STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035274	A. BUILDING _____ B. WING _____	06/20/2019

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NEURORESTORATIVE	5301 EAST THOMAS ROAD PHOENIX, AZ 85018

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 0550 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation and staff interviews, the facility failed to ensure that one resident (#3) was treated with dignity and respect. The deficient practice could result in residents experiencing a negative psychosocial outcome and decrease in quality of life. Findings include: Resident #3 was admitted to the facility (MONTH) 8, (YEAR), with [DIAGNOSES REDACTED]. A care plan for activities of daily living revised on (MONTH) 11, 2019 revealed the resident had a self-care performance deficit. A goal was to maintain current level of function in activities of daily living with slight improvement. An intervention included for extensive assistance by 1 staff with toileting. Another care plan revised on (MONTH) 11, 2019 identified that the resident was at risk for falls. A goal included to reduce fall risk. Interventions included the resident's call light would be within reach, encouraged the use of the call light for assistance as needed, and the resident needs prompt response to all requests for assistance. Review of a Nurse Practitioner (NP) note dated (MONTH) 4, 2019, revealed the resident has left [MEDICAL CONDITION] and is wheelchair bound. A Change in Status MDS (Minimum Data Set) assessment dated (MONTH) 29, 2019, revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. The MDS also included the resident had not rejected care. Review of a facility investigation revealed resident #3 reported that over the weekend (June 15 approximately 8 a.m.), he pressed his call light because he needed assistance to use the toilet and had 2-3 accidents, because it was taking staff too long to answer his call light. He said that during one of these incidents, a registered nurse (RN/staff #12) took too long to help him, which resulted in him urinating in his brief. The resident reported that he heard staff #12 say she didn't have time for this, as she was coming towards his room and that she sounded frustrated. The resident stated that when staff #12 came to his room, he told her that he was not able to hold it and had urinated in his brief. He said that staff #12 asked why couldn't he wait. He said that staff #12 was asking a lot of questions while she was changing him and he felt like he was being scolded. The investigation included an interview with staff #12, who stated that while walking down the hallway, she may have said that she didn't have time for this under her breath, but she did not say it to the resident. Per the report, staff #12 said that she was frustrated because she was the only one answering the resident's call light and she wasn't even assigned to provide care to him. She stated that she asked the resident several questions about his incontinence, because the resident had five episodes that day and she wanted to make sure the resident did not have symptoms related to [MEDICAL CONDITION] activity or a urinary tract infection. An interview was conducted on (MONTH) 18, 2019 at 9:27 a.m., with resident #3. He stated that a couple of days ago, he had to wait 30 minutes, 4 different times for staff to come and assist him with using the toilet. He said that during one of these incidents he thought staff #12 was mad at him, because she said that she didn't have time for this. An interview was conducted on (MONTH) 20, 2019 at 8:40 a.m. with the Executive Director of Operations (staff 30), who stated that she had spoken to staff #12 who reported that she didn't think she said I don't have time for this. She said the other nurse was assigned to the resident and she had already changed the resident five times, so when the resident's call light was on again, she may have said it while she was in the hall by the resident's room. Staff #30 told staff #12 that the resident reported hearing her say that she did not have time for this and it hurt his feelings. Staff #12 said that if she did say something, it was not directed towards the resident. An interview was conducted on (MONTH) 20, 2019 at 9:38 a.m., with staff #12. She stated that a lot of times she answers the call lights, because staff are not answering them. She stated that she had answered the resident's call light for the second time that day and he had soiled his pants again. She said that she asked the resident why he kept soiling his pants and he told her that staff are not answering his call light soon enough. She stated that she told the resident that he is able to find staff when he wants a cigarette, so why can't he find staff when he needs to use the toilet. She stated that she was frustrated because the resident had already been changed four times that shift. She said that she may have said something under her breath, but she would not have said something directly to the resident.
F 0641 **Level of harm -** Potential for minimal harm **Residents Affected -** Some	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record reviews, staff and resident interviews and review of the Resident Assessment Instrument (RAI) manual, the facility failed to ensure that the Minimum Data Set (MDS) assessments for four of five resident's (#1, #5, #6, #2) sampled accurately reflected their status relating to restraints. The deficient practice could result in an inaccurate plan of care for residents. Findings include: -Resident #1 admitted to the facility on (MONTH) 23, 2010, with [DIAGNOSES REDACTED]. Review of a current care plan for resident #1 dated (MONTH) 19, 2019 revealed that resident #1 needed total assistance with ADL's and was totally dependent of 1-2 staff for repositioning and turning in bed, and was totally dependent for toileting and transfers. A physician's orders [REDACTED]. Review of an annual MDS for resident #1 dated (MONTH) 6, 2019, revealed the resident was rarely/never understood and decision making skills were severely impaired. The MDS included the resident required total assistance with mobility and ADL's (Activities of Daily Living) and that walking did not occur. The MDS also included the resident used a bed rail daily, as a physical restraint. The physical restraint Care Area Assessment (CAA) included the resident had [MEDICAL CONDITION]/paresis and that staff provided total assistance with all ADL's. A current care plan dated (MONTH) 11, 2019 for resident #1 included the resident uses physical restraints (bilateral upper side rails) related to being at risk for falls. A goal was that the resident would remain free of complications related to restraint use. A nurse practitioner note dated (MONTH) 6, 2019 revealed the resident was a quadriplegic. An observation of resident #1 was conducted on (MONTH) 18, 2019 at 9:04 a.m. The resident was observed lying in bed with upper side rails raised on both sides. During the observation, the resident was not observed to exhibit any active

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

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F 0641 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	(continued... from page 1) movements. Another observation of resident #1 was conducted on (MONTH) 20, 2019 at 9:10 a.m. The resident was observed lying in bed with upper side rails raised on both sides. During the observation, the resident was not observed to exhibit any active movements. An interview was conducted with a Certified Nursing Assistant (CNA/staff #26) on (MONTH) 20, 2019 at 9:43 a.m. She stated that resident #1 had raised upper side rails on both sides of the bed. Staff #26 said that resident #1 was not mobile and would be unable to get out of the bed with or without the side rails. -Resident #2 was admitted to the facility on (MONTH) 22, (YEAR), with [DIAGNOSES REDACTED]. Review of the current care plan dated (MONTH) 20, 2019 revealed the resident had an ADL self-care deficit related to ALS. Interventions indicated the resident was totally dependent with bed mobility, toilet use and transfers. This care plan was revised on (MONTH) 26, 2019 to reflect the use of physical restraints (bilateral upper side rails) per resident's request. A goal was that the resident would remain free of complications related to restraint use. A physician's orders [REDACTED]. A physical restraint informed consent form dated (MONTH) 28, 2019 revealed the resident verbally consented to bilateral upper side rails, per his preference. Review of an annual MDS assessment dated (MONTH) 3, 2019 revealed the resident had a BIMS (Brief Interview for Mental Status) score of 15, indicating intact cognition. The MDS included the resident required total assistance for bed mobility and transfers and required total assistance with all ADL's. The MDS also included the resident utilized a bed rail, as a restraint daily. A Nurse Practitioner note dated (MONTH) 3, 2019 revealed the resident had no purposeful movement of bilateral extremities and was quadriplegic. A quarterly MDS assessment dated (MONTH) 3, 2019 revealed the resident had a BIMS score of 15. The MDS included the resident required total assistance with bed mobility and transfers and with ADL's. The MDS also included the resident utilized a physical restraint daily in the form of a bed rail. A Nurse Practitioner note dated (MONTH) 17, 2019 revealed the resident had no purposeful movement of bilateral extremities and was quadriplegic. An observation of resident #2 was conducted on (MONTH) 18, 2019 at 10:03 a.m. The resident was observed in bed with both upper side rails in the raised position. The resident was not observed to exhibit any active movements, beyond eye movements. Another observation of resident #2 was conducted on (MONTH) 20, 2019 of the resident in bed with upper side rails raised bilaterally. During the observation, the resident was not observed to exhibit any active movements, beyond eye movements. An interview was conducted with a CNA (staff #26) on (MONTH) 20, 2019 at 11:22 a.m. She stated that resident #2 has upper side rails raised on both sides of the bed but the side rails do not keep him from getting out of bed, as he is functionally unable to initiate a transfer from the bed and requires a mechanical lift. -Resident #5 was admitted to the facility on (MONTH) 28, (YEAR), with a readmission on (MONTH) 18, 2019. [DIAGNOSES REDACTED]. Review of a care plan dated (MONTH) 11, (YEAR) revealed the resident had an ADL self-care performance deficit, related to weakness/[MEDICAL CONDITION]. Interventions included the resident required total assistance with bed mobility and transfers with a mechanical lift; utilizes half rails per doctor's order for safety during care provision and to observe for injury or entrapment related to side rail use. A physical restraint informed consent form for resident #5 dated (MONTH) 19, 2019 revealed that the resident's husband consented to the use of a restraint, bilateral upper side rails up bilaterally, on a temporary basis. Review of the physician's orders [REDACTED]. Review of a admission MDS assessment for resident #5 dated (MONTH) 29, 2019 revealed the resident had a BIMS score of 12 which indicated the resident had moderately impaired cognition. The assessment further noted that the resident was total assist with bed mobility, and transfers, and did not walk. The assessment noted that the resident had a physical restraint used daily in the form of a bed rail. The physical restraint CAA associated with this MDS included that the resident used a bed rail as a restraint daily, had [MEDICAL CONDITION] and needed assist with mobility. The care plan was revised on (MONTH) 11, 2019 to reflect the resident utilizes physical restraints which included for bilateral upper rails per resident request. A goal was that the resident will remain free of complications related to restraint use. A nurse practitioner's note dated (MONTH) 17, 2019 revealed the resident was a quadriplegic and has paralysis of extremities.An observation of resident #5 was conducted on (MONTH) 18, 2019 at 11:40 a.m. The resident was observed in bed with both upper side rails in the raised position. The resident was able to move her arms up and down and side to side and turn her head, however, she made no movements with her lower body. An interview with the resident was conducted during the above observation. The resident stated that she prefers the side rails up, as she has no truck support and the pillows used to support her trunk rest against the side rails. She stated that she is not able to move her body from the nipple line down related to a car accident with spinal injuries, and would be unable to get out of bed with or without the side rails in place. She stated the side rails have no impact on her access to her own body or her ability to get in and out of bed. An interview was conducted with a CNA (staff #26) on (MONTH) 20, 2019 at 11:22 a.m. She stated that resident #5 has upper side rails raised on both sides of the bed but the side rails do not keep her from getting out of bed, as she is functionally unable to initiate a transfer from the bed and requires a mechanical lift. -Resident #6 was admitted to the facility on (MONTH) 17, (YEAR), with [DIAGNOSES REDACTED]. Review of a care plan dated (MONTH) 20, 2019 revealed the resident had an ADL self-care performance deficit related to erased mobility and decreased endurance. Interventions included the resident required one staff to turn and reposition in bed and was totally dependent on staff for transferring. A physical restraint informed consent form for resident #6 dated (MONTH) 26, 2019, revealed the resident had bilateral upper side rails, per their preference. The form did not contain the signature of the resident or the responsible party, however, there was a signature for the physician obtaining the consent and two signatures for the licensed nurse verifying proof of consent. The physician's orders [REDACTED]. A review of a care plan dated (MONTH) 12, 2019 revealed the resident uses physical restraints of bilateral upper side rails related to impaired safety awareness per family request. A goal was that the resident would remain free of complications related to restraint use. A quarterly MDS assessment dated (MONTH) 23, 2019 revealed that the BIMS could not be completed as the resident was rarely/never understood. The MDS included the resident had memory problems and had moderate impairment with decision making skills, and was totally dependent on staff for bed mobility and ADL's except with dressing, which was extensive assist. The MDS also noted that the resident had a physical restraint used daily in the form of a bed rail. An observation of resident #6 was conducted on (MONTH) 18, 2019 at 12:30 p.m. The resident was observed in bed with both upper side rails raised. There were no significant body movements noted. The resident was observed blinking his eyes and moving some fingers. Another observation of resident #6 was conducted on (MONTH) 20, 2019 at 2:43 p.m. The resident was in bed with upper side rails raised bilaterally. There were no significant body movements noted. The resident was observed blinking his eyes and moving some fingers. An interview was conducted with a CNA (staff #26) on (MONTH) 20, 2019 at 11:22 a.m. She stated that resident #6 has upper side rails raised on both sides of the bed but the side rails do not keep him from getting out of bed, as he is functionally unable to initiate a transfer from the bed and requires a mechanical lift. An interview was conducted with a Licensed Practical Nurse (LPN/staff #18) on (MONTH) 20, 2019 at 11:43 a.m. She stated that side rails could be considered a restraint, if they keep a resident from getting out of bed. She stated that she none of the side rails used in the facility were keeping the residents from getting out of bed or acting as a restraint, as resident #1,#2, #5 and #6 are not able to initiate getting out of bed due to their functional status. An interview was conducted with the MDS coordinator (Registered Nurse/RN/staff #32) on (MONTH) 20, 2019. She stated that the

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F 0641 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	(continued... from page 2) MDS is always supposed to be accurate and that everything documented on an MDS requires supportive documentation. She stated that in the electronic system used for the MDS, she has access to the RAI manual and is able to look up any questions she may have. She further stated that side rails are always a restraint according to her training in RAI class and according to the RAI manual, side rails are considered a restraint. She stated that resident #1 has to have the head of his bed raised and would slide out without the side rails. Staff #32 said resident #1 would not be able to initiate a transfer from the bed and that the rails do not interfere with access to his body. She stated that resident #2 requires a ventilator, tube feeing and boots on his feet and if the boots came off the bed, he would slide to the floor. She stated that she did not believe that resident #2 could physically initiate a transfer out of bed and the side rails did not interfere with the resident's access to his own body. She stated that resident #5 was alert and oriented and requires the bed rails, because the head of her bed is raised when she sleeps and when turned, she could fall out of bed without the side rails. She stated that the head of the bed for resident #6 has to be raised and that the side rails are required to be raised to keep him from slipping out of bed. She stated that she does not know if resident #6 could purposely transfer out of bed. She said the side rails were not interfering with resident #6's access to his body. An interview was conducted with the Administrator (staff #1) on (MONTH) 20, 2019. He stated that he would expect the MDS's to be accurate. He stated that the facility does not have a policy for MDS accuracy and instead use the RAI manual, as a reference to complete the MDS. He stated that to be a restraint, the device has to limit the ability of a resident to move freely and that the side rails for residents #1, #2, #5 and #6 do not meet the definition of a restraint. He said that as a result, the MDS's were coded inaccurately and did not follow facility expectations for accurate assessments. Review of the current RAI manual revealed that a physical restraint is defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or access to one's body. The directions for coding physical restraints indicate to code as not used if the item was used but did not meet the definition. The manual included that bed rails include any combination of partial or full rails (e.g., one-side half-rail, one-side full rail, two-sided half-rails or quarter-rails, rails along the side of the bed that block three-quarters to the whole length of the mattress from top to bottom, etc.). If bed rails are used as positioning devices and meet the definition of a physical restraint the nursing home must code their use as a restraint. The manual noted that bed rails used with residents who are immobile and cannot voluntarily get out of bed because of a physical limitation or because proper assistive devices were not present, the bed rails do not meet the definition of a physical restraint.
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, interviews, and policy review, the facility failed to ensure professional standards of quality were met during medication administration for 2 sampled residents (#2 and #4). The deficient practice could result in contaminated needles being used for residents. Findings include: -Resident #2 was admitted to the facility on (MONTH) 22, (YEAR) with [DIAGNOSES REDACTED]. A physician order [REDACTED]. A medication administration observation was conducted on (MONTH) 20, 2019 at 9:00 a.m. with a Licensed Practical Nurse (LPN/staff #18). Staff #18 was observed to draw up resident #2's [MEDICATION NAME] for administration with a syringe. After drawing the medication up into the syringe, the needle was not capped. The LPN stated that this type of syringe was unable to be recapped once uncapped, therefore she did not recap it prior to administration. Staff #18 then continued to prepare resident #2's medications, take the medications and the uncapped syringe into the resident's room and set the syringe down on the resident's bedside table. The medications were then administered to resident #2 including the [MEDICATION NAME]. -A second observation of insulin administration for resident #4 was conducted on (MONTH) 20, 2019 at 7:57 a.m. At this time, a Licensed Practical Nurse (LPN/staff #18) was observed to draw up insulin into a syringe, then laid the unprotected syringe with a needle exposed on the top of her cart, while she collected the other medication supplies. The nurse did not utilize the safety shield (a locking mechanism which covers the needle and protects the user from accidental needlestick injury). The nurse then walked down the hallway into the resident's room, as she held the uncapped insulin syringe in her hand, with the needle pointing upwards and outwards, at the same time holding 3-4 medication cups. She then walked into the resident's room and placed the insulin syringe with the exposed needle on a table. She walked around the resident's bed and administered the other medications. She walked back to the other side of the bed where the insulin syringe was laying on the table and prepared the resident for the injection. After administering the insulin, she pulled the safety cap up on the syringe and then disposed of it in the sharps container. An interview was conducted with staff #18 on (MONTH) 20, 2019 at 2:03 PM. She stated that safe handling of needles includes using the safety shield after drawing up insulin into a syringe, and before transporting it into a resident's room. She said she didn't cap the needle because she was nervous and knew that she did not do it right. An interview was conducted on (MONTH) 20, 2019 at 2:12 PM, with the Director of Nursing (DON/staff #2). She stated her expectation for nurses is to cap the needle or utilize the safety shield. The facility policy titled, Medication Administration Subcutaneous Insulin stated to administer subcutaneous insulin as ordered in a safe, accurate and effective manner. Additionally, the policy stated the needle is to be recapped using the safety device to permit safe transportation. Review of facility's policy for receiving pharmacy products and services dated (YEAR) revealed that MAR indicated [REDACTED]. Review of the facility's policy for subcutaneous insulin revealed that stated to administer subcutaneous insulin as ordered in a safe, accurate and effective manner. Additionally, the policy stated the needle is to be recapped using the safety device to permit safe transportation.
F 0756 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interview, and policy review, the facility failed to ensure recommendations from the pharmacist were reviewed and acted upon by the physician for one of five sampled residents (#2). The deficient practice could result in residents receiving unnecessary medications. Findings include: -Resident #2 was admitted to the facility on (MONTH) 22, (YEAR) with [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. A annual Minimum Data Set (MDS) assessment dated (MONTH) 3, 2019 included the resident had no problems with short term or long term memory and was independent with daily decision making. The assessment also included the resident received an antidepressant medication for the 7 days of the look-back period. A recommendation made by a licensed pharmacist dated (MONTH) 11, 2019 included resident #2 had been receiving [MEDICATION NAME] 30 mg once a day for management of depressive symptoms since 2/23/18 and recommended an initial attempt at a gradual dose reduction (GDR). The recommendation also included reducing the dose of [MEDICATION NAME] to 15 mg once a day. However, review of the clinical record revealed no evidence the pharmacist's recommendation was reviewed and acted upon by the physician. Review of the Medication Administration Record [REDACTED]. In an interview with the interim Director of Nursing (DON/staff #2) on (MONTH) 20, 2019 at 12:36 p.m., she stated the pharmacy reviews are sent by the consultant pharmacist to the administrator and DON via email. Staff #2 stated any recommendations are then printed out and put in the physician communication book for them to review. The DON stated that the physician reviews the recommendations and signs them, and that any new orders would be put into the electronic charting system. A facility's policy titled Patient Specific Therapeutic Interchange included, The prescriber will receive patient specific

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F 0756 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) therapeutic interchange (PSTI) requests from an authorized pharmacist .Facility staff should notify the physician/prescriber when a request for PSTI is received by the facility and is awaiting action. The physician/prescriber should review the request and accept or deny the request based on resident characteristics, clinical condition, and other medical assessment criteria. All acceptances and denials must be signed by the physician/prescriber.
F 0757 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews and policy and procedures, the facility failed to ensure one of five sampled residents (#4) was free of unnecessary drugs, by failing to administer pain medication according to physician's orders [REDACTED]. Findings include: Resident #4 was admitted on (MONTH) 21, (YEAR), with [DIAGNOSES REDACTED]. A pain care plan revised on (MONTH) 20, 2019 included the resident experienced pain related to disease processes. The goal was for the resident to be free of any discomfort or adverse side effects from pain medication through the review date. Interventions included to administer [MEDICATION NAME] medications as ordered by the physician and monitor/document side effects and effectiveness every shift. A quarterly Minimum Data Set (MDS) assessment dated (MONTH) 7, 2019 revealed the resident had severely impaired decision making skills and was rarely/never understood. In Section J of the MDS, the resident was assessed to not have pain during the 7 day lookback period. A physician's orders [REDACTED]. Further review of the physician orders [REDACTED]. Review of the (MONTH) 2019 Medication Administration Record [REDACTED]. An interview was conducted on (MONTH) 20, 2019 at 1:19 p.m., with a Licensed Practical Nurse (LPN/staff #18). She stated that her process for administering pain medications includes looking at the ordered parameters. She said if the resident's pain level was less than the ordered parameters, she would hold the [MEDICATION NAME] and offer a non-opioid [MEDICATION NAME] instead. She said if there were no orders for a non-opioid [MEDICATION NAME], she would call the physician. An interview was conducted on (MONTH) 20, 2019 at 2:03 p.m., with the Director of Nursing (DON/staff #2). She stated her expectation for nursing is to follow the physician's orders [REDACTED]. Review of a facility policy titled, General Dose Preparation and Medication Administration revealed that prior to each administration of medication, facility staff should verify that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, and for the correct resident.
F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview, and policy review, the facility failed to ensure one of five sampled residents (#2) medication regimen was free from unnecessary medications and failed to ensure an as needed (PRN) antipsychotic medication was limited to 14 days for one of five sampled residents (#4). The deficient practice could result in residents receiving [MEDICAL CONDITION] medications which are unnecessary and could result in residents experiencing possible adverse consequences Findings include: -Resident #2 was admitted to the facility on (MONTH) 22, (YEAR) with [DIAGNOSES REDACTED]. A physician's order dated (MONTH) 11, (YEAR) included for [MEDICATION NAME] (antidepressant) 30 milligrams (mg) via [DEVICE] at bedtime for depression as evidenced by sadness. A care plan dated (MONTH) 11, (YEAR) included the resident used the antidepressant medication [MEDICATION NAME] related to depression as evidenced by sadness. Interventions included administering the medication as ordered by the physician and monitoring for side effects and effectiveness every shift. A annual Minimum Data Set (MDS) assessment dated (MONTH) 3, 2019 included the resident had no problems with short term or long term memory and was independent with daily decision making. The assessment also included the resident received an antidepressant medication for the 7 days of the look-back period. A recommendation made by a licensed pharmacist dated (MONTH) 11, 2019 included resident #2 had been receiving [MEDICATION NAME] 30 mg once a day for management of depressive symptoms since 2/23/18 and recommended an initial attempt at a gradual dose reduction (GDR). The pharmacist's recommendation also included reducing the dose of [MEDICATION NAME] to 15 mg once a day. However, review of the clinical record revealed no evidence the pharmacist recommendation was reviewed and acted up on by a physician or that a GDR had been attempted. Review of the Medication Administration Record [REDACTED]. In an interview with the interim Director of Nursing (DON/staff #2) on (MONTH) 20, 2019 at 12:36 p.m., she stated the pharmacy reviews are sent by the consultant pharmacist to the administrator and DON via email. She stated any recommendations are then printed out and put in the physician communication book for them to review. The DON stated the physician reviews the recommendations and signs them and that any new orders would be put into the electronic charting system. The facility's policy regarding psychotherapeutic medications revealed each quarter, at a minimum, the Interdisciplinary Team members review with the physician and evaluate the continued need for, or reduction of, psychotherapeutic medication(s). The physician will enter comments and sign the Psychotherapeutic medication Summary Sheet. -Resident #4 was admitted on (MONTH) 21, (YEAR), with [DIAGNOSES REDACTED]. A physician's order dated (MONTH) 4, (YEAR) included for [MEDICATION NAME] (anxiolytic) 0.5 milligrams (mg), 1 tablet via Gastronomy-Tube ([DEVICE]) every 8 hours as needed (PRN) for anxiety. The order did not include a 14 day stop date. According to the August, (MONTH) and (MONTH) (YEAR) Medication Administration Records (MARs), the resident received [MEDICATION NAME] 0.5 mg approximately 5 times each month. Review of the clinical record revealed no documentation by the physician/nurse practitioner (NP) regarding the rationale for the continued use of [MEDICATION NAME] beyond 14 days. The annual Minimum Data Set (MDS) assessment dated (MONTH) 5, (YEAR) revealed the resident was rarely/never understood. Section N revealed the resident received anxiolytic medication 1 out of 7 days during the look back period. Physician orders included the [MEDICATION NAME] was discontinued on (MONTH) 7, (YEAR). A physician's order dated (MONTH) 8, (YEAR) included for [MEDICATION NAME] 0.5 mg, 1 tablet via [DEVICE] every 8 hours PRN for anxiety. The order did not include a 14 day stop date. Further review of the clinical record revealed there was no documentation by the physician/NP regarding the rationale for continuing the use of [MEDICATION NAME] PRN. Review of the (MONTH) (YEAR) MAR indicated [REDACTED]. Review of the (MONTH) (YEAR) MAR indicated [REDACTED]. Physician orders included [MEDICATION NAME] was discontinued on (MONTH) 30, (YEAR). However, another physician's order dated (MONTH) 31, 2019 was obtained for [MEDICATION NAME] 0.5 mg, 1 tablet via [DEVICE], every 8 hours as needed for anxiety. The order did not include a 14 day stop date or any rationale for its continued use. A pharmacy consultation report dated (MONTH) 15, 2019 included the following documentation by the pharmacist's: The resident has had an as needed order for an anxiolytic, which has been in place for greater than 14 days without a stop date. The pharmacist's recommendation was to discontinue the medication or if the medication could not be discontinued, current

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	035274	A. BUILDING _____ B. WING _____	06/20/2019

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NEURORESTORATIVE	5301 EAST THOMAS ROAD PHOENIX, AZ 85018

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 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) regulations require that the provider document the indication for use, the intended duration of therapy and the rationale for extending the time period. Review of the (MONTH) 2019 MAR indicated [REDACTED]. A pharmacy recommendation dated (MONTH) 1, 2019 - (MONTH) 12, 2019 revealed a repeated recommendation to discontinue the as needed [MEDICATION NAME] 0.5 mg, due to the order being in place for greater than 14 days without a stop date. The pharmacist's recommendation was to discontinue the medication or if the medication could not be discontinued, current regulations require that the provider document the indication for use, the intended duration of therapy, and the rationale for the extending the time period. Further review of the pharmacy recommendation dated (MONTH) 1, 2019 - (MONTH) 12, 2019 revealed a provider response/rationale which included that due to the resident's history and status, the resident needed the PRN [MEDICATION NAME] to keep him safe and less anxious. However, the provider response did not include a duration for the PRN [MEDICATION NAME]. Review of the (MONTH) 2019 MAR indicated [REDACTED]. Another pharmacy recommendation dated (MONTH) 1, 2019 - (MONTH) 31, 2019 included a recommendation to discontinue the PRN [MEDICATION NAME], or provide a rationale for it's continued use, which has been in place for greater than 14 days without a stop date. According to the (MONTH) 2019 MAR, the resident received [MEDICATION NAME] 0.5 mg as PRN more than 7 times. A physician's order dated (MONTH) 23, 2019 included to discontinue [MEDICATION NAME] 0.5 mg every 8 hours as needed. An interview was conducted on (MONTH) 20, 2019 at 2:09 p.m., with the Director of Nursing (DON/staff #2). She stated that it is her expectation for the 14 day limit for as needed psychoactive medications to be communicated between pharmacy and the physician and visa versa. She said the pharmacist comes in monthly to review medications, and that he does an exit interview with staff. She said that the facility also receives a report via email, which is printed and either given to the Nurse Practitioner or Medical Doctor (MD) or placed in a communication book. Ideally, she said the MD would respond, but things have fallen through the cracks and there wasn't any follow up during the change of administration. Review of the facility policy titled, General Dose Preparation and Medication Administration and Restraints - Psychotherapeutic Medication revealed no information regarding the Federal regulation which limits as needed [MEDICAL CONDITION] medications to 14 days, except if a rationale and end date are provided.
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 and procedures, the facility failed to ensure that expired drugs and biologicals were discarded and not available for resident use. Findings include: An observation of the medication room was conducted on (MONTH) 18, 2019 at 10:38 a.m. with a Registered Nurse (staff #10). The following items were found stored on shelves and/or the counter and were expired: [MEDICATION NAME] HFA ([MEDICATION NAME] sulfate inhalation aerosol)-with an expiration date of (MONTH) 2019 Orange topped vacutainer (8-10 tubes)- with an expiration date of (MONTH) 31, (YEAR) Orange topped vacutainer (5-8 tubes)-with an expiration date of (MONTH) 31, (YEAR) EZ swab collection transport system (7)-with an expiration date of (MONTH) 31, 2019 Blue topped vacutainer bag of 20-30 tubes, with an expiration date of (MONTH) 31, (YEAR) Blue topped vacutainer bag of 20-30 tubes-with an expiration date of (MONTH) 30, (YEAR) Blue topped vacutainer bag of 20-30 tubes-with an expiration date of (MONTH) 31, 2019 [MEDICATION NAME] lock flush (1 box/approximately 30)-with an expiration date of (MONTH) 14, (YEAR) Purple topped vacutainer (8-10 tubes)-with an expiration date of (MONTH) 31, (YEAR) Purple topped vacutainer (8-10 tubes)-with an expiration date of (MONTH) 30, 2019 Green topped vacutainer (10-12 tubes)-with an expiration date of (MONTH) 31, (YEAR) An interview was conducted on (MONTH) 18, 2019 at 10:57 a.m., with staff #10. She stated that nursing used to use the blood collection supplies, but since the facility switched lab companies, a phlebotomist comes out to draw blood. She stated that nurses are to check the expiration dates prior to administration. However, she did not know whose responsibility it was to remove the expired medications/items from the medication room. An interview was conducted on (MONTH) 20, 2019 at 2:09 p.m., with the Director of Nursing (DON/staff #2). She stated that her expectation is for nursing to maintain professional standards in all areas related to resident care, including to discard outdated supplies. The facility policy titled, Storage and Expiration of Medications, Biologicals, Syringes and Needles revealed the facility should ensure that medications and biologicals that have an expired date on the label or have been retained longer than recommended by the manufacturer or supplier guidelines, or have been contaminated or deteriorated, are stored separate from other medications until destroyed or returned to the pharmacy or supplier.
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 personnel record reviews, staff interviews and policies and procedures, the facility failed to ensure that one of 10 sampled employees (#18) had current evidence of freedom from infectious [MEDICAL CONDITION] (TB). The deficient practice could result in the potential of residents and employees being exposed to TB. Findings include: A review of the personnel record for a Licensed Practical Nurse (LPN/staff #18) revealed a hire date of (MONTH) 19, (YEAR). The record further contained documentation of a negative TB skin test dated (MONTH) 20, (YEAR). However, there was no current documentation that staff #18 was free of TB. An interview was conducted with a Corporate RN, the Executive Director of Operations (staff #30) on (MONTH) 19, 2019 at 9:32 a.m. She stated that staff #18 received TB testing from her former employer on (MONTH) 20, 2019 and did not have a current TB test. She said they were now doing the testing process at this time. Another interview was conducted with staff #30 on (MONTH) 20, 2019 at 9:20 a.m. She stated the facility does TB screens by the first day of hire and if the staff member had a current TB test from a previous job, they would do a second TB test to make it a two-step test. She stated that all employees receive a health screen/including TB screening each year. She stated that staff #18 received her TB testing late which increased the risk of exposure to TB by residents and employees. She further stated that the facility did not follow their policy/protocol, as the LPN should have had the second step upon hire and then tested annually. A review of the policy regarding [MEDICAL CONDITION] screening for employees revealed the purpose was to promote resident and employee safety and well-being, by screening employees for [MEDICAL CONDITION] and initiating appropriate follow-up. For new employees, a Mantoux Purified Protein Derivative (PPD) skin test must be formed and that the skin testing will employ the two-step procedure. The policy included that employees with a negative skin test history will have an annual PPD skin test and an annual symptom screening using the [MEDICAL CONDITION] Symptom-Screen Questionnaire.
F 0881 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Implement a program that monitors antibiotic use.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility documents, staff interviews and policy review, the facility failed to establish and implement an Antibiotic Stewardship Program that includes antibiotic use protocols and a system to monitor antibiotic use. Failure to promote and monitor appropriate use of antibiotics may lead to increased drug events and drug interactions, serious diarrheal infections from [MEDICAL CONDITION], and/or colonization and/or infection with antibiotic-resistant organisms.

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F 0881 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 5) Findings include: Review of the facility Antibiotic Stewardship binder from (MONTH) - (MONTH) 2019, revealed there was a floor map of the facility for each month. The floor map included room numbers with a colored dot to indicate an active infection such as eye infection urinary tract infection. On each page there were 2-4 residents listed. On additional forms, the names of the resident's were listed, along with the type of infection. However, the tracking logs did not indicate if any cultures had been done, any strains of bacteria which were identified and no antibiotic treatment information. An interview was conducted on (MONTH) 20, 2019 at 11:51 AM with the Director of Nursing (DON/staff #2). She stated that the facility follows the McGreer's Criteria (definitions of infection for surveillance in Long Term Care facilities). She further stated that there's really not a correct antibiotic stewardship program in place at this time. She said as far as implementing an infection surveillance plan for identifying, tracking, monitoring and reporting of infections, the facility is not really up-to-date. Staff #2 stated she had been at this facility for approximately 2 months and currently was in charge of the program. She said that during the transition in administration, some things had fallen through the cracks and that the Antibiotic Stewardship Program was one of them. Review of the facility Antimicrobial Stewardship Program policy revealed a list of infection control committee members which should include at a minimum, the Medical Director of the facility, the Director of Nursing Services, the facility Infection Control Designee, and the consultant pharmacist. The program overview stated that the antimicrobial stewardship program would provide guidance for optimal antimicrobial therapy prescribed by the facility physician/prescribers, with the intent to minimize the risk of antibiotic resistance. The policy stated the essential data to be reviewed by the committee should include antimicrobial orders and utilization, clinical documentation supporting resident condition and assessment, supplemental information from: infection surveillance logs, microbiology testing, other tests used to confirm infection, such as imaging, trends in infections by unit and facility-wide, trends by prescriber and effective communication of suspected infections, confirmed infections, and antimicrobial orders among nursing staff and between nurses, physicians/prescribers and the pharmacy. Additionally, the policy stated the program should be evaluated by conducting an assessment of current antimicrobial use practices and reassess practices at least annually. The facility assessment should include pharmacy, infection surveillance, microbiology, the list of positions by job description that are the core of the program, the reporting of data and barriers to the implementation of the program. The facility policy titled, Antimicrobial Stewardship Program stated it is the policy of the facility to implement an antimicrobial stewardship program which would promote appropriate use of antibiotics while optimizing the treatment of [REDACTED]. Further, the document stated that the policy had the potential to limit antibiotic resistance, while improving treatment efficacy and resident safety.