a completion date of (MONTH) 17, 2019. Review of the MDS Final Validation Report revealed the assessment was transmitted and accepted by CMS on (MONTH) 21, 2019, and the submission date was more than 14 days after the assessment completion date. In an interview with a MDS nurse (staff #87) on (MONTH) 24, 2019 at 12:30 p.m., she stated that she currently worked at a sister facility and has been helping out at this facility with MDS assessments. She stated MDS assessments should be completed 14 days after the ARD (assessment reference date). She also stated the assessment should then be transmitted to CMS 14 days after the assessment is complete. She stated she did not have access to transmit MDS assessments until recently. She was unsure why the assessments would not have been transmitted timely. In an interview with the Director of Nursing (DON/staff #44) on (MONTH) 24, 2019 at 1:19 p.m., she sated the expectation is that MDS assessments should be completed and transmitted in a timely matter. A facility policy titled, Resident Assessment Instrument (RAI/MDS) dated (MONTH) 2011 included, The Resident Assessment Instrument (RAI) will be completed timely and accurately, per Federal Guidelines, and will serve as a foundation for the comprehensive care planning process. Further, :The completed MDS will be electronically transmitted to the State per policy of the Federal and state guidelines. Review of the RAI manual revealed the quarterly MDS assessment completion date, which is the date the Registered Nurse (RN) certifies the assessment is complete with a signature, must be no later than 14 days after the Assessment Reference Date (ARD). The manual also included the quarterly assessment must be transmitted within 14 days of the MDS assessment completion date to the CMS system.
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 review, the facility failed to ensure that a baseline care plan was developed within 48 hours of admission for one resident (#293). The facility census was 43 residents. The deficient practice could result in resident care needs not being met. Findings include: Resident #293 was readmitted on (MONTH) 13, 2019, with [DIAGNOSES REDACTED]. Review of a nutritional assessment dated (MONTH) 13, 2019 revealed the resident was at risk for malnutrition as evidenced by significant weight loss times three months and disease progression with dementia. Review of the physician's orders [REDACTED]. -Total 24 hour fluid intake, every night shift for hydration. Recommended 24 hour total to be over 1500 milliliters (ml). Notify physician if resident does not meet recommended intake less than or equal to 4 days out of 7. -[MEDICATION NAME] (a blood pressure medication) 12.5 milligrams (mg) by mouth one time a day. Hold for Systolic Blood Pressure (SBP) less than 100 millimeters of mercury (mmHg); hold for heart rate less than 60 beats per minute (BPM). -Eliquis (a blood thinner) 5 mg by mouth two time a day for prevention of venous thromoboembolism (a kind of blood clot). -[MEDICATION NAME] (an antipsychotic medication) 25 mg intramuscularly every 14 days related to [MEDICAL CONDITION]. In addition, the clinical record also showed that the resident had behaviors of self isolation and verbal and physical aggression toward staff and residents. However, there was no evidence that a baseline care plan had been developed for the resident which addressed the above concerns. An interview was conducted on (MONTH) 24, 2019 at 9:59 a.m. with a Licensed Practical Nurse (LPN/staff #61). She stated when a resident comes into the facility, the Director of Nursing (DON) initiates the baseline care plan and she or social services will go over the baseline care plan with the resident or their representative. She said they have to start the baseline care plan within 24 hours of admission. An interview was conducted on (MONTH) 24, 2019 at 10:09 a.m. with a Registered Nurse (RN/staff #54). Staff #54 stated when a resident is admitted , the baseline care plan is initiated by the MDS coordinator. He stated the DON and Director of Staff Development go over the baseline care plan with the resident and/or their representative. He said the baseline care plan is supposed to be initiated in the first 24 hours of admission. An interview was conducted on (MONTH) 24, 2019 at 12:52 p.m. with the DON (staff #44). The DON stated the baseline care plan is developed by the floor nurse on admission and should be completed within 24 hours. She stated that she did not know what had happened with the baseline care plan for this resident. The DON stated when an admit comes in, the baseline care plan should be initiated and completed within 24 to 48 hours of admission by the nurses. She said that is is part of the admission process. She stated that she expects the nurse who is admitting the resident to go over the baseline care plan with the resident or their representative at the time of admission. After reviewing the clinical record for resident #293, the DON stated the baseline care plans should have been initiated for this resident after admission. Review of the policy titled, Care Plan, Baseline and Comprehensive revealed it is the policy of the facility to develop an interim care plan for the resident upon admission. A baseline care plan will be implemented within 48 hours of admission.
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation, resident and staff interviews and policy review, the facility failed to ensure one sampled resident (#293) received an adequate number of showers. The deficient practice could result in

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F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4) hygiene needs not being met. Findings include: Resident #293 was initially admitted on (MONTH) 4, (YEAR), and discharged on (MONTH) 18, 2019. The resident was then readmitted on (MONTH) 13, 2019, with [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. Review of the psychiatric progress note dated (MONTH) 18, 2019, revealed the resident was oriented to person, time and place. The note also included the resident needed bathing assistance and assistance with dressing, toileting and transfers. Review of the activities of daily living (ADL) documentation for showers for the month of (MONTH) 2019 revealed the resident refused a shower once on (MONTH) 21, and received one shower on (MONTH) 25. There was no other documentation that the resident received any additional showers in September. Review of the ADL documentation for showers for the month of (MONTH) 2019 revealed the resident received a shower on (MONTH) 2 and (MONTH) 16, and refused a shower on (MONTH) 19. There was no other documentation that the resident received any additional showers in October. During an interview conducted with resident #293 on (MONTH) 21, 2019 at 10:18 a.m., the resident stated no showers or bed baths were given to her since her admission which was about a month ago. She stated that she has asked staff to shower her many times and they don't say anything, they just turn around and walk out. During the interview in the resident's room, there was a strong odor of urine. An interview was conducted with a Certified Nursing Assistant (CNA/staff #5) on (MONTH) 23, 2019 at 8:44 a.m. She stated that all residents are scheduled to have a shower at least two times a week. Staff #5 said if a resident refuses a shower, they document the refusal in the electronic record under ADL's for showers and report the refusal to the nurse. Staff #5 stated if the shower is provided, it is documented in the electronic record under ADL's for showers and includes the type of assistance provided. She also stated that some times they are not able to complete all the scheduled showers, because the resident keeps putting the shower off for later and they don't have time at the end of the shift. She said if this happens, they pass it on in report and the other CNA is supposed to give the shower. An interview was conducted with a CNA (staff #10) on (MONTH) 23, 2019 at 10:28 a.m. She stated if a resident is given a shower, it is documented in the electronic record under showers in tasks and a skin sheet is filled out and given to the nurse. The CNA stated if the resident refuses the shower, the refusal is documented in the electronic record. She stated that all residents have assigned showers twice a week and there has never been an instance where she was unable to complete her assigned showers. An interview was conducted on (MONTH) 23, 2019 at 10:41 a.m., with a licensed practical nurse (LPN /staff #65). The LPN stated the CNA's are responsible to give a shower and document it. The LPN said if a resident refuses a shower the CNA will notify the nurse and the nurse will try to encourage the resident to take a shower. The LPN said if the resident continues to refuse, then the CNA's are expected to document the refusal in the electronic record. An interview was conducted on (MONTH) 24, 2019 at 12:52 p.m., with the Director of Nursing (DON/staff #44). She stated the residents are scheduled for showers twice a week. She stated that she expects the CNA's to give residents their showers on their shower days. Staff #44 said when the CNA gives a shower they are supposed to document it under the task for showers and if a resident refused a shower the CNA is supposed to notify the nurse who should be encouraging the resident to take a shower. The DON said if the resident continues to refuse then she expects it to be documented in the electronic records. Review of a policy titled, Resident Care Routine revealed that basic nursing care task (which included personal cleanliness and routine activities of the daily living) will be provided to each resident based on resident needs. It also stated that each resident is to receive bed bath or showers at least twice weekly and they can be scheduled at various time of the day, and can be modified according to the residents' condition, preferences or desires whenever possible.
F 0686 **Level of harm** - 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 observation, clinical record review, resident and staff interviews and policies and procedures, the facility failed to complete thorough and timely assessments for one of two sampled residents (#16) who developed a pressure ulcer. The deficient practice resulted in a lack of consistent monitoring of skin breakdown/pressure ulcers and a delay in identifying any wound deterioration and implementing additional interventions. Findings include: Resident #16 was re-admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A care plan identified that the resident was at risk for skin breakdown related to decreased mobility, weakness and a right above the knee amputation and a left [MEDICAL CONDITION]. The goal was to keep the resident free from pressure injuries with preventative measures. The interventions included extensive assistance in turning and repositioning as needed or requested, monitoring nutritional status, monitoring skin daily and use of a pressure reducing mattress on the bed and a pressure reducing cushion to the wheelchair. A nurses note dated 7/11/2019 at 5:16 p.m. included the resident had no new skin issues. A weekly skin check dated 7/11/2019 at 5:44 p.m. revealed the resident's skin was in good condition. There are no wounds identified on this assessment. A nurses note dated 7/12/2019 2:57 p.m. revealed the resident refused to have her skin checked by the nursing staff. The resident told the staff that she wanted it done at night when she got into bed. Per the note, the nurse told the resident that there's a certain amount of time that we have to obtain a skin check. Another nurses note dated 7/12/2019 at 4:25 p.m. revealed the resident refused a second attempt at a skin check. A Braden Scale for Predicting Pressure Sore Risk was completed on 7/12/2019 and the resident was at risk for developing a pressure sore. A physician's orders [REDACTED]. Review of the clinical record revealed there was no documentation that the resident had a pressure ulcer to the buttocks area from readmission on (MONTH) 11 through (MONTH) 18. A weekly skin check was completed on 7/19/2019 at 2:44 p.m. and identified that the resident had an area on the right and left ischium that required follow-up. No further information was included. According to a Skin and Wound Evaluation dated 7/19/2019 at 2:47 p.m., the resident had moisture associated skin damage, but no wounds were identified. The documentation included that the issues on the right and left ischium were resolved, but the resident was still at risk for impaired skin related to staying in her wheelchair the majority of the day, without offloading. A weekly skin check dated 7/24/2019 revealed the resident's skin did not have any open areas or redness. A quarterly admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. Per the MDS, the resident required extensive assistance with bed mobility and transfers and was at risk for pressure injuries, however none were present. A Braden scale was completed on 8/2/2019 and the resident was at risk for developing a pressure sore. A weekly skin check was completed on 8/8/2019 and the resident's skin was described as being in good condition. There were no wounds identified on this assessment. The nurses monthly summary completed on 8/9/19 revealed the resident did not have any skin conditions requiring treatment or monitoring. Review of the (MONTH) 2019 Medication Administration Record/Treatment Administration records (MAR/TAR) revealed no documentation that barrier cream had been applied to the buttocks area. The nurses monthly summary completed on 9/9/19 revealed the resident did not have any skin conditions requiring treatment or monitoring. Weekly skin checks were completed on 9/11/2019 and 9/18/19 and revealed the resident's skin was in good condition. There were no wounds identified on the assessments. A physician's orders [REDACTED]. A weekly skin check was completed on 9/25/2019 and the resident's skin was identified as being in good condition. There were no wounds identified on this assessment. Review of the (MONTH) 2019 MAR/TAR revealed no documentation that barrier cream had been applied to the buttocks area. The

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F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 5) TAR did include the order for a Roho cushion to wheelchair, check for proper inflation every day. Per the documentation, this was done from (MONTH) 21-30. A physician's orders [REDACTED]. Per the (MONTH) 2019 MAR/TAR, the Zinc Oxide was applied on (MONTH) 1 and 2. Despite a physician's orders [REDACTED]. A weekly skin check dated 10/3/19 included that the resident's skin was in good condition. There was no mention of excoriation to the buttocks area and no wounds were identified on this assessment. The order for Zinc Oxide 25% paste was discontinued on 10/3/2019. A physician's orders [REDACTED]. According to the MAR/TAR for (MONTH) 2019, the Zinc Oxide was applied as ordered from (MONTH) 3-7. A nurses note dated 10/7/19 revealed that a CNA reported the resident had a skin issue to the buttocks. It was determined by the nurse practitioner (NP) on site that the area was excoriated and she would order [MEDICATION NAME] cream and a dressing to the area. Per the note, the resident was instructed to rotate positions while sitting and to lay down to offload pressure on the site. A physician's orders [REDACTED]. Per the (MONTH) 2019 TAR, this treatment was initiated on (MONTH) 8 on the evening shift. In addition, the (MONTH) 2019 MAR indicated [REDACTED]. As a result, the [MEDICATION NAME] treatment to the buttocks was completed twice a day from (MONTH) 8-17, once on the day shift and once on the evening shift, instead of once a day as ordered. A weekly skin check was completed on 10/8/19 and noted that the resident had excoriation to the buttocks (left and right gluteal fold) that required follow-up. The nurses monthly summary dated 10/9/2019 at 5:36 p.m. revealed the resident had excoriation that required treatment and monitoring. A nursing note entered on 10/9/19 at 6:00 p.m. included the resident was on Change of Condition (C[NAME]) for treatment of [REDACTED]. The note stated treatment done as ordered and the nurse will continue to monitor. A weekly skin check was completed on 10/11/19 which identified that the resident had excoriation to the buttocks. A weekly skin check was completed on 10/17/2019 and the resident had excoriation to the buttocks. A nurses note dated 10/17/2019 revealed the resident was on a C[NAME] for excoriation to the buttocks and complained of generalized pain. Despite ongoing documentation that the resident had excoriation to the buttocks area, there was no documentation of a thorough assessment of the area, which included a description, measurements and specific location of the excoriated area from 10/1/19 through 10/17/19, for a period of 17 days. A nurses note dated 10/18/2019 at 2:43 p.m. revealed the resident spent a good time up in her wheelchair and complained of pain, and that the resident was on a C[NAME] for excoriation of the buttocks. Further review of the (MONTH) 2019 TAR revealed the order for a Roho cushion to wheelchair and to check for proper inflation every day. Per the documentation, this was done from (MONTH) 1-18. Review of a Skin and Wound Evaluation dated 10/18/19 at 7:29 p.m., revealed the resident had a medical device related pressure injury on the left ischeal tuberosity, which was identified as a stage 3 (full thickness skin loss). The documentation included it was a new in-house acquired injury. Per the documentation, the pressure ulcer wound bed was pink/red, measured 0.9 centimeters (cm) by 2.5 cm by 0.0 cm in depth, no undermining or tunneling, had a light amount of serosanguineous exudate, no odor, the wound edges appeared flush with the wound and the surrounding tissue was denuded. The evaluation indicated therapy to monitor for proper wheelchair cushion. A physician's orders [REDACTED]. Another order on 10/18/19 included to monitor the stage 3 pressure injury to the left ischium for signs and symptoms of infection or deterioration every day with wound care. A care plan was initiated on 10/18/19 for the mechanical stage 3 pressure injury to the left ischium related to cushion placement. The goals were that the resident would have no complications related to the left ischium pressure injury and that the injury would show signs of healing. Interventions were to assist the resident to change positions frequently in bed and chair, educate the resident and caregivers of causative factors and measures to prevent skin injury, follow the facility protocols for treatment of [REDACTED]. Nurses notes dated (MONTH) 19, 20 and 21, 2019 included the resident was on a C[NAME] for excoriation to the buttocks. An interview was conducted with the resident on 10/21/19 at 11:47 a.m. Resident #16 stated the wounds on her bottom started at the facility over the last few months. She stated the cushion on her chair hurts her bottom and it feels like a sharp pressure. She said that she has told the staff many times that she is in pain and sometimes when she needs to lay down to get off her bottom, the staff are too busy to help. She stated that every time the staff touches her bottom or when she sits in the wheelchair it hurts. A nurses note dated 10/21/2019 at 8:09 p.m. stated the resident was on a C[NAME] for excoriation to buttocks and complained of generalized pain. A nurses note dated 10/22/2019 at 5:21 a.m. stated the resident was on a C[NAME] for excoriation to buttocks and complained of generalized pain. A wound observation was conducted on 10/22/19 at 12:51 p.m., with a Licensed Practical Nurse (LPN/staff #65). Resident #16 was placed on her right side and staff #65 removed the old dressing. The nurse then cleansed the pressure ulcer to the left ischeal tuberosity with a wound cleanser. The entire wound area was observed to be approximately 4 cm long by 4 cm wide and was beefy red, except for an area at the top of the wound which was approximately the size of a dime and was dark in color. Within this area, there was a hole with depth. No odor or drainage were noted. At this time, staff #65 only measured the dime sized area and did not measure the entire wound area. Staff #65 was then asked to measure the entire wound. When asked about the depth of the wound, she stated that the wound had no depth. The nurse then completed the wound treatment as ordered. An interview was conducted with staff #65 on 10/23/19 at 10:03 a.m. She stated that the Restorative Nursing Assistant (RNA) manages the resident's ROHO cushion. She stated she was not aware of any current issues with the cushion. An interview was conducted with a CNA (staff #11) on 10/23/19 at 11:41 a.m. She stated that the wound started out as a small little wound that just got bigger over time. She stated she first noticed it about three weeks ago. She stated that anytime she notices any changes in the resident during showers she gets the nurse right away. She stated that over the past week, the resident has been complaining about the ROHO cushion, but the provider was aware. An interview was conducted with a RNA (staff #52) on 10/23/19 at 12:03 p.m. She stated sometimes the resident complains that the cushion is not balanced. She stated to adjust the cushion she continues to add air until she doesn't hear it anymore. Then she placed her hand between the resident and the cushion to ensure there was a space. She said the resident likes to have the air taken out so that it is softer for her and so she can move around from side to side. She stated that she spoke with the provider on 10/22/2019 about the cushion and was instructed to adjust the air in the cushion. She stated the resident has never told her of any issues with her cushion except on 10/22/2019. She stated the resident told her it didn't fit right. An observation of the resident was conducted on 10/23/19 at 8:25 a.m. The resident was observed approaching the nurse and reported that she was in pain and would like some Tylenol. The nurse asked the resident what her pain level was and the resident stated her pain was a 10 out of 10. The resident said to the nurse that she needs a new ROHO cushion, because hers is too hard. A clinical record review revealed that on 10/23/19 at 2:24 p.m., a new ROHO cushion for the wheelchair was ordered. An interview was conducted with a LPN (wound nurse/staff #89) on 10/23/19 at 12:45 p.m. She stated that she was notified of the wound on the 10/18/19. She stated the injury was related to the ROHO cushion being too small for the resident's wheelchair. She stated that she did not notify the provider herself. An interview was conducted with the Director of Nursing (DON/staff #44) and the Corporate Educator (staff #86) on 10/24/19 at 10:31 a.m. The DON stated that CNA's should be looking at the residents' skin daily and should report changes to the nurse, and the nurse should then assess the resident and report their findings in the electronic health record (EHR) and to the physician. She stated the nurses complete a weekly skin assessment and the wound nurse should do an assessment based on the physician orders. Staff #86 said the excoriation on this resident was first identified on (MONTH) 8 and it became an

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F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 6) open wound on (MONTH) 18. Staff #86 said the resident has had previous pressure ulcers and she doesn't have normal skin, so she is more likely to develop such wounds. She stated a pressure injury can develop within hours. Staff #44 stated that the previous interventions in place was an overlay mattress and the ROHO cushion. She said the nursing staff are responsible for documenting that a resident refuses care or treatment for [REDACTED].#86 stated the staff would then educate the resident on the risks related to not receiving the treatment and notify the physician that the resident is not wanting care. The DON and staff #86 both stated the pressure injury is improving. The DON further stated if the team meets and notices changes in the resident's condition, then the provider is notified. She stated those meetings are held weekly to review the resident's record, checking the resident to assess the current status and speaking with the resident, and asking staff if the care plan is working. She stated that appropriate interventions for a resident at risk for a pressure injury would include a pressure reducing mattress, a referral to occupational therapy for a wheelchair cushion, an order for [REDACTED]. Continued in this same interview staff #86 stated that she did not believe the cushion caused the wound, as it did not have sole ownership of the wound. She stated it does not matter if the cushion is too small or too big. Review of a policy titled, Wound Management Guidelines revealed It is the philosophy of this facility to ensure that resident skin status is assessed and appropriate interventions are implemented. The goal is to maintain skin integrity, assist in wound healing and prevent avoidable skin breakdown as determined for each individual resident. The policy included that the pressure injury wound treatment and prevention program will focus on the following strategies: Evaluate the resident for risk of pressure injuries and any existing pressure injuries; manage tissue loads (i.e. support surfaces); wound care and treatment; managing infection, education and quality improvement; providing adequate nutrition and nutritional supplementation and treatment as ordered. A policy titled, Change of Condition, Resident revealed It is the policy of this facility to identify, inform the physician and resident or resident representative, and intervene to provide medical or nursing care for a resident experiencing an acute medical change of condition in a timely and effective manner . The policy included that upon noting or receiving a report of a change in the resident's status, the nurse will evaluate the resident's condition and notify the resident's physician of the clinical findings and implement new orders as given and to document assessments and interventions in the clinical record. Review of a policy titled, Licensed Nurses - Assessments and Notes revealed Meaningful and informative notes shall be written by a licensed nurse to reflect the care and treatment, observations and assessments and other appropriate entries.
F 0697 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide safe, appropriate pain management for a resident who requires such services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, resident and staff interviews and policy and procedures, the facility failed to thoroughly assess and adequately manage one of two sampled resident's (#16) pain. The deficient practice could result in unrelieved pain for residents. Findings include: Resident #16 was re-admitted to the facility on [DATE] and readmitted on [DATE], with [DIAGNOSES REDACTED]. A care plan was initiated due to chronic pain related to spinal stenosis of the lumbar region with placement of a neurostimulator, phantom limb syndrome from bilateral amputations and bladder pain (being seen by urology). The goal was to provide normal activities uninterrupted by pain. The interventions included the following: anticipating the resident's need for pain relief and respond immediately to any complaint of pain; evaluate the effectiveness of pain interventions every shift and as needed; review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results; impact on functional ability; give scheduled and as needed pain medications as ordered and as requested; adjust neurotransmitter as needed and charge battery of transmitter as ordered; monitor and record pain characteristics every shift and as needed: quality (e.g. sharp, burning), severity (1-10 scale), anatomical location, onset, duration (e.g. continuous, intermittent), aggravating factors and relieving factors and monitor/record/report to nurse any signs or symptoms of non-verbal pain such as; labored breathing, grunting, moaning, yelling out, mood/behavior changes, restlessness, sadness, crying, aggressive behaviors and grimacing. The interventions further included to notify the physician if interventions were unsuccessful or if current complaint is a significant change from past experience of pain. Review of the (MONTH) 2019 Medication Administration Record (MAR) revealed the resident was receiving the following medications: [REDACTED]. Also included in these orders were non pharmacological interventions (NPI) which were to be implement: one-on-one, activity, adjust room temperature, back rub, change position, give fluids, give food, redirect, refer to nurses notes, remove resident from environment, return to room and toilet. Nurses notes dated (MONTH) 12, 13 and 14, 2019 included the resident complained of chronic pain and was medicated with good results. Review of an admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. Per the MDS, the resident required extensive assistance with bed mobility and transfers and received scheduled and as needed pain medication for almost constant pain. According to the (MONTH) 2019 MAR, the resident received [MEDICATION NAME] 1 tablet as needed approximately 46 times for pain levels between 5-10. The documentation also showed that the medication was effective when given. However, review of the clinical record revealed there was no consistent documentation in (MONTH) 2019 regarding non pharmacological interventions which were implemented to address the resident's pain, and there was no consistent documentation regarding the monitoring and recording of pain characteristics which included quality, location, onset, duration, aggravating factors and relieving factors as care planned, which corresponded to when the resident was experiencing pain. A nurses monthly summary completed on 8/9/19 included the resident had a pain level of 5 (indicating moderate pain), which was partially or fully controlled by medication. Review of the (MONTH) 2019 MAR revealed the orders for [MEDICATION NAME] and Tylenol, including the non pharmacological interventions to be implemented. Further review revealed the resident was administered [MEDICATION NAME] as needed approximately 73 times for pain levels between 4-9. Review of the clinical record revealed there was no consistent documentation in (MONTH) 2019 regarding non pharmacological interventions which were implemented to address the resident's pain, and there was no consistent documentation regarding the monitoring and recording of pain characteristics which included quality, location, onset, duration, aggravating factors and relieving factors as care planned, which corresponded to when the resident was experiencing pain. Another physician's order dated 9/1/19 included for [MEDICATION NAME] 10-325 mg 1 tablet by mouth every 6 hours as needed for pain levels of 5-10. The order also included for non pharmacological interventions as follows: one-on-one, activity, adjust room temperature, back rub, change position, give fluids, give food, redirect, refer to nurses notes, remove resident from environment, return to room and toilet. This order was discontinued on 9/3/2019. A physician's order dated 9/3/2019 included for [MEDICATION NAME] 10-325 mg 1 tablet by mouth every 6 hours as needed for pain levels of 5-10. A physician's order dated 9/3/2019 also included for Tylenol 325 mg 2 tablets by mouth every 8 hours as needed for pain levels of 1-4. A nurses monthly summary dated 9/9/19 revealed the resident had a pain level of 6 (indicating moderate pain), which was partially or fully controlled by medication. The pain was described as [MEDICAL CONDITION], phantom, chronic and back pain.Review of a nurses note dated 9/14/19 at 12:26 p.m. revealed the resident approached the nurses station requesting pain medication and the nurse told the resident that it was too early, and it was unavailable at this time. Per the note, the resident became agitated and stated that she knew when she received it and could she have it now. The nurse told the resident it would be available in a half hour. According to the (MONTH) 2019 MAR, the resident received the last dose of [MEDICATION NAME] at 5:30 a.m. on 9/14. The order stated the resident could receive the medication every 6 hours as needed for pain. Based on the MAR documentation, the resident could have had the next dose of [MEDICATION NAME] at 11:30 a.m. However, the MAR showed the next [MEDICATION NAME] was administered to the resident at 2:15 p.m. Also included on the (MONTH) 2019 MAR was an order to adjust the spinal cord stimulator level as needed for comfort (the start date was noted as 9/17/2014). However, there was no documentation on the MAR that the spinal cord stimulator level

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035247	A. BUILDING _____ B. WING _____	10/24/2019

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MARYLAND GARDENS CARE CENTER	31 WEST MARYLAND AVENUE PHOENIX, AZ 85013

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 0697 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 7) had been adjusted. There were also no physician orders for any parameters for the spinal cord stimulator levels. Further review of the (MONTH) 2019 MAR revealed the orders for [MEDICATION NAME] 10-325 mg 1 tablet by mouth every 6 hours and for Tylenol 325 mg 2 tablets every 8 hours. The MAR also included the following non pharmacological interventions to be implemented for each medication: one-on-one, activity, adjust room temperature, back rub, change position, give fluids, give food, redirect, refer to nurses notes, remove resident from environment, return to room and toilet. The (MONTH) 2019 MAR also included documentation that the resident was administered [MEDICATION NAME] as needed approximately 87 times for pain levels between 5-10, and that Tylenol was given on two occasions. The documentation included that the medications were effective. Review of the clinical record revealed there was no consistent documentation in (MONTH) 2019 regarding non pharmacological interventions which were implemented to address the resident's pain, and there was no consistent documentation regarding the monitoring and recording of pain characteristics which included quality, location, onset, duration, aggravating factors and relieving factors as care planned, which corresponded to when the resident was experiencing pain. A physician's order dated 10/8/19 included for Tylenol 325 mg 2 tablets by mouth every 8 hours as needed for pain levels of 1-4. Review of a nurse practitioners (NP) note dated 10/9/19 revealed the resident reports 9-10 pain consistently. Resident asks for increased pain medication during every visit and asks for pain medication early multiple times per day. Resident becomes very tearful when told no. Resident does not exhibit facial grimacing, writhing, moaning or restlessness. When asked where location of pain is she often states back and bladder, but does not pinpoint. Resident displays signs of drug seeking behaviors. Despite documentation by the NP that the resident displays drug seeking behaviors, there was no care plan developed to address this, nor were there any interventions implemented to address any drug seeking behaviors. A nurses monthly summary completed on 10/9/19 revealed the resident had a pain level of 8 (indicating excruciating pain), which was partially or fully controlled by medication. Nurses notes from (MONTH) 10-13, 2019 indicated the resident complained of tactile pain and back pain and was medicated with good results. A nurses note dated 10/14/19 at 6:15 p.m. stated the resident was requesting something for pain from the nurse and the nurse told the resident it was too early for a pain pill. Review of the (MONTH) 2019 MAR revealed [MEDICATION NAME] was given at 12:45 p.m. A nurses note dated 10/17/19 at 5:19 a.m. revealed the resident was receiving treatment for [REDACTED]. Per the note, the resident received as needed medication with positive effect. Review of a Skin and Wound Evaluation dated 10/18/19 revealed the resident developed a medical device related pressure injury on the left ischeal tuberosity, which was identified as a stage 3. The documentation included the resident experienced intermittent pain. Nurses notes dated (MONTH) 18 and 19 included the resident was complaining of pain and was administered medication with positive effects and that the resident frequently requests as needed pain medication. A physician's order dated 10/20/19 included for Tylenol 325 mg 2 tablets by mouth every 8 hours as needed for pain levels of 1-4. The orders included for non pharmacological interventions as follows: redirect, 1:1, activity, return to room, toilet, give food, give fluids, change position, adjust room temperature and back rub. Nurses notes dated (MONTH) 21 and 22, 2019 revealed the resident complains of pain and was medicated with good results. Review of the MAR from (MONTH) 1 through 22, 2019 revealed the resident was provided as needed pain medication approximately 57 times. Continued review of the clinical record revealed there was no consistent documentation in (MONTH) 2019 regarding non pharmacological interventions which were implemented to address the resident's pain, and there was no consistent documentation regarding the monitoring and recording of pain characteristics which included quality, location, onset, duration, aggravating factors and relieving factors as care planned, which corresponded to when the resident was experiencing pain. An interview was conducted with the resident on 10/21/19 at 11:47 a.m. She stated that she was told to lay down when her pressure injury sores on her bottom get too painful from sitting in the wheelchair. She said the staff is often too busy to get her into bed to help ease some of the pain. She stated that she is in so much pain all the time. A wound care observation was conducted on 10/22/19 at 12:51 p.m., with a Licensed Practical Nurse (LPN/staff #65). Resident #16 was placed on her right side and then staff #65 removed the old dressing by pulling out and down away from the wound. As this was done, the resident yelled out in pain. Staff #65 stated that the resident did not get pain medication prior to this procedure, because the resident is on scheduled pain medication. At this time, the resident informed the nurse that she was in pain. The nurse replied to the resident that the pain was from the removal of the dressing and that she already received pain medication earlier that morning. A few minutes later, the resident informed the nurse that the wound felt like it was burning. Staff #65 continued providing wound care to the resident. In a review of the (MONTH) 2019 MAR, the documentation showed that resident was last medicated at 4:30 a.m. on (MONTH) 22, with 1 tablet of [MEDICATION NAME]. In reviewing the Narcotic Count Sheet for the resident, the documentation showed that 1 tablet of [MEDICATION NAME] had been signed out at 10:30 a.m. on (MONTH) 22, by staff #65. However, this was not documented on the MAR. Staff #65 acknowledged that the medication was signed out on the narcotic count sheet, but was not documented on the MAR. An interview was conducted with the resident on 10/22/19 at 1:56 p.m. She stated that she is still in pain from the dressing change on her pressure injury. She said that during the entire dressing change she was in pain. The resident said that she was told that she has to wait until 4:30 p.m. for her next pain medication. An observation of the resident was conducted on 10/23/19 at 8:25 a.m. The resident approached the nurse administering medications and reported that she was in pain and would like Tylenol. The nurse prepared the resident's morning medications and then asked the resident what her pain level was. The resident stated her pain was 10 out of 10. An interview was conducted with staff #65 on 10/23/19 at 10:03 a.m. She stated that she would consider several things when assessing if a resident is in pain. She said that she would look at how they are moving their body if they are guarding, if they have verbal or facial expressions of pain or any changes in behaviors. She said that she would ask the resident what their pain level was using the 1-10 pain scale and would have the resident describe their pain. She said she would then medicate and re-evaluate in 30 minutes. She stated that she charts the assessment in the electronic health record. She stated the reason she did not give the resident pain medication during the dressing change was because the resident did not have pain, until the dressing was taken off. An interview was conducted with the Director of Nursing (DON/staff #44) and the Corporate Educator (staff #86) on 10/24/19 at 10:31 a.m. The DON stated that staff use the 1-10 pain scale to assess a resident's pain and they need to ask residents their pain level. She stated the staff need to identify residents on pain management and anticipate their needs. She said the nurses are to check the order to make sure the correct medication is being administered for the pain level, and reassess within an hour to see if the medication was effective or not. She said that even if a resident is on scheduled pain medication, they may also have an order for [REDACTED]. The DON stated that care is driven by the provider orders which are used to develop the plan of care for each individual resident. She also said the documentation of care should be entered into the electronic medical record, per facility policy. Review of a policy titled, Pain Management revealed This facility recognizes a patient's right to be free of pain and promotes pain relief through the use of the Pain Management Plan during the patient duration of stay at the facility to help the patient attain or maintain his or her highest practicable level of well-being and to prevent or manage pain to the extent possible. Staff are able to recognize when the patient is experiencing pain and identify circumstances when pain can be anticipated, evaluate the existing pain and the cause(s), pain is assessed when a patient complains of pain and after an [MEDICATION NAME] is given to determine effectiveness of the [MEDICATION NAME]. When pain is identified assessment and documentation includes pain scale rating, location, duration, intensity, and character. Effectiveness of current pain management techniques is discussed in the interdisciplinary patient team conference according to divisional requirements. A policy titled, Record Content: Licensed Nurses - Assessments and Notes included Meaningful and informative notes shall be written by a licensed nurse to reflect the care and treatment, observations and assessments and other appropriate entries.

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F 0697 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 8)
F 0732 **Level of harm -** Potential for minimal harm **Residents Affected -** Some	**Post nurse staffing information every day.** Based on observations, review of the nurse staffing information, staff interviews and policy review, the facility failed to ensure that the nurse staffing information was posted on a daily basis. Findings include: During an observation conducted on (MONTH) 21, 2019 at 8:36 a.m., the Daily Staff Posting was in a frame, on a small stand in the lobby adjacent to the Human Resources Office. The Daily Staff Posting form was dated (MONTH) 10, 2019. The posted nurse staffing information included the number of RN's (Registered Nurses), LPN's (Licensed Practical Nurses), CNA's (Certified Nursing Assistants), RNA's (Restorative Nursing Assistants) and the actual staff hours worked for each shift. Review of Daily Staff Posting forms conducted on (MONTH) 23, 2019 at 10:30 a.m. revealed there were Daily Staff Posting forms which had been completed from (MONTH) 2, through (MONTH) 22, 2019. During an interview conducted on (MONTH) 23, 2019 at 10:48 a.m. with the Health Information Director (staff #46), she stated that each day she fills out the Daily Staff Posting form and provides it to the Administrator (staff #15), who is responsible for posting it and maintaining a file of the previous Staff Posting forms in her office. During an interview conducted on (MONTH) 23, 2019 at 12:50 p.m. with the Administrator, she stated that she thought the Daily Staff Posting forms were completed by the Health Information Director and that the previously posted forms are filed in her office. She also stated that the previous staff member responsible for posting the staffing forms quit on (MONTH) 11, 2019 and no other staff has been in charge of it since. The Administrator stated we've been doing it but I don't know if they (the Daily Staff Posting forms) were being posted. A policy and procedure titled, Nurse Staffing revealed that the required nurse staffing information will be posted. The policy did not include that the nursing staff information is required to be posted daily.