STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035135	A. BUILDING ______ B. WING _____	**12/07/2018**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MONTECITO POST ACUTE CARE AND REHABILITATION	**51 SOUTH 48TH STREET 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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff and resident interviews, and facility documentation, the facility failed to ensure one allegation of misappropriation of resident property was reported to the State Agency (SA) in a timely manner. Findings include: Resident #51 was admitted to the facility on (MONTH) 21, (YEAR), with [DIAGNOSES REDACTED]. An annual Minimum Data Set (MDS) assessment dated (MONTH) 8, (YEAR), revealed a Brief Interview for Mental Status score of 15 which indicated the resident was cognitively intact. Review of the facility's Grievance Resolution Form dated (MONTH) 26, (YEAR) revealed resident #51 reported that she went to the shower room and when she came back her wallet was missing. The documentation revealed 2 credit cards, a debit card, and $120 were missing. The unit manager/assistant director of nursing (ADON/staff #201) was assigned to investigate. During an interview conducted with resident #51 on (MONTH) 3, (YEAR) at 9:35 a.m., she stated that her wallet was stolen last week. The resident stated that the wallet had $120, 2 credit cards, a debit card, her ID card, health insurance card, social security card, and a check book in it. She stated that she made staff aware and that the staff #201 spoke to her about it. During an interview conducted with the Director of Nursing (DON/staff #216) on (MONTH) 3, (YEAR) at 10:36 a.m., she stated they were aware of the resident's concerns and a grievance form had been started. An interview was conducted with staff #201 and staff #216 on (MONTH) 5, (YEAR) at 11:45 p.m. Staff #201 stated resident #51 reported on (MONTH) 26, (YEAR) that she was missing a coral color wallet that contained a credit card and $120. Staff #216 stated that this concern would have been reported to the State Agency if the resident would have stated that the wallet and the items inside had been stolen. Review of the State Agency data base did not reveal the allegation had been reported.
F 0641 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interviews, and policy review, the facility failed to ensure Minimum Data Set (MDS) assessments were accurate for three residents (#39, #51, and #145). Findings include: -Resident #39 was readmitted on (MONTH) 13, (YEAR) with [DIAGNOSES REDACTED]. Review of the clinical record revealed an admission assessment dated (MONTH) 13, (YEAR) that included the resident had an open wound to the left ankle. A wound physician note dated (MONTH) 14 and 28, (YEAR) revealed the resident had a left lateral ankle stage 3 pressure ulcer. The note also included the resident had the ulcer for several years. Weekly pressure ulcer assessments dated (MONTH) 18 and 25, (YEAR) included a stage 3 pressure ulcer to the resident's left outer ankle. However, an annual Minimum Data Set assessment dated (MONTH) 1, (YEAR) included the resident had a stage 3 pressure ulcer but that it was not present upon admission. During an interview conducted with the wound nurse (staff # 248) on (MONTH) 4, (YEAR) at 1:32 p.m., she stated the resident was admitted with the pressure ulcer to his left ankle. -Resident #51 was admitted to the facility on (MONTH) 21, (YEAR), with [DIAGNOSES REDACTED]. A care plan regarding [MEDICAL CONDITION] medication revised on (MONTH) 23, (YEAR), revealed the resident required the level two Preadmission Screening and Resident Review (PASRR) process due to serious mental illness (SMI) with an axis 2 [DIAGNOSES REDACTED]. Interventions included psych follow up to monitor symptoms and to adjust psych medications and to contact the PASRR Coordinator if the resident is transferred or discharged to another facility or lower level of care. Review of the clinical record revealed a letter dated (MONTH) 30, (YEAR) that the resident had a level two PASRR screening done on (MONTH) 23, (YEAR). The letter included the resident had SMI but was able to have needs met at the nursing facility level of care. However, an annual MDS assessment dated (MONTH) 8, (YEAR), revealed the resident was not considered by the state level two PASRR process to have a serious mental illness. During an interview conducted with the MDS Registered Nurse (RN/staff # 244) on (MONTH) 6, (YEAR) at 10:12 a.m., she stated that the MDS assessment should have been coded yes because the resident was considered by the level two PASRR process to have a SMI at the time of the assessment. -Resident #145 was admitted to the facility on (MONTH) 30, (YEAR) with [DIAGNOSES REDACTED]. The resident was discharged on (MONTH) 7, (YEAR). Review of the clinical record revealed a physician's orders [REDACTED]. A discharge summary dated (MONTH) 7, (YEAR) included the resident had returned to functional baseline and that the resident's health had improved sufficiently that the resident no longer needed the services of the facility. Nursing notes dated (MONTH) 7, (YEAR) revealed the resident was discharged home with home health services around 6:30 p.m. However, review of a discharge return not anticipated MDS assessment dated (MONTH) 7, (YEAR), revealed the resident had an unplanned discharged to an acute hospital. An interview was conducted with the MDS coordinator (staff #38) on (MONTH) 6, (YEAR) at 10:12 a.m. She stated physician orders, wound notes, social services notes, dietary notes, activity notes, nursing notes, and therapy notes are reviewed to complete MDS assessments. After reviewing the clinical record for this resident, she stated that the resident did discharge home and that the discharge MDS assessment coding was a mistake. During an interview conducted with the Director of Nursing (DON/staff #216) on (MONTH) 6, (YEAR) at 12:49 p.m., she stated that her expectation is that the MDS assessments be complete and accurate. Review of a facility policy titled, Resident Assessment: Accuracy of Assessment included, It is the policy of this facility to ensure that the assessment accurately reflect the resident's status.
F 0657 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.**

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 0657 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interviews, review of the clinical record, and policy review, the facility failed to ensure a care plan was revised for one resident (#106). Findings include: Resident #106 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A fall risk care plan initiated on 11/08/18 related to the resident gait/balance problems included a goal that the resident will not sustain serious injury through the review date. A review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a Brief Interview for Mental Status score of 15 which indicated the resident was cognitively intact. The MDS assessment also included the resident was totally dependent and required 2 or more staff for transfers. The fall risk care plan was revised on 11/30/18 to include the resident had an assisted fall with no injuries. A Nursing Progress note dated 11/30/2018 at 2:17 PM revealed the nurse was alerted to the room where the nurse found the resident on the floor, sitting on her butt. The note included the CNA stated that the patient fell to the floor due to the mechanical lift tipping over and that the resident was slowly assisted to the floor. The note also included the resident complained of side pain from the fall and that she sustained a little abrasion to the right inner arm. The patient had pain, but no swelling, tenderness, or bruising on the fall side. The note included the resident was assisted to bed by 5 staff members. During an initial interview conducted with resident #106 on 12/03/18 at 10:37 AM, the resident communicated, through writing, that the staff were transferring her between the wheel chair and bed when the mechanical lift caught on the bed and the resident fell to the floor with the lift almost tipping over on her. The resident included in the statement that no injuries were suffered and the staff were able to lower her slowly to the floor as the lift was tipping. The resident also included there were three Certified Nursing Assistants (CNAs) helping with the transfer. The fall care plan was revised on 12/03/18. Interventions included the following: anticipate and meet needs; avoid rearranging furniture; be sure the call light is within reach and encourage the resident to use it to call for assistance as needed; educate the resident/family/caregivers about safety reminders and what to do if a fall occurs; encourage the resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility; and therapy evaluation and treatment per physician orders. However, additional review of the care plans did not reveal any information regarding the type of transfer required, any special equipment needed for transfer, or the number of staff that may be required to safely transfer the resident. An interview was conducted on 12/06/18 at 1:45 PM with CNA (staff#116) who stated that it took 5 people to get the resident back to bed from the fall that occurred on 11/30/18, and that in the future they may have to have 4-5 staff to transfer the resident. During an interview conducted on 12/06/18 at 02:13 PM with the Director of Nursing (DON/staff #216), the DON stated that because of the resident's weight, the resident may require more than 3 people to assist with her transfers. An interview was conducted with the Assistant Director of Nursing (ADON/staff #201) on 12/06/18, who stated that she updated the Care Guidelines, but not the care plan to include using 4-5 people for transfers for this resident. Staff #201 stated that the Care Guidelines is an updated daily list of residents that contains some of the care requirements that CNAs can refer to. The ADON stated that the nurses refer to the care plan. Review of the facility's policy titled Fall Management System included that the resident's existing care plan will be updated and the interventions will address those elements determined by investigation as probable causal factors that contributed to the fall.
F 0679 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide activities to meet all resident's needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, staff interviews, and policy review, the facility failed to ensure that individualized activities were consistently offered to one resident (#29). Findings include: Resident #29 was admitted on (MONTH) 23, (YEAR) with [DIAGNOSES REDACTED]. Review of the annual MDS (Minimum Data Set assessment dated (MONTH) 3, (YEAR), revealed the resident prefers listening to music. A care plan regarding activities dated (MONTH) 22, (YEAR), included interventions for the resident to have Sensory Stimulation Program for 3-4 times weekly in her room. Interventions also included activities such as reading, music, smell, touch, etc. and that it is very important for the resident to listen to music. The quarterly MDS (Minimum Data Set) assessment dated (MONTH) 24, (YEAR), revealed the resident was rarely/never understood and had severely impaired cognitive skills for daily decision making. Review of the activity participation log for the resident revealed the following: September (YEAR): September 1-8: tactile stimulation on the 4th. September 9-15: tactile stimulation on the 10th and 13th. September 16-22: tactile stimulation on the 18th and on the 19th. September 23-30: tactile stimulation of reading on the 26th. Review of activities for (MONTH) (YEAR) did not reveal music was provided to the resident. October (YEAR): October 1-6: lotion and music on the 2nd and singing and television on the 5th. October 7-13: tactile stimulation on the 8th, lotion applied/television on the 11th, and lotion applied on the 12th. October 14-20: lotion applied/television on the 16th. October 21-27: reading/poem on the 22nd and nails/television on the 26th. October 28-31: talking about Halloween TV movie on the 30th and Halloween decorations on the 31st. Review of activities for (MONTH) (YEAR) revealed music was provided to the resident on the 2nd and on the 5th. November (YEAR): November 1-7: reading on the 1st and reading/tactile stimulation on the 5th. November 8-14: reading on the 14th. November 22-30: one on one activity on the 28th. Review of the activities for (MONTH) (YEAR) revealed no music was provided to the resident. December (YEAR): November 29th to (MONTH) 5th: one on one activity on (MONTH) 3rd and 4th. During an observation conducted on (MONTH) 3, (YEAR) at 3:08 PM, the resident was observed in bed with her eyes open. No music was on. An observation of the resident was conducted on (MONTH) 4, (YEAR) at 8:31 AM. The resident was observed in bed sleeping. No music was on. During an observation conducted on (MONTH) 4, (YEAR) at 11:45 AM, the resident was observed sleeping in bed. No music was on. An interview was conducted with a Certified Nursing Assistant (CNA/staff# 111) on (MONTH) 4, (YEAR) at 1:58 PM who stated that if a resident's family tells them that the resident likes to watch television or listen to music, they will turn on the television and music for the resident. During an interview conducted with a CNA (staff# 233) on (MONTH) 4, (YEAR) at 2:05 PM, the CNA stated that activities come in every day to work with the resident. An interview was conducted with a Licensed Practical Nurse (LPN/staff #241) on (MONTH) 4, (YEAR), at 2:11 PM. The nurse stated that music and the television is on all day and that the activities staff provides one on one activity to the resident almost daily. He stated that the resident's daughter told them that resident likes to watch the game shows and to listen to music. The LPN stated the daughter brought an iPod to leave at the resident's bedside for music and instructed the staff on the specific channels to play. However, the nurse was unable to find the iPod.

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F 0679 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) An interview was conducted with the Activities Supervisor (staff #252) on (MONTH) 4, (YEAR) at 2:21 PM. Staff #252 stated that they provide activities for non-verbal resident at least 2-3 times a week and more if the resident is restless or having a bad day. She stated the type of activities provided for resident #29 includes reading, singing, and tactile stimulation. Staff #252 stated that their book is the only documentation of activities provided to the resident. She stated that for day to day activities it is a team effort with the CNAs and the activities staff. During an interview conducted with the Director of Nursing (DON/staff# 216) on (MONTH) 6, (YEAR), at 1:51 PM, the DON stated that the families of non-verbal residents tell the staff about the resident's likes and dislikes. She stated that the care plan is developed according to the resident's needs and that her expectation is that staff follow the care plan. The DON also stated that any care or activity provided to a resident needs to be documented. The facility's policy regarding Activity revealed that activities, social events, and schedules are developed in conjunction with the resident's interests, assessments, and plan of care. The policy also included activities can be adapted to accommodate a resident's change in functioning due to physical or cognitive limitations.
F 0761 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**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 observation, staff interviews, and policy review, the facility failed to ensure controlled medications were not returned to the broken seal card and secured with tape. Findings include: A medication storage observation was conducted on (MONTH) 3, (YEAR) at 3:15 PM with a Registered Nurse (RN/staff #226). A medication card for [MEDICATION NAME] (antianxiety) 0.5 mg (milligrams) was observed with the seal broken with the medication secured with a strip of tape over the seal. A medication card for [MEDICATION NAME]-[MEDICATION NAME] (narcotic [MEDICATION NAME]) 5/325 mg was also observed with the seal broken with the medication secured with a strip of tape over the seal. An interview was immediately conducted with staff #226 who stated that if a narcotic is refused, the narcotic is supposed to be wasted with two nurses. The RN stated that they are not to tape the pill back in the card and that this was done on the night shift. An interview was conducted with the Director of Nursing (DON/staff #216) on (MONTH) 6, (YEAR) at 1:23 PM. The DON stated that the nurse is expected to waste a narcotic with another nurse not tape the narcotic back in the card. Staff #216 stated that nurses are not pharmacists, therefore they cannot repackage medications. The DON also stated that the night shift nurse repackaged the pill because she did not have another nurse to waste the pill with. The facility's policy regarding Medication Access and Storage revealed the provider pharmacy dispenses medication in containers that meet legal requirements and that medications are kept and stored in these containers. The policy included that transfer of medications from one container to another is done only by a pharmacist. The policy also included reconciliation of controlled medications are done at least every shift by the incoming and outgoing Licensed Nurses at the change of shifts.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews, clinical record review, and policy review, the facility failed to ensure transmission based precautions were implemented for one resident (#24). Findings include: Resident #24 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the quarterly Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status score of 15, which indicated the resident was cognitively intact. A nurse practitioner note dated 12/4/2018 included the resident had [MEDICAL CONDITION] with a generalized rash with macules and that the treatment was completed on 11/2/18. The note also included a plan for Dermatology to biopsy the recurrent rash. A physician's orders [REDACTED]. Review of the dermatology consult note dated 12/06/18 revealed the dermatologist believed this was a case of classic scabies rash around the waist, rib cage, and arms and recommended following scabies protocol in the facility. An observation conducted on 12/07/18 at 09:15 AM of the resident's room revealed no indication that transmission precautions should be used when entering and caring for the resident. An interview was conducted on 12/07/18 at 09:15 AM with Licensed Practical Nurse (LPN/staff #77) who stated that she applied cream to the resident that morning but did not notice the resident was not on isolation precaution. She stated that she washed her hands after applying the cream. During an interview conducted on 12/07/18 at 09:20 AM with a LPN (staff #124), the LPN stated that she did not see the part of the dermatologist note that indicated the resident had scabies, so the resident was not placed on transmission based precautions. An interview was conducted on 12/07/18 at 09:22 AM with the Registered Nurse/Infection Control Nurse (staff #183), who stated this resident should have been placed in isolation. Staff #183 stated that she was not told about the dermatologist note that indicated the resident had classic scabies. Review of the facility's policy titled Transmission Based Precautions and Isolation included in the policy statement that, It is the policy of this facility to implement infection control measures to prevent the spread of communicable diseases and conditions . Review of the facility's policy titled Infection and Prevention Control Program included Prevention of spread of infections is accomplished by use of Standard Precautions and/or other transmission based precautions .