STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035071	A. BUILDING _____ B. WING _____	03/07/2019

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MISSION PALMS POST ACUTE	6461 EAST BAYWOOD AVENUE MESA, AZ 85206

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
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, observation, facility documentation, and resident and staff interviews, the facility failed to ensure 1 of 3 sampled residents (#295) received an adequate number of showers. The deficient practice could result in hygiene needs not being met. Findings include: Resident #295 was admitted to the facility on (MONTH) 26, 2019 with [DIAGNOSES REDACTED]. Review of the admission Minimum Data Set assessment dated (MONTH) 5, 2019, revealed a Brief Interview for Mental Status score of 13 which indicated the resident was cognitively intact. The assessment included the resident was totally dependent for bathing and required extensive assistance for personal hygiene and dressing. An interview was conducted with resident #295 on Tuesday, (MONTH) 5, 2019 at 8:25 AM. The resident stated that she had not had a shower since admission. She stated she was supposed to receive a shower twice a week. She said that on her last scheduled shower day, the Certified Nursing Assistant (CNA) informed her there was no time to give her a shower on the day shift and that the next shift would assist her with a shower. The resident stated when she asked the CNA on the next shift for a shower, the CNA did not respond. Review of the facility's shower schedule revealed the resident was scheduled for showers on Wednesday/day shift and Saturday/night shift. A second interview was conducted with resident #295 on Thursday, (MONTH) 7, 2019 at 1:16 PM. The resident stated that she still had not received a shower despite several requests. She stated the CNA currently on shift told her that she could not give her a shower because she had three other showers scheduled for that day. She stated the CNA also told her that her shower day was on Wednesday. The resident stated she did not receive a shower yesterday. During the interview, the resident was observed sitting in her wheelchair in her room. The resident was dressed in pajamas and her hair did not appear to be combed. Review of the shower book containing shower sheets for (MONTH) 2019 revealed one shower sheet for resident #295. The shower sheet was dated (MONTH) 2, 2019 and contained documentation that a shower was not provided due to only one CNA being on shift. The sheet was signed by the CNA and the charge nurse. An interview was conducted with the resident's CNA (staff #71) on (MONTH) 7, 2019 at 1:25 PM. The CNA stated residents receive showers twice a week and upon request. She stated the CNAs document the shower on a shower sheet and have the nurse sign it. The CNA said if a resident refuses a shower, the refusal and the reason for the refusal will be documented on the shower sheet and the resident will be asked to sign the sheet. The CNA also stated that showers are sometimes missed due to short staffing. She stated that she knows if a resident had a shower by looking in the shower book. She said if there is no shower sheet she would assume the shower was not provided. The Administrator (staff #65) was asked if there were any additional shower sheets as there was only one in the shower book. Approximately 2 hours later the Director of Nursing (staff #84) provided two more shower sheets. One was dated (MONTH) 3, 2019 which included the resident received a shower. The second sheet was dated (MONTH) 7, 2019 which included the resident received a shower. A follow up interview was conducted with staff #71 on (MONTH) 7, 2019 at 3:03 PM. Staff #71 stated she was working on (MONTH) 3, 2019 but she did not give resident #295 a shower that day. The CNA stated she just cleaned her up a little bit but it was not even a bed bath. She also stated the sheet was not in the shower book earlier today because she had just filled it out. She stated one of the supervisors asked her to sign it. The CNA also stated that resident #295 was provided a shower today, (MONTH) 7, 2019.
F 0687 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide appropriate foot care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, and family and staff interviews, the facility failed to provide care and treatment for one (#2) of two sampled residents with routine foot care, which resulted in an infection to the resident's toe. The facility census was 99. Findings include: Resident #2 was admitted to the facility on (MONTH) 15, (YEAR), with [DIAGNOSES REDACTED]. A care plan for alteration in skin due to mobility limitations dated (MONTH) 2, (YEAR) included a goal that the resident would be free from additional skin breakdown/irritation. An approach included .Podiatry consult and treatment as indicated .A significant change MDS (Minimum Data Set) assessment dated (MONTH) 8, (YEAR) revealed the resident's BIMS (Brief Interview for Mental Status) score was 13, indicating intact cognition. The MDS further revealed the resident required extensive assistance of one person with personal hygiene. Review of the Comprehensive CNA (certified nursing assistant) Shower Reviews dated (MONTH) 3, 22 and 26, (YEAR), (MONTH) 12 and 19, 2019, and (MONTH) 6, 13, 26 and 20, 2019 revealed the following: .Does the resident need his toenails cut? Yes . The Shower Reviews were signed by a licensed nurse. However, there was no clinical record documentation that the resident's toenails were cut from (MONTH) (YEAR) through (MONTH) 2019. Review of a Comprehensive CNA Shower Review dated (MONTH) 2, 2019 revealed .Does the resident need his toenails cut? Yes. Right big toenail is coming off. The Shower Review sheet was signed by a licensed nurse. There was no clinical record documentation that the resident's right toenail had been addressed on (MONTH) 2 or 3 or on (MONTH) 4, 2019, prior to 2:07 p.m. An interview was conducted on (MONTH) 4, 2019 at 2:07 p.m., with the resident and a family member. The family member stated that podiatry care had been requested, but they were informed that the podiatrist was just at the facility or the resident was not on the podiatry list. The resident's family member stated that the resident's toenails are long and needed to be cut. The resident's family member then proceeded to take the resident's socks off. The resident's toenails were observed to be approximately 1/4 inch past the tips of his toes and the right great toe was red and swollen. The family member immediately notified a RN (registered nurse/staff #107). An assessment of the resident's right great toe was conducted on (MONTH) 4, 2019 at 3:08 p.m., by the wound nurse. Per the Wound Assessment Note the following was documented: Resident seen today as report of right great toe possibly infected. Resident's nail on right great toe lifted, area below nail red and warm, blanchable at this time. Reported to primary

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

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F 0687 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) doctor. New orders received for daily dressing change using [MEDICATION NAME] and Kerlix. Also orders for antibiotic therapy for five days. Podiatrist contacted with permission from family and primary doctor. Toenails were trimmed during this visit but needs a podiatry visit. A Physician's Note dated (MONTH) 4, 2019 included .Right great toe redness with discharge .Right great toe infection concerning for underlying infection, placed on [MEDICATION NAME] (antibiotic) 100 milligrams twice a day for five days . A physician's orders [REDACTED]. A Podiatry Note dated (MONTH) 5, 2019 documented .Patient seen for examination and care of feet and nails. Seen for follow-up care of feet and nails .Nails painful and uncomfortable. Patient unable to cut own toenails .Nurses state patient jammed right foot and great toenail is loose .Nails elongated 1 - 5 bilaterally. Thickened, yellow, dystrophic painful nails 1-5 left and 1-5 right. Lytic (infection) right first toenail. Localized [DIAGNOSES REDACTED] and serosanguinous drainage. Subungual hematoma. Tender to palpation .Pitting [MEDICAL CONDITION] bilaterally 2/4 or greater .Reduced nails 1-5 bilaterally, manual and mechanical debridement .Elevate legs throughout the day as much as possible to reduce swelling. Nail removed following cleansing area with alcohol pad .[MEDICATION NAME] and Band-Aid applied to be changed every day for 5 days. Notify if any increased signs of infection occur, including but not limited to purulence, swelling, redness and streaking . Another physician's orders [REDACTED]. Pat dry. Apply [MEDICATION NAME] (antibiotic ointment) and Band-Aid daily times seven days. Monitor for signs of infection. A Nurse's Note dated (MONTH) 5, 2019 documented Patient on oral [MEDICATION NAME] for right great (toe) infection. First dose started today. Podiatrist in facility today to treat patient's toes. Dressing change daily with [MEDICATION NAME] . An interview was conducted with a CNA (staff #66) on (MONTH) 6, 2019 at 1:51 p.m. Staff #66 stated that if she noticed that a resident's toenails were long she would document it on the Shower Review sheet, and then the licensed nurses are supposed to cut the resident's toenails. The CNA stated that she had noticed that the resident's toenails were long. An interview was conducted with a LPN (licensed practical nurse/staff #118) on (MONTH) 7, 2019 at 9:31 a.m. Staff #118 stated that if a CNA documented on the Shower Review sheet that a resident needed their toenails cut, she would assess the resident and cut the toenails if needed. An interview was conducted with a RN (staff #107) on (MONTH) 7, 2019 at 10:19 a.m. Staff #107 stated that when she signs the Shower Review sheets, she is just acknowledging that the resident received a shower. Staff #107 stated that the resident's toenails were very hard and he needed a podiatrist to trim his nails. Staff #107 stated the resident has been at the facility for almost two years, but she did not know if the resident had ever been seen by the podiatrist. Staff #107 further stated that she had asked the resident why he didn't tell her that he needed his toe nails cut. An interview was conducted with the DON (Director of Nursing/staff #84) on (MONTH) 7, 2019 at 10:34 a.m. Staff #84 stated that if anything new is documented on the Shower Review sheets, the licensed nurses should assess the resident. Staff #84 stated that if the resident is diabetic or the licensed nurse was unable to cut the resident's toenails, the licensed nurse should write a consult for podiatry care. Another interview was conducted with staff #84 on (MONTH) 7, 2019 at 11:40 a.m. Staff #84 stated that the facility did not have a policy regarding foot care, but it was a standard of practice.
F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews and facility and hospital documentation, the facility failed to ensure that adequate supervision was provided to one (#193) of two sampled residents during care, resulting in a fall with a fracture. The resident census was 99. Findings include: Resident #193 was admitted to the facility on (MONTH) 11, 2014, with [DIAGNOSES REDACTED]. Review of a quarterly MDS (Minimum Data Set) assessment dated (MONTH) 1, (YEAR), revealed the resident had a BIMS (Brief Interview for Mental Status) score of 6, which indicated severe cognitive impairment. In Section G, Functional Status, the resident was assessed to require the assistance of two or more with bed mobility. A care plan included the resident had a self care deficit, as evidenced by maximum assist for most ADL's (activities of daily living) related to muscle weakness with additional risk related to orthostatic [MEDICAL CONDITION] . The goals were Will participate to ability .Will be washed, dressed . Approaches included Setup, cue and assist as needed for ADLs. Encourage participation to ability. Task segmentation as needed .Provide assist as needed for completion of ADL cares . The care plan did not include that the resident required the assistance of two or more with bed mobility. A Nurse's Note dated (MONTH) 18, (YEAR) documented .total care with ADLs, bed mobility and transfers. Another Nurse's Note dated (MONTH) 29, (YEAR) documented the resident was total care with ADLs, bed mobility and Hoyer lift for transfers. A Medicare Note dated (MONTH) 28, (YEAR) included .was changing the patient in bed. Patient fell out of bed and onto the floor .Patient was still in pain at time of transfer but was alert again and able to answer some questions appropriately but still had a noticeable change in mentation. A written statement by a RN (registered nurse/staff #110) dated (MONTH) 28, (YEAR) documented the supervisor (staff #110) was notified that the resident was involved in a fall. The CNA (certified nursing assistant/staff #136) reported that he was cleaning the patient in bed without the assistance of another CN[NAME] Per the statement, he had the resident roll on his side with the resident's body facing toward him. The CNA reported that the resident began to roll into his body and off the bed and that he attempted to break the patient's fall with his body, but the resident ultimately fell to the ground. The CNA was asked how hard the resident had hit the floor and the CNA responded with some force. The CNA was asked if the resident hit his head and he responded no. The floor nurse reported that he entered the room to find the resident on the floor face down. When supervisor entered the room, the resident was already placed back in bed. Supervisor assessed the resident. His face was pale and he had a dazed look in his eyes. Pupils were sluggish to react. Resident was asked if he was feeling any pain and stated that he had a headache which he rated at a 7 out of 10, with 10 being the worst pain he ever felt. Also noted a 12 centimeter circular skin tear to the right arm. When asking the resident if he was experiencing any pain in his arm, he stopped responding to questions. His head fell back onto the pillow and he seemed to lose consciousness. MD was notified. He advised to send the resident to the emergency department for assessment. Hospital documentation dated (MONTH) 28, (YEAR) included the following: .A CNA was attempting to wash the patient while on his bed. The bed was raised at the time with no safety rails as the CNA rolled the patient to wash his back. The patient fell off his bed and on to the ground. The patient hit his head resulting in loss of consciousness .Stable small presumed left frontal subdural hygroma without mass effect .Stable low-density 8 millimeter left frontal potential subdural hygroma without significant interval change .There is a mildly impacted [MEDICAL CONDITION] humeral neck . A Nurse's Note dated (MONTH) 29, (YEAR) revealed Late entry (MONTH) 28, (YEAR). Patient fell out of bed during patient care by CN[NAME] Assessment done and charge nurse during shift notified .Patient sent out to .hospital. Review of the facility's Reportable Event Record Report dated (MONTH) 2, (YEAR) revealed .At approximately 6:00 a.m. on (MONTH) 28, (YEAR), the CNA was performing bed bath/linen change on resident .when resident appeared to no longer participate and subsequently rolled out of the bed. Immediate assessment following the fall concluded significant symptomatic [MEDICAL CONDITION]. Resident .was transported to (name of hospital) and admitted for symptomatic [MEDICAL CONDITION]. On (MONTH) 29, (YEAR), per hospital records, x-rays of bilateral shoulder and bilateral hand/wrists were obtained and conclusive for positive [MEDICAL CONDITION] shoulder . Further review of the clinical record revealed the resident was readmitted to the facility on (MONTH) 3, (YEAR) and was enrolled in hospice services. A Change in Condition Note dated (MONTH) 9, (YEAR) documented Late entry (MONTH) 8, (YEAR) .Time of death called .at 7:07 p.m . An interview was conducted with a RN (staff #110) on (MONTH) 6, 2019 at 9:13 a.m. Staff #110 stated that a CNA (staff #136) was caring for the resident at the time of the fall. Staff #110 said the CNA rolled the resident toward himself to provide

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F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) care and the resident stiffened and fell out of bed. Staff #110 stated the resident's bed was at the normal height and that the resident only required one person for cares while in bed. Multiple attempts were made to contact staff #136 by telephone on (MONTH) 6 and 7, 2019, however were unsuccessful. An interview was conducted with the Therapy Director (staff #11) on (MONTH) 7, 2019 at 9:54 a.m. Staff #11 stated that if a resident required maximum assistance for bed mobility it would mean that one or two staff were required to assist the resident. An interview was conducted with the MDS coordinator (staff #64) on (MONTH) 7, 2019 at 10:45 a.m. Staff #64 stated that the resident was a big guy and should of had two staff for bed mobility. An interview was conducted with a CNA (staff #58) on (MONTH) 7, 2019 at 11:15 a.m. Staff #58 stated that if he was unsure if a resident required one or two staff for bed mobility and cares, he would check with a nurse. An interview was conducted with the DON (Director of Nursing/staff #84) on (MONTH) 7, 2019 at 11:21 a.m. Staff #84 stated that the facility only initiated a two person assist for bed mobility after a fall, or if a resident had a large abdominal girth, which would put the resident at risk with turning in a bed. Staff #84 stated the facility's Smart Charting (CNA charting tool) is updated by the MDS. Staff #84 stated that she was unable to review how much assistance the resident required at the time of this fall, as the resident was readmitted to the facility and she was only able to review the most recent admission. Staff #84 stated that if the MDS included that the resident required a two person physical assist for bed mobility, this information should have auto-populated to the Smart Charting.
F 0725 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record reviews, resident and staff interviews, and the facility's assessment, the facility failed to ensure there were sufficient nursing staff to meet the needs of multiple residents (#248, #247, #69, #7, #28, #250, #2, #26, #295 and #46). The deficient practice resulted in residents' needs not being met. The resident census was 99.Findings include: Interviews were conducted with multiple residents regarding staff response time to residents' call lights and nursing services and included the following: -Resident #248 was interviewed on (MONTH) 4, 2019 at 12:27 p.m. He stated that he has waited up to 30 minutes for his call light to be answered. The admission Minimum Data Set (MDS) assessment dated (MONTH) 22, 2019, revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident's cognition was intact. -Resident #247 was interviewed on (MONTH) 4, 2019 at 12:57 p.m. He stated he has waited up to 45 minutes for assistance. The admission MDS assessment dated (MONTH) 2, 2019 revealed a BIMS score of 15, which indicated the resident was cognitively intact. -Resident #69 was interviewed on (MONTH) 4, 2019 at 1:12 p.m. She stated it takes about 30 minutes for staff to answer her call light. The resident stated staff will come into her room, turn the call light off and say they will come back, but that they never return. She stated the staffing is low at night and that there is only one Certified Nursing Assistant (CNA) for the entire hall. The quarterly MDS assessment dated (MONTH) 3, 2019 revealed a BIMS score of 12, which indicated the resident had moderate cognition impairment. -During the same interview conducted with resident #69, her roommate resident #7 stated that she has urinated through her clothes onto the wheelchair several times waiting for staff to assist her. The quarterly MDS assessment dated (MONTH) 22, 2019 revealed a BIMS score of 12, which indicated the resident had moderate cognition impairment. -Resident #28 was interviewed on (MONTH) 4, 2019 at 1:13 p.m. She said she is receiving [MEDICATION NAME] (diuretic) and she has waited a long time to have her brief changed especially at night. The admission MDS assessment dated (MONTH) 25, 2019 revealed a BIMS score of 13, indicating the resident was cognitively intact. -Resident #250 was interviewed on (MONTH) 4, 2019 at 1:27 p.m. He said that he has waited for 20 minutes for staff to assist him. The admission MDS assessment dated (MONTH) 6, 2019 revealed a BIMS score of 14, which indicated the resident had intact cognition. -Resident #2 was interviewed on (MONTH) 4, 2019 at 1:50 p.m., with a family member present. The family member stated resident #2 will not ask to be changed. It was observed the resident had a dried wet spot on his shorts. The Significant Change in Status MDS assessment dated (MONTH) 28, (YEAR) for resident #2, included a BIMS score of 13, indicating the resident was cognitively intact. -Resident #26 was interviewed on (MONTH) 4, 2019 at 2:21 p.m. He stated the facility is short staffed on the night shift and the weekends most of the time. He said there was one CNA providing care to 43 residents this past weekend. Review of the quarterly MDS assessment dated (MONTH) 10, (YEAR), revealed a BIMS score of 14, which indicated the resident had intact cognition. -Resident #295 was interviewed on (MONTH) 5, 2019 at 8:25 a.m. The resident stated she had not had a shower since admission (February 26, 2019). She stated she was supposed to receive a shower twice a week. She said that on her last scheduled shower day, the CNA informed her there was no time to give her a shower on the day shift and that the next shift would assist her with a shower. The resident stated when she asked the CNA on the next shift for a shower, the CNA did not respond. Review of the shower book containing shower sheets for (MONTH) 2019 revealed one shower sheet for resident #295. The shower sheet was dated (MONTH) 2, 2019 and contained documentation that a shower was not provided, due to only one CNA being on shift. The sheet was signed by the CNA and the charge nurse. At 8:36 a.m., resident #295 stated it can take up to an hour for staff to answer her call light. She said staff come into the room, turn the call light off, and tell her they will be right back. Resident #295 stated the staff are supposed to assist her to the toilet and that some of the staff have told her to go in her brief. Review of the admission MDS assessment dated (MONTH) 5, 2019 included a BIMS score of 13, which indicated the resident had intact cognition. Resident #295 was interviewed again on (MONTH) 7, 2019 at 1:16 p.m. The resident stated that she still had not received a shower despite several requests. She stated the CNA currently on shift told her that she could not give her a shower, because she had three other showers scheduled for that day. She stated the CNA also told her that her shower day was on Wednesday. The resident stated she did not receive a shower yesterday. During the interview, the resident was observed sitting in her wheelchair in her room. The resident was dressed in pajamas and her hair did not appear to be combed. -Resident #46 was interviewed on (MONTH) 5, 2019 at 9:29 a.m. She stated sometimes there is only one CNA on the night shift and the nurses work double shifts. Review of the quarterly MDS assessment dated (MONTH) 29, 2019 for resident #46 included a BIMS score of 15, indicating the resident was cognitively intact. Multiple residents were interviewed during a Resident Council meeting conducted on (MONTH) 6, 2019 at 2:23 p.m. Several residents stated there were not enough CNAs to provide care for the residents, and that sometimes residents have to wait 1 hour or longer to receive assistance. The residents stated often, only one CNA is working on station 1 during the evening shift. The residents also stated they will not put on their call light unless it is emergent, because one CNA cannot help all the residents on that station. An interview was conducted on (MONTH) 7, 2019 at 11:59 a.m. with the Staffing Coordinator (staff #55). Staff #55 stated staffing is determined by the acuity of care and the census. He stated when they are short staffed, staff will be asked to stay over to help and that he, the Assistant Director of Nursing (ADON), or the Charge Nurse will work a shift if needed.

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F 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) He stated there is never a time when there is only one CNA working on a unit. He then stated there is usually one CNA working once or twice a week on the night shift on Station 1. The Staffing Coordinator stated when this occurs, he will ask 2 CNAs from the day shift to stay and help for 2-3 hours to get residents ready for bed and that sometimes he will ask CNAs to come in early to help get residents up. He stated two CNAs are scheduled for Station 1 on the night shift and the expectation is that 2 CNAs work the entire shift. He said the census for Station 1 is always around 40 and requires two CNAs for the night shift. After reviewing the staff schedule for Friday, (MONTH) 1, 2019 and Saturday, (MONTH) 2, 2019, staff #55 acknowledged 2 CNAs did not work the entire shift on those nights and that the day shift CNAs did not stay to help for 2-3 hours and that no one came in early to assist the night CN[NAME] He further stated he had not heard of residents waiting for assistance for an hour or more. He also stated the nurses pass medications around 7:00 to 8:00 p.m. and the CNAs start assisting residents to bed around 7:00 p.m., so some residents may have to wait for a nurse to help with ADLs when there is only 1 CNA available. The Staffing Coordinator stated that he had not heard any residents complain the facility was short staffed. He stated it is usually the CNAs that complain about needing more help. An interview was conducted on (MONTH) 7, 2019 at 12:44 p.m. with the Administrator (staff #65), who stated the number of residents on Station 1 is usually stable. The administrator stated one CNA would be appropriate for a maximum of 15 residents for the day shift. She stated the night shift on station 1 required 2 CNAs and that a floater CNA and the charge nurse should be available to help. She stated that if a CNA called off, staff #55 would be responsible for working that shift or finding staff to work the shift. The Administrator stated that she has cut back on staff because they were overstaffed and the residents were used to having staff available at all times. During an interview conducted with a CNA (staff #71) on (MONTH) 7, 2019 at 1:25 PM, the CNA stated showers are sometimes missed due to short staffing. Review of the facility assessment revised (MONTH) 25, 2019 included how the facility determines and reviews individual staff assignments for coordination and continuity of care for residents, within and across assignments. The facility determines individual staff assignments based on the residents needs including activities of daily living to be done each shift and assign staff accordingly.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews and policies and procedures, the facility failed to ensure that medications available for resident use on 3 of 6 medication carts were not expired, failed to ensure that medications were not pre poured, and failed to ensure that narcotics were properly stored for destruction. The deficient practices could result in expired medications being administered to residents; increased risk for potential medication errors among residents; and allowed easier access to narcotics. Findings include: -An observation was conducted on (MONTH) 7, 2019 at 9:29 AM, with a Registered Nurse (RN/staff #102) of the Oasis back hall medication cart. Inside the cart was one bottle of [MEDICATION NAME], which had an expiration date of (MONTH) 2019. -An observation was conducted on (MONTH) 7, 2019 at 10:26 AM of the Station 1 front hall medication cart, with a Licensed Practical Nurse (LPN/staff #124). One bottle of Vitamin D was observed with an expiration date of (MONTH) 2019. Also, in the top drawer of the cart, there were three medication cups with pills, which were labeled with the residents' name and room number. An interview was immediately conducted with staff #124. She stated the residents were not in their rooms when she went to administer their medications, so she stored their medications in the cart to administer to them later. The LPN stated it is not the facility's policy to pre-pour medications. Regarding the expired medication, staff #124 said when preparing a resident's medication, the expiration date should be checked. -An observation was conducted on (MONTH) 7, 2019 at 10:47 AM, with a LPN (staff #136) of the Station 2 back hall medication cart. Inside the cart was one bottle of normal control solution and one bottle of high control solution, which are used for glucometer calibration. The bottles had an expiration date of (MONTH) (YEAR). An interview was conducted with the Director of Nursing (DON/staff #84) on (MONTH) 7, 2019 at 12:10 PM. She stated supervisors conduct focus rounds on medication carts every day and the night nurse check for expired medications, but that it is ultimately the nurse's responsibility to check the expiration date on a medication when preparing the medication for administration. The DON stated that medications that are prepared in a medicine cup cannot be saved in the cart. She said if the resident is not available, the medications should be destroyed. During this same interview, the DON also stated that narcotics waiting for destruction are stored in a drawer in her office. The DON then proceeded to walk to her office. The door to the DON's office was observed wide open with no one inside. An observation of the desk drawer where the narcotics are stored revealed a single lock and one card of narcotics inside. The DON stated she has the only key to the drawer and the only key to her office. Multiple observations throughout the survey revealed the DON's office door was frequently wide open, with no one inside. With the door to the DON's office often observed being unlocked and open, the narcotics stored in the locked drawer were not stored under a double lock system. The facility's policy regarding medication administration revealed that medications are to be administered at the time they are prepared. The policy included that once removed from the package/container, unused medication doses shall be disposed of according to the nursing care center policy. The policy included the Medication Administration Record [REDACTED]. After completing the medication pass, the nurse returns to the missed resident to administer the medication. The policy further instructs to check expiration dates on the package/container and that no expired medication will be administered to a resident. Review of the facility's policy for controlled medication storage revealed that controlled medications remaining in the nursing care center after the order has been discontinued are retained in the nursing care center in a securely double locked area, with restricted access until destroyed as outlined by state regulation.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, facility documentation and policies and procedures, the facility failed to ensure eating utensils were properly cleaned prior to being stored for use, failed to ensure that quaternary sanitizing solution was maintained at the required level, and failed to ensure that food items stored in 1 of 3 nourishment refrigerators were properly dated, labeled and discarded, prior to their expiration dates. The deficient practices could result in the spread of possible foodborne illnesses. Findings include: -During an observation conducted on [DATE] at 08:56 AM in the dining room with the District Food Service Manager (staff #134), several coffee cups were observed being wiped down with a damp cloth and set up for use by a dietary aid (staff #37). An interview was conducted with staff #37 on [DATE] at 09:02 AM. Staff #37 stated that he uses a cloth damp with sanitizing solution to wipe down the cups and utensils prior to service because they come out of the dishwasher with a thin white calcium film. He stated he was instructed to and has been doing this practice for more than 5 years. Staff #37 stated the sanitizing solution was diluted with water and is also used as the solution to wipe down kitchen surfaces. During an interview conducted with the staff #134 on [DATE] at 11:20 AM, she stated she was unaware that staff #37 was wiping down the utensils with a cloth damped with sanitizing solution. She stated this is an unacceptable procedure and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035071	A. BUILDING _____ B. WING _____	**03/07/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MISSION PALMS POST ACUTE	**6461 EAST BAYWOOD AVENUE MESA, AZ 85206**

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 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) that the utensils should be rinsed with water prior to use. An interview was conducted with the Administrator (Staff #65) on [DATE] at 01:21 PM. The administrator stated it is her expectation that the dietary staff should not apply a cloth with sanitizing solution directly to eating utensils that are being set out for use without first rinsing the utensils with water to prevent possible chemical contamination. Review of the Material Safety Data Sheet for the Oasis 146 Multi-quat Sanitizer revealed the product is not to be ingested as it may cause mouth irritation. The sheet included that after dilution, contacted skin area should be rinsed with water for several minutes. The sheet also included toxicological information that the solution may cause irritation, watering or redness to contacted areas. The facility's Meal Distribution: Infection Control Considerations policy revealed dining service staff will be knowledgeable in proper techniques including chemical sanitizer dispensing. -An observation was conducted in the kitchen with staff #134 on [DATE] at 10:01 AM. Staff #134 used Litmus paper test strips to verify that the strength of the sanitizing solution being used to wipe down counter tops and other food equipment was within the required strength level of 150 ppm (parts per million) to 200 ppm. The strip used in the solution in one of the buckets did not register any strength revealing the sanitization solution was below the required strength. During an interview conducted with staff #134 on [DATE] at 11:20 AM., the manager stated the sanitizer solution should be between 150 ppm and 200 ppm. An interview was conducted with the Administrator (Staff #65) on [DATE] at 01:21 PM. The administrator stated that it is her expectation the sanitizing solution be at the correct strength at all times to properly sanitize the equipment. She stated the deficient strength of the solution is not an acceptable practice. -An observation was conducted on [DATE] at 10:02 AM of the nourishment refrigerators with the manager (staff #134) and the dietary manger (staff #133). The refrigerator for Hall 1 was observed to have one sandwich which was unlabeled and a bottle of mayonnaise with an expiration date of (MONTH) (YEAR). During an interview conducted with staff #134 on [DATE] at 11:20 AM, staff #134 stated the refrigerators are checked weekly and that unlabeled and expired food should not be in the refrigerators. An interview was conducted with the staff #133 on [DATE] at 01:10 PM. Staff #133 stated that he checks the snack refrigerators several times a week to ensure food items are properly labeled and not expired. He stated he missed the expired mayonnaise and that it must have been brought in by an outside source. The facility's Labeling and Dating guidelines revealed items in the refrigerator should be labeled with a use-by date for removal and that the manufacturer's expiration date, when available, is the use by date. The guidelines included items must be in an airtight package or a sealed container with the resident's name, contents, and the date placed in the refrigerator to prevent cross contamination.
F 0814 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Dispose of garbage and refuse properly.** Based on observations, staff interviews, and policy and procedure, the facility failed to ensure garbage was disposed of properly in the dumpster area for 2 of 2 dumpsters. The deficient practice could result in an unsanitary condition and the harborage of pests and insects. Findings include: During an initial kitchen observation conducted on 03/04/19 at 10:37 AM with the Dietary Manager (staff #133), the area behind two dumpsters was observed with several plastic wrappers, dirty tissues, an empty bottle of lotion, and two pair of gloves. An interview was conducted with the Food Service Director (staff #134) on 03/06/19 at 11:20 AM. Staff #134 stated the garbage dumpster area is checked frequently by the maintenance director and each time garbage bags are put into a dumpster. She also stated that garbage outside the dumpster is a health hazard and is not acceptable. An interview was conducted with the Administrator (staff #65) on 03/06/19 at 01:21 PM. The administrator stated that it is her expectation that the dumpster areas be free of trash and checked on a regular basis. She stated garbage behind or around the dumpster is an unacceptable violation. An interview was conducted with the Maintenance Director (staff #137) on 03/07/19 at 10:23 AM. The Maintenance Director stated that the garbage area is checked three times weekly and is cleaned up regularly. He stated that trash outside the dumpster is not acceptable. During an interview conducted with the Dietary Services Director (staff #133) on 03/07/19 at 01:10 PM, staff #133 stated there should be no garbage in the area around the dumpsters. Review of the facility's policy and procedure titled Dispose of Garbage and Refuse dated 8/2017 revealed the Dining Services Director coordinates with the Director of Maintenance to ensure the area surrounding the exterior dumpster area is maintained in a manor free of rubbish or other debris.
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 observation, staff interviews, and policy review, the facility failed to ensure infection control practices were followed during medication administration. This deficient practice could result in cross contamination, spreading infections to others. The census was 99. Findings include: A medication administration observation was conducted on (MONTH) 6, 2019 at 7:57 a.m. with a Registered Nurse (RN/staff #75). Staff #75 performed hand hygiene before preparing the medications. Four medications from multi-use bottles were observed being scooped from the bottle with her bare finger into the medication cup. The RN was then observed to pop a medication out of a bubble pack into her bare palm and place it into the medication cup. The medications were administered to the resident at 8:05 a.m. An interview was conducted immediately after the observation with staff #75. The RN stated that she puts the medications into her hand so they do not spill. She also stated this practice is not in compliance with their policy. In an interview conducted with the Director of Nursing (DON/staff #84) on (MONTH) 6, 2019 at 10:05 a.m., she stated her expectation is that medications removed from multi-use bottles be placed into the cap of the bottle and then into the medication cup. She stated if the nurse needs to touch the medication, they should wear gloves. The DON stated that if the medication becomes contaminated in any way, it should be disposed of. Review of the facility's policy titled Medication Administration dated (MONTH) (YEAR) revealed Medications are administered as prescribed in accordance with .good nursing principles and practices . Under Medication Preparation, the policy revealed, Hands are washed with soap and water and gloves applied prior to handling tablets.