STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035196	A. BUILDING _____ B. WING _____	**02/28/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MESA CHRISTIAN HEALTH AND REHABILITATION CENTER	**255 WEST BROWN ROAD MESA, AZ 85201**

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

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F 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policy review, the facility failed to ensure advanced directive information was accurate for one resident (#23). Findings include: Resident #23 was admitted to the facility on (MONTH) 8, (YEAR) and readmitted on (MONTH) 21, (YEAR), with [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. A quarterly Minimum Data Set (MDS) assessment dated (MONTH) 6, (YEAR) revealed a Brief Interview for Mental Status of 15, which indicated the resident was cognitively intact. However, further review of the clinical record revealed a Prehospital Medical Care Directive (Do Not Resuscitate) signed by the resident (no date) and a licensed health care provider dated (MONTH) 8, (YEAR). An Advanced Directive Decisions form was found in the clinical record, however it was blank. In an interview conducted with a Licensed Practical Nurse (LPN/staff #49) on (MONTH) 28, 2019 at 10:50 a.m., she stated that when residents are admitted to the facility, their advanced directive status is assessed and the nurse makes sure the resident fills out an advanced directive form. The LPN stated that if residents are readmitted from the hospital, their code status is checked to ensure it has not changed. She also stated that if a resident was to code and she needed to know their code status, she would look on the paper MAR (Medication Administration Record) on her chart to determine the code status. Review of the resident's MAR indicated [REDACTED]. In an interview conducted with another LPN (staff #49) on (MONTH) 28, 2019 at 11:58 a.m., she stated the admitting nurse is responsible for ensuring the resident fills out an advanced directive form. The LPN stated that if she needed to know the code status of a resident, she would look in the hard chart. Review of resident #23's hard chart revealed a DNR form. During an interview conducted with the Director of Nursing (DON/staff #37) on (MONTH) 28, 2019 at 12:06 p.m., he stated that the admission nurse assists the resident with filling out the advanced directive form which should be done within the first 24 hours of admission to the facility. He stated if a resident is readmitted from the hospital, the code status should be confirmed when they return. A facility's policy titled, Health Care Decision Making revealed It is the right of all patients to participate in their own health care decision making, including the right to decide whether they wish to accept or refuse life prolonging measure or other treatments. The policy also revealed the purpose is To assure that patients' wishes concerning health care decisions are communicated to all staff so that patients' rights will be honored and their wishes will be executed at the appropriate time.
F 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and resident and staff interviews, the facility failed to provide a homelike environment, by failing to ensure the environment was free of pervasive odors. Findings include: During an interview conducted with a resident on (MONTH) 25, 2019 at 10:12 a.m., the resident stated there are frequent strong odors of urine and poop outside of rooms 118-125. The resident also stated the residents have as much right to clean air and being clean as anyone else. An interview was conducted with another resident on (MONTH) 25, 2019 at 2:05 p.m. The resident stated that the shower in their room smelled like a sewer. The resident's room was on the hall that included rooms 127-130. During an observation conducted on (MONTH) 25, 2019 at 3:25 p.m., the hallway outside of rooms [ROOM NUMBERS] had a urine odor. An observation was conducted on (MONTH) 26, 2019 at 2:17 p.m. A urine odor was noted outside of rooms 127-130. On (MONTH) 28, (YEAR) at 10:00 a.m., an interview was conducted with the housekeeping manager (staff #180). She stated the housekeeping staff will deodorize rooms when there is an odor present that lingers. Staff #180 stated staff will find the source of the odor and deodorize as well. She also stated there are focus rooms that have been identified to have more frequent odors. She stated that those rooms are checked at least 3 times a day. Staff #180 said that because of lingering odors, they periodically will have to clean the bed mattress and change the linens. An interview was conducted with the Director of Nursing (DON/staff #37) on (MONTH) 28, 2019 at 12:50 p.m. He stated that when there are odors, they will attempt to find the root cause of the abnormal smell. He stated if the foul odor lingers, they will conduct a room by room search, working with housekeeping. The DON also stated the nursing staff will ensure residents are clean. The DON said a room was identified this week with an odor and the bed sheets were removed and the bed was scrubbed with a cleaner. He stated it did not eliminate the order, so a new bed was obtained. The DON stated the staff does a good job checking for odors.
F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, documentation and policy and procedures, the facility failed to ensure that one resident (#4) was provided with an escort to a medical appointment. Findings include: Resident #4 was admitted to the facility on (MONTH) 10, (YEAR) with [DIAGNOSES REDACTED]. The resident resided on the secured dementia unit. Review of the Baseline Care Plan dated (MONTH) 10, (YEAR), revealed the resident would have several appointments. The care

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 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) plan included the resident would get anxious when she went to an appointment and was not able to remember why she was at the appointment. The care plan also included the resident required an escort to appointments and that the insurance plan was assisting with providing an aide to accompany the resident on appointments. The admission MDS (Minimum Data Set) assessment dated (MONTH) 17, (YEAR), included a Brief Interview for Mental Status score of 2, which indicated the resident had severe cognitive impairment. Further review of the clinical record revealed there were no progress notes for (MONTH) (YEAR). Review of an email dated (MONTH) 21, (YEAR) between the former Director of the secured unit (staff #20) and the resident's representative revealed the resident was sent to an appointment in (MONTH) (YEAR), without an escort. In the email, staff #20 apologized for the incident, as the Licensed Practical Nurse (LPN/staff #79) sent the resident to an appointment without an escort last week. The email included the Director of Nursing (DON/staff #37) was notified. Review of an In-Service training dated (MONTH) 25, (YEAR) which included transportation revealed that staff #79 attended the training. An interview was conducted via telephone on (MONTH) 26, 2019 at 11:00 a.m. with a resident's representative. She stated that in (MONTH) (YEAR), the resident was sent to an appointment without an escort. She said before the resident was admitted to the facility, she had multiple discussions with staff #20, regarding the care the resident would need. She stated the discussions included the multiple appointments the resident would need and that the resident required an escort to the appointments. She stated that she also spoke to the DON regarding the resident requiring an escort to appointments. During an interview conducted on (MONTH) 26, 2019 at 11:25 a.m. with a Certified Nursing Assistant (CNA/staff #131), the CNA stated that her training included any resident on the secured unit has to be escorted when leaving the unit. She stated if a family member is not available, a CNA would take the resident to the appointment. An interview was conducted (MONTH) 26, 2019 at 11:36 a.m. with a LPN (staff #120), who stated that every resident residing on the secured unit has to have an escort when leaving the unit, because of impaired memory. The LPN stated that when a resident is scheduled for an appointment, the nurse completes a transportation form which includes the transportation company, date, time and the name of the escort. She stated the CNA scheduled to take a resident to an appointment is supposed to sign the sign-out book, when leaving the unit with a resident. On (MONTH) 26, 2019 at 11:46 a.m., an interview was conducted with the Assistant Director of Nursing (ADON/staff #134), who said the nurse notifies the staffing coordinator (staff #23) when a resident needs an escort to an appointment. She stated that staff #23 would then schedule a specific CNA to escort the resident to the appointment. The ADON stated it is her expectation that the nurse would document in the nursing progress notes when the resident was picked up. The ADON further stated the facility recently started using a new system and that she was not able to access progress notes from (MONTH) (YEAR) for this resident. An interview was conducted with staff #23 on (MONTH) 26, 2019 at 12:05 p.m. She confirmed that she was responsible for scheduling the CNAs to escort residents to appointments. She stated that she would have to verify who was scheduled to escort resident #4 to her appointment on (MONTH) 15, (YEAR), and would provide a copy, however, it was not provided. On (MONTH) 26, 2019 at 12:10 p.m., an interview was conducted with the former Director of the Secured unit (staff #20), who stated that all residents residing on the secured unit require an escort, when leaving the unit. She stated the expectation was for the nurse to document in the nurses progress note, when the resident went to an appointment. She stated that it was the responsibility of the nurse on duty to ensure that a CNA escorted the resident off the unit. She stated the LPN (staff #79) had been working on the secured unit for a while and was aware that residents needed an escort when they left the unit. Staff #20 stated that she and the DON spoke to the LPN and the LPN attended an in-service training about transportation. An interview was conducted on (MONTH) 26, 2019 at 12:59 p.m. with the DON (staff #37), who stated that no resident leaves the secured unit without an escort. He stated a CNA is assigned to escort a resident to an appointment and that the resident should not leave the unit without the CN[NAME] The DON stated he conducted an investigation and it was determined that staff #79 was aware that the resident had left with the driver from the transportation company and was not accompanied by an escort. She stated the LPN was required to attend an in-service training on transportation. Another interview was conducted with staff #37 on (MONTH) 27, 2019 at 2:00 p.m., who stated the resident was never alone. He stated the driver took the resident to the doctor's office and was told that he could not leave the resident there alone. He said the driver called the facility to ask what he should do and was instructed to bring the resident back to the facility. Review of the facility's transportation policy revised on (MONTH) 1, 2013, revealed the purpose of the policy is to assure patient safety. The policy included that staff will provide assistance in making arrangements for transportation for patients who need transportation outside of the center and that staff may escort patients, if needed.
F 0688 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review and staff interviews, the facility failed to ensure care and services were provided for one resident (#9) with a contracture. Findings include: Resident #9 was admitted on (MONTH) 9, 2010, with [DIAGNOSES REDACTED]. A skin integrity care plan with a revised date of 6/5/18 identified the resident had decreased mobility and incontinence. The goal was that the resident's skin would be clean, dry and odor free. Interventions included for treatments as ordered and for soft hand rolls as ordered. According to a Care Plan Conference Summary dated 9/6/18, the resident had end stage Alzheimers disease, was dependent for all cares and had no increase in contractures. A quarterly Minimum Data Set (MDS) assessment dated [DATE] included the resident had long and short term memory impairment and was severely impaired with cognitive skills for daily decision making. The MDS included the resident had upper and lower extremity impairment on both sides, and required extensive assistance with activities of daily living. A physician's orders [REDACTED]. Review of the (MONTH) (YEAR) and (MONTH) (YEAR) Treatment Records revealed the orders for a soft hand roll to the right hand at all times and check every shift for placement. The documentation showed that the hand roll was applied each shift except on (MONTH) 29 on the night shift, and on (MONTH) 22 on the night and day shift. A nursing note dated 2/11/19 included the resident had upper extremity impairments on both sides and had a right hand contracture. A care plan dated (MONTH) 12, 2019 identified the resident was at risk for skin breakdown related to immobility, contractures and incontinence. One of the goals was the resident would not show signs of skin breakdown. The care plan included for bilateral hand rolls to protect palms, observe for signs or symptoms of skin breakdown, and evaluate for any localized skin problems. An observation of resident #9 was conducted on (MONTH) 25, 2019 at 1:00 p.m. The resident was sitting in a wheelchair in her room, facing the wall. The resident's eyes were partially closed and her hands were clenched and her fingernails were long. There were no hand rolls in place. Multiple observations were conducted of resident #9 on (MONTH) 26, 2019 from 8:00 a.m. to 3:30 p.m. During these observations, the resident did not have hand rolls in place to either hand. Another observation of resident #9 was conducted on (MONTH) 27, 2019 at 2:45 p.m. The resident was laying in bed awake. There were no hand rolls in place to either hand. The resident's fingernails on both hands were long and appeared to be digging into her palms. An interview was conducted with a registered nurse (staff #49) on (MONTH) 28, 2019 at 10:13 a.m. She stated that when resident #9 is her patient, she ensures that her nails are trimmed and that the hand rolls are in place each day. She said sometimes the CNA (Certified Nursing Assistant) does it, then reports back to her and she follows up. She stated that since the resident is a diabetic, the nurse would clip her nails. She stated that usually the CNA would notice if the hand rolls

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F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) were not in place and correct it, and that the CNAs usually place the hand rolls when they get the resident out of bed each morning and that she always checks. An interview was conducted on (MONTH) 28, 2019 at 11:02 a.m., with a licensed practical nurse (staff #143). She stated that she thinks therapy gives nursing the hand rolls, then nursing applies them. She stated the resident was already up when she arrived for her shift today. Staff #143 said it is the responsibility of whoever gets the resident up to place the hand rolls. She admitted that ultimately as the resident's nurse, it was her responsibility to ensure the resident had the handrolls in place. She stated that she wasn't sure who was supposed to cut the resident's nails, but thought it was podiatry. On (MONTH) 28, 2019 at 9:54 a.m., an interview was conducted with a CNA (staff #128), who stated that it is the nurses' responsibility to place the hand rolls in resident #9's hands and also to cut her nails. On (MONTH) 28, 2019 at approximately 10:00 a.m., the Director of Nursing (staff #37) stated that it was nursing's responsibility to ensure the hand rolls are in place. The DON said the facility did not have a policy, but it is professional standards of practice for nursing to follow the physician's orders [REDACTED].
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** Based on observations and staff interviews, the facility failed to ensure that infection control standards were followed during medication administration. Findings include: An observation of medication administration was conducted on (MONTH) 27, 2019 at 7:35 a.m., with a Licensed Practical Nurse (LPN/staff #43). The LPN was observed to prepare and administer medication to a resident. However, the nurse did not perform hand hygiene before or after administering medication to the resident. Following this, staff #43 then proceeded to prepare and administer medication to another resident. Again, no hand hygiene was performed before or after administration. An interview was conducted with the Director of Nursing (DON/staff #37) on (MONTH) 27, 2019 at 9:07 a.m. The DON stated that nurses should be doing hand hygiene between each resident, when administering medications. An interview was conducted with staff #43 on (MONTH) 27, 2019 at 10:25 a.m. He stated that he has hand sanitizer on his cart, but realized he did not use it between residents during the observation.