STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035174	A. BUILDING _____ B. WING _____	10/03/2019

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PARK AVENUE HEALTH AND REHABILITATION CENTER	2001 NORTH PARK AVENUE TUCSON, AZ 85719

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 0602 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Protect each resident from the wrongful use of the resident's belongings or money.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed clinical record review, facility documentation, staff interviews and policy review, the facility failed to ensure one resident's (#317) funds were not misappropriated. The deficient practice could result in other residents' funds being misappropriated. Findings include: Resident #317 was admitted to the facility on (MONTH) 30, (YEAR), with [DIAGNOSES REDACTED]. Review of the clinical record revealed the resident expired on (MONTH) 7, 2019. Review of the facility's investigation revealed that on (MONTH) 12, 2019, the Business Office Manager noted discrepancies in the resident's debit card account regarding purchases which occurred after the resident's death. The Business Office Manager reported her concerns to the Administrator on (MONTH) 12, 2019 at 12:30 p.m. The Administrator requested assistance from the Attorney General's office on (MONTH) 12, 2019. The Administrator received a photograph on (MONTH) 17, 2019 of a person utilizing the deceased resident's debit card at a store. The person in the photograph was identified as Licensed Practical Nurse (LPN/staff #149). On (MONTH) 18, 2019, staff #149 was arrested and confessed to using the debit card. An interview was conducted with the Director of Nursing (DON/staff #139) and Administrator (staff #148) on (MONTH) 1, 2019 at 10:06 a.m. The Administrator stated the resident had been living at the facility for three years and during that time she chose to keep her debit card on top of her bedside stand. She stated that they had attempted to have the resident keep her debit card in a safe or locked drawer, but each time the resident had refused. She said all of the staff were aware that the card was there and it was never used inappropriately. The Administrator stated that she was able to identify the person using the card as staff #149. The DON stated the nurses had reported to her that the resident's purse and debit card were locked in the medication room, upon the death of the resident. The DON stated that ordinarily residents' valuables were locked in the Social Worker's office. The DON stated that staff #149 had worked around the time of the resident's death and as a LPN, she would have access to the card and purse which were locked in the medication room. During an interview conducted on (MONTH) 3, 2019 at 10:49 a.m., the DON stated that staff #149's employment was terminated for gross misconduct and that she had not worked in the facility since (MONTH) 14, 2019. Attempts to contact staff #149 by telephone were unsuccessful. Review of a policy regarding Abuse: Prevention of and Prohibition Against revised on (MONTH) 14, 2019, revealed it is the policy of the facility that each resident has the right to be free from abuse, including misappropriation of resident property. The facility will provide oversight and monitoring to ensure that its staff deliver care and services in a way that promotes and respects the rights of the residents to be free from abuse, neglect and misappropriation of resident property. Per the policy, misappropriation of resident property was defined as the deliberate misplacement, exploitation or wrongful, temporary, or permanent use of the resident's belongings or money, without the resident's consent.
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 follow physician orders for pain medication for one resident (#17). Findings include: Resident #17 was admitted to the facility on (MONTH) 29, (YEAR), with [DIAGNOSES REDACTED]. Review of the quarterly Minimum Data Set (MDS) assessment dated (MONTH) 8, 2019, revealed resident #17 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. The MDS also identified the resident experienced pain frequently which was rated at a 5 on a scale of 0-10. The MDS included the resident had received as needed (PRN) pain medications in the past 5 days. A pain care plan revealed the resident was at risk for pain related to immobility, [MEDICAL CONDITION] and back pain at times. Goals were to have no interruption in normal activities due to pain and verbalize adequate pain relief. Interventions included to administer [MEDICATION NAME] medications per orders, evaluate the effectiveness of pain interventions, monitor for side effects of pain medication and notify physician if interventions are unsuccessful. A care plan for opioid medication use included the resident has a potential for adverse outcomes related to opioid use. The goal was the resident will be free of adverse reactions related to opioid use. Interventions included to administer opioid as prescribed and monitor for adverse effects. Review of the (MONTH) 2019 physician's orders revealed the following orders: [MEDICATION NAME] ([MEDICATION NAME]) 650 mg by mouth every 4 hours as needed (PRN) for mild pain 1-3; for [MEDICATION NAME] (non-steroidal anti-[MEDICAL CONDITION]) give 220 mg by mouth every 12 hours PRN for back pain (no pain parameters were included); and for [MEDICATION NAME] (opioid) 5 mg give 1 tablet by mouth every 8 hours PRN for pain level of 7-10. These orders did not include administering pain medication for pain levels between 4-6. Review of the (MONTH) 2019 Medication Administration Record [REDACTED]. Review of the progress notes, including the e-Mar notes revealed no documentation as to why the [MEDICATION NAME] was administered outside of the ordered parameters or that the physician was notified regarding the pain medication orders. In an interview conducted on (MONTH) 3, 2019 at 9:59 a.m. with a Licensed Practical Nurse (staff #133), she stated that the resident has pain daily, but he tries to spread out taking pain medication. She stated the ordered parameters for the [MEDICATION NAME] are for a 7-10 pain level. She said it is not ordinary for the nurses to give an opioid for a pain level of 5, and that she was unable to explain why that happened. During an interview with the LPN Unit Manager (staff #37) conducted on (MONTH) 3, 2019 at 10:29 a.m., staff #37 stated that the resident should not have received the opioid medication for a pain level of 5. During an interview with the Director of Nursing (DON/staff #139) conducted on (MONTH) 3, 2019 at 11:20 a.m., the DON stated that there are times when the nurse may administer medications outside of the parameters ordered but there are steps they must take, such as notifying the physician and documentation of the deviation in the clinical record. Another interview with staff #37 was conducted on (MONTH) 3, 2019 at 12:03 p.m. Staff #37 stated that she had determined the medication was given outside of the parameters, because the physician orders did not include PRN medication for moderate pain. She stated that she had contacted the physician and obtained orders and that she would be informing the nursing staff and the resident of the new orders. A review of the facility policy and procedure titled, Medication Administration: Administration of Drugs revised in (MONTH) (YEAR), revealed it is the policy of the facility that medications shall be administered as prescribed by the attending physician. The procedure includes that medications must be administered in accordance with the written orders of the attending physician. The policy also referenced the 7 rights of medication administration to ensure safety and accuracy of

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) administration which included the right dose-medications are administered according to the dose prescribed, and the right documentation-document administration or refusal of the medication after the administration or attempt and note any concerns.
F 0686 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, interviews and review of policies and procedures, the facility failed to ensure one (#169) of three sampled residents with multiple pressure ulcers was provided the necessary care and treatment. The deficient practice could result in delayed treatment and deterioration of pressure ulcers. Findings include: Resident #169 was admitted to the facility on (MONTH) 27, 2019 with [DIAGNOSES REDACTED]. Review of the admission nursing assessment dated (MONTH) 27, 2019 revealed the resident was assessed to be alert and oriented x 3, could make herself understood and had the ability to understand others. The resident was also assessed to be incontinent of bowel and bladder. The assessment did not include that the resident had any skin breakdown to the buttocks/coccyx area. A licensed nurse functional performance evaluation dated (MONTH) 27, 2019, revealed the resident was dependent on staff for bed mobility. Review of a licensed nurse initial admission record signed by the nurse on (MONTH) 28, 2019, revealed the resident was alert to place and time, was able to follow simple commands and had bowel and bladder incontinence. Under skin integrity, it was documented that the resident had Crack red split, redness to buttock. The admission record did not include any further description of the buttock area. The admission record also included the resident did not have an alternating air mattress or a pressure re-distributing overlay mattress in place. A care plan dated (MONTH) 28, 2019 for potential/actual impairment to skin integrity included the resident had stage 2 pressure tissue injuries to the buttocks/coccyx. The goal was for the resident to be free from injury through the review date. Interventions included the following: educate resident and family of causative factors and measures to prevent skin injury; identify/document potential causative factors and eliminate/resolve where possible; monitor/document location, size and treatment of [REDACTED]. Review of an Activity of Daily Living (ADL) care plan dated (MONTH) 28, 2019 revealed the resident had a self care performance deficit related to weakness, diabetes and infection. The goal was for the resident to not develop complications through the review date. Interventions included the resident required staff participation for toilet use, transfers, bed mobility, repositioning and turning self in bed, and to monitor/document/report to physician any changes with self care deficits and declines in function. Review of the Certified Nursing Assistant (CNA) ADL flowsheet for (MONTH) 28, 29 and 30, 2019, revealed a section for bed mobility with a specific area for CNA's to initial that the resident was turned and repositioned every shift. The only instructions on the form was to indicate Y (yes) or N (no) to the question if the resident was turned and repositioned. The documentation included a Y for each shift along with the CNA initials, indicating the resident was repositioned. However, there was no documentation to indicate how often the resident was repositioned each shift. Further documentation on the flowsheet included the resident was totally dependent on two staff for repositioning. Review of the clinical record revealed there was no evidence that a thorough assessment of the buttocks/coccyx area was completed, which included measurements, a description of the wound bed and surrounding skin, and if any drainage or odor was present on (MONTH) 28 and (MONTH) 29, 2019. There was also no evidence of any physician ordered treatment that was provided to the buttock/coccyx area on (MONTH) 28 or 29. An interview was conducted with a family member on (MONTH) 30, 2019 at 12:07 p.m. At this time, the resident was observed laying in bed on her back, with her eyes closed. The family member stated that she had been in the resident's room all morning and the resident had not been repositioned for the last three hours. The family member stated she had been in the resident's room the day before and the resident had not been repositioned for over nine hours. The family member stated the resident had been admitted to the facility with more than one pressure ulcer on her bottom and if she is not repositioned on a regular basis, the pressure ulcers will probably get worse. The family member also stated that the resident was incontinent of bowel and bladder. An observation of the resident was conducted on (MONTH) 30, 2019 at 1:06 p.m. The resident was observed laying in bed on her back. A family member stated the resident had not been repositioned since approximately 9:00 a.m. this morning. Another observation of the resident was conducted on (MONTH) 30, 2019 at 1:49 p.m. The resident was observed laying in bed on her back. A family member stated that she had not left the room and the resident had not been repositioned. An observation was conducted on (MONTH) 30, 2019 at 3:28 p.m. of the resident laying in bed on her back. A family member stated she had not left the room and the resident had not been repositioned since approximately 9:00 a.m. this morning. An observation of the resident was conducted on (MONTH) 1, 2019 at 8:27 a.m. The resident was observed to be sitting up in bed eating breakfast. Another observation was conducted on (MONTH) 1, 2019 at 10:45 a.m. and the resident was observed to be laying in bed on her back. The family member stated the resident had not been repositioned since breakfast. A skin observation was conducted on (MONTH) 1, 2019 at 11:11 a.m., with a Licensed Practical Nurse (LPN/wound nurse/staff #142). The resident was laying on her right side and staff #142 proceeded to lift various skin areas and buttock folds to inspect the skin. The resident was observed to have multiple open areas to the buttock area. The open areas were red in color and varied in size from a nickel to the size of a quarter. Staff #142 described the open areas as reddened and raw, and stated they were shearing and incontinence acquired [MEDICAL CONDITION]. Later during the observation, staff #142 stated the open areas would be identified as stage 2 pressure ulcers located on the coccyx, buttocks fold, lateral right ischial fold and left ischial area, for a total of four pressure ulcers. During the observation, staff #142 did not measure the open areas, as requested by the surveyor. Staff #142 stated the resident was to get a specialized low air loss mattress later today, as this type of mattress was to aid in the prevention and healing of skin breakdown, including pressure ulcers. He further stated that he would obtain an order for [REDACTED]. Review of the (MONTH) 2019 Treatment Administration Record (TAR) revealed for Venelex ointment to buttocks/gluteal cleft every shift to promote skin integrity. The order date was listed as (MONTH) 29, however, the documentation showed that the treatment was initiated on (MONTH) 1. A physicians order dated (MONTH) 1, 2019 included for a low airloss mattress to bedframe. Review of the (MONTH) 2019 physician orders [REDACTED]. An interview was conducted with the resident and a family member on (MONTH) 1, 2019 at 12:50 p.m. The resident was observed to be sitting in a wheelchair. At this time, a family member stated the resident was transferred to a wheelchair at approximately 12:00 p.m. The resident stated that her bottom where the sores are hurts a little bit, when sitting up in the wheelchair. The resident further stated that sitting up is still better than laying on her bottom in bed all the time. An interview was conducted with a Licensed Practical Nurse (staff #44) on (MONTH) 2, 2019 at 9:29 a.m. Staff #44 stated any resident who requires full assistance for repositioning in bed has to be turned every 2 hours. Staff #44 stated it would be very important for a resident at high risk for skin breakdown or pressure ulcers to be repositioned every 2 hours. An interview was conducted with a CNA (staff #145) on (MONTH) 2, 2019 at 10:38 a.m. She stated the usual routine for a resident who needs staff assistance for repositioning is to check on them every 2 hours and reposition them. Staff #145 stated this was especially important if the resident was at risk for skin breakdown or had skin breakdown like pressure ulcers. At this time, staff #145 showed how repositioning residents is documented in the CNA section of the electronic chart. She stated the CNA's initial that repositioning was completed for their shift by only initialing one time and that there was no way to indicate if the resident was actually repositioned every 2 hours. An interview was conducted with the Assistant Director of Nursing (staff #144) on (MONTH) 2, 2019 at 2:25 p.m. She stated that CNA's are expected to reposition a resident every 2 hours when the resident is unable to reposition on their own. She stated it is a standard of practice to do this and it is very important when the resident is incontinent and is at risk for pressure ulcer development, or has actual pressure ulcers or skin breakdown. An interview was conducted with the wound nurse (staff #142) on (MONTH) 3, 2019 at 10:30 a.m. Staff #142 said that he now would describe the multiple open areas on resident #169 as incontinence acquired [MEDICAL CONDITION] and not stage 2

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F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) pressure ulcers. Staff #142 stated the facility follows the staging protocol and guidelines of the National Pressure Ulcer Advisory Panel (NPUAP). Another interview was conducted with the Assistant Director of Nursing (staff #144) on (MONTH) 3, 2019 at 11:58 a.m. She stated it is her expectation and standard of practice for skin assessments to be completed and pressure ulcers to be staged accurately. Staff #144 said when staff #142 identified the multiple open areas as pressure ulcers, the skin integrity care plan was immediately revised to reflect this, as this was a significant development. Staff #144 stated residents who are incontinent of bowel and bladder and who are at risk for skin breakdown, need to be repositioned on a routine basis. Staff #144 also stated the facility follows the guidelines and procedures from the NPUAP. Review of a facility policy regarding Activity of Daily Living services revealed the following: It is the policy of this facility that residents are given the appropriate treatment and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with a written plan of care. If a resident is unable to carry out ADLs, then the necessary services will be provided by qualified staff. According to a policy regarding pressure ulcers and wound management, it is the policy of this facility that a resident who enters the facility without pressure ulcers does not develop pressure ulcers unless the resident's clinical condition or other factors demonstrate that a developed pressure ulcer was unavoidable, and a resident having pressure ulcers receives necessary treatment and services to promote healing, prevent infection, and prevent new and avoidable sores from developing. The policy included that in accordance with the guidance issued by the NPUAP, the facility recognizes that defined and implemented interventions that are consistent with individual goals and recognized standards of practice are monitored and evaluated and revised as approaches are appropriate. The policy further included the nurse responsible for assessing and evaluating the resident's condition on admission is expected to complete comprehensive assessments to identify risk and any alterations in skin integrity. Once a wound has been identified, assessed and documented, nursing shall administer treatment to each affected area as per the physician's orders [REDACTED]. Regarding prevention the policy stated that in order to prevent the development of skin breakdown or prevent existing pressure ulcers from worsening, nursing staff shall implement the following: 1) Stabilize, reduce or remove any existing underlying risks. 2) Monitor the impact of the interventions and modify as appropriate. 3) Reposition the resident. 4) Use pressure relieving/reducing and redistributing devices including low air loss mattresses. Review of a facility policy regarding the staging of pressure ulcers revealed the following: It is the policy of this facility to stage pressure ulcers according to the NPUAP. A pressure ulcer is localized injury to the skin or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction. Description of Stage 2 pressure ulcers included the following: Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. Presents as a shiny or dry shallow ulcer without slough or bruising.
F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident and staff interviews and policy review, the facility failed to ensure that restorative nursing services were provided as ordered by the physician for one of four sampled residents (#66). The deficient practice could result in residents experiencing a decrease in range of motion, mobility and functional status. Findings include: Resident #66 was admitted to the facility on (MONTH) 21, 2019, with [DIAGNOSES REDACTED]. The initial admission record dated (MONTH) 21, 2019 included the resident was alert and oriented to time, place and person. Review of an ADL (Activities of Daily Living) care plan dated (MONTH) 22, 2019 revealed the resident had a self-care performance deficit related to leg pain, numbness and functional decline. Interventions included for therapy evaluation and treatment per physician orders. According to the PT (physical therapy) evaluation and treatment plan dated (MONTH) 22, 2019, the resident had a [DIAGNOSES REDACTED]. Treatment approaches included gait training and therapeutic exercises. A NP (nurse practitioner) note dated (MONTH) 23, 2019 included the resident was alert and oriented x 3 and was fearful of the outcome of her condition. Per the note, the chief complaints were debility and weakness. The plan included for PT. The admission MDS (Minimum Data Set) assessment dated (MONTH) 28, 2019 included the resident had a BIMS (Brief Interview for Mental Status) score of 12, which indicated moderate cognitive impairment. A review of the IDT (interdisciplinary team) care plan review dated (MONTH) 4, 2019 revealed the resident was making progress with ambulation and was ambulating 50 feet with fair balance. Review of the clinical record revealed the resident received physical therapy from (MONTH) 22, 2019 through (MONTH) 13, 2019.The PT Discharge summary dated (MONTH) 13, 2019 included the resident ambulated 60 to 75 feet with FWW (front-wheeled walker), with cues for increase base of support and heel/toe gait. Per the assessment, the resident's prognosis to maintain current level of functioning was good. Discharge recommendations included for restorative ambulation program and gait training with FWW. On (MONTH) 16, 2019, a physician's orders [REDACTED]. The ADL care plan was revised on (MONTH) 17, 2019 to include the intervention for RNA services for stairs and ambulation with FWW 4x per week as resident is willing to participate. However, review of the RNA documentation from (MONTH) 16, 2019 through (MONTH) 30, 2019, revealed the following: -Week of (MONTH) 16 through 21: The resident received RNA for stairs and ambulation with FWW only on (MONTH) 18. No additional RNA services were provided during this week. -Week of (MONTH) 22 through 28: The resident received RNA for ambulation, but did not receive RNA for stairs on (MONTH) 22 and 23. On (MONTH) 24, the resident refused RNA for stairs and ambulation and on (MONTH) 25, the resident received RNA for stairs and ambulation. There were no RNA services provided on Thursday (MONTH) 26, on Friday (MONTH) 27, or on Saturday (MONTH) 28. Review of the clinical record revealed no evidence that the resident refused to participate in RNA services during the above times frames, except on (MONTH) 24. There was also no documentation as to why RNA services were not consistently provided as ordered, nor documentation that the physician was notified that RNA services were not being provided as ordered. During an interview conducted on (MONTH) 30, 2019 at 2:10 p.m., resident #66 stated that she was admitted to the facility for therapy and was then transferred to long term care. She stated that after being moved to long term care, she only receives walking exercises once every 2-3 weeks. She said that she wants to walk, but she does not receive enough exercise to do so. An interview with the RNA supervisor (staff #37) was conducted on (MONTH) 2, 2019 at 12:05 p.m. Staff #37 said the orders for RNA come from therapy, upon being discharged from therapy. Staff #37 stated the RNA program for resident #66 was started on (MONTH) 16, 2019. She stated that treatment provided should be documented electronically in the clinical record. She stated the RNA weeks go from Sunday through Saturday. She said when a resident refuses treatment, it should be marked as RR in the RNA documentation. She also said the RNA's have the 1st through the 15th of the following month to write a monthly note for a resident on RN[NAME] She said there is no monthly note completed for resident #66 yet. Staff #37 further stated that the RNA program should be provided as ordered by the physician. An interview was conducted on (MONTH) 3, 2019 at 9:17 a.m. with the RNA (staff #10), who was assigned to provide treatment to resident #66. Staff #10 stated she has been a RNA for [AGE] years, but sometimes also helps as a CNA when needed. She stated the orders for RNA services regarding how many times a week the services will be provided comes from the therapy department. She said the orders do not say how long each treatment is, but usually say as resident tolerates. She stated when the order says 4x per week, it means that RNA has to be offered to the resident 4x per week. She said when a resident refuses, it should be documented electronically in the RNA documentation. She stated RNA documentation is done daily. Regarding resident #66, staff #10 stated the resident receives RNA for gait and stairs, and actively participates during RN[NAME] In another interview with the RNA supervisor (staff #37) conducted on (MONTH) 3, 2019 at 10:16 a.m., she stated the facility has two RNA's in the building and they divide the nursing hall for their resident assignments. She stated that staff #10

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F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) only works Sunday through Wednesday, and the other RNA works Thursday through Saturday. At this time, the RNA documentation in the clinical record for resident #66 was reviewed with staff #37. She stated the RNA order was received on (MONTH) 16, and the resident was assigned to staff #10, who started the RNA program on (MONTH) 18, 2019, which was a Wednesday. Staff #37 said there was no RNA program provided to the resident from (MONTH) 19 (Thursday) through the 21 (Saturday). She said the other RNA did not pick up resident #66 for treatment, because the resident was already assigned to staff #10. Regarding the week of (MONTH) 22 through 28, she stated the documentation only showed that the resident was provided RNA for ambulation on (MONTH) 22, 23, and 25 and that the resident refused on (MONTH) 24. Staff #37 stated that she did not know what happened and why RNA for stairs was only provided once this week. She stated that resident refusal should be documented in the RNA documentation. During an interview with the DON (Director of Nursing/staff #139) conducted on (MONTH) 3, 2019 at 11:34 a.m., she stated that she expects staff to implement physician orders, including the RNA program. She said restorative nursing orders come from therapy and are transcribed into the care plan to trigger RNA documentation. She stated when a resident refuses RNA, it should be documented in the RNA documentation sheet and the nurse should write refusals in the progress notes. She said the facility has only two RNA's who split the nursing halls. She stated one RNA works Sunday through Wednesday and the other works Thursday through Saturday. She said the facility has a healthy number of residents under RNA, however, could not say the approximate number of residents. Regarding the RNA documentation for resident #66, staff #139 stated that staff #10 may have documented the resident refusal on the week in question on the RNA worksheet, which is not part of the clinical record. In a later interview with the DON conducted on (MONTH) 3, 2019 at 1:50 p.m., she stated that staff #10 documented resident refusals on the RNA worksheet (which is not part of the clinical record) and not in the RNA documentation sheet (which is part of the clinical record). However, she was unable to provide any documentation of the resident refusing in (MONTH) (other than (MONTH) 24). Review of the policy on Restorative Care revealed that restorative care will be provided to each resident according to his/her individual needs and desires, as determined by assessment and interdisciplinary care planning. The policy included the resident will receive services to attain and maintain the highest possible mental/physical functional status and psychosocial well-being defined by the comprehensive assessment and plan of care. A policy titled, Physician order [REDACTED]. of care.
F 0697 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe, appropriate pain management for a resident who requires such services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, interviews and policies and procedures, the facility failed to ensure one of three sampled residents (#169) was provided pain management in accordance with professional standards of practice. The deficient practice could result in unrelieved pain and additional complications. Findings include: Resident #169 was admitted to the facility on (MONTH) 27, 2019 with [DIAGNOSES REDACTED]. Review of the admission nursing assessment dated (MONTH) 27, 2019, revealed the resident was assessed to be alert and oriented x 3, could make herself understood, and had the ability to understand others. The resident was also assessed to be incontinent of bowel and bladder. According to the licensed nurse functional performance evaluation dated (MONTH) 27, 2019, the resident was dependent on staff for bed mobility. An initial care plan dated (MONTH) 27, 2019 identified a focus area of chronic pain complicated by a decline in the resident's functions. The goal was to not have an interruption in normal activities due to pain through the review date. Interventions included to monitor/record/report to the nurse any signs or symptoms of non verbal pain, notify physician if interventions are unsuccessful or if current complaint is a significant change from the residents past experience of pain. Review of a care plan dated (MONTH) 28, 2019 identified a focus area of an Activity of Daily Living (ADL) performance deficit regarding weakness and diabetes. The goal was to not develop complications and to have the resident improve. An intervention related to bed mobility included the resident required staff participation to reposition and turn self in bed.Review of a care plan dated (MONTH) 28, 2019 identified a focus area of potential/actual impairment to skin integrity and the presence of stage 2 pressure tissue injuries to the buttocks and coccyx. The goal was to heal the pressure injuries. Interventions included to identify potential causative factors and eliminate or resolve the factors where possible. An intervention was to educate family members of causative factors to prevent skin injury. A care plan dated (MONTH) 28, 2019 identified a focus area of chronic pain complicated by a decline in the resident's functions. The goal was to not have an interruption in normal activities. An intervention was to reposition the resident for comfort. Review of the admission physician orders [REDACTED]. An interview was conducted with a family member on (MONTH) 30, 2019 at 12:06 p.m. in the resident's room. The family member stated the resident had pressure ulcers on her bottom and when the resident tells staff the area hurts, the staff does nothing. The resident was observed to be laying on her back in bed. A Certified Nursing Assistant (CNA) then was observed to enter the room and moved the resident from a laying position to a sitting position. As the CNA was moving the resident from a laying position to a sitting position, the resident stated Ow, ow several times and the CNA continued moving the resident. The CNA did not address the resident's pain and then left the resident's lunch tray and exited the room. A skin observation was conducted on (MONTH) 1, 2019 at 11:11 a.m., with a Licensed Practical Nurse (wound nurse/staff #142). The resident was observed laying on her right side. During the observation which lasted approximately 6 minutes, staff #142 lifted various overlapping skin to inspect the areas. During this process, the resident cried softly throughout the observation. When staff #142 lifted the skin to the buttock folds, the resident moaned frequently and said, ow, ow. Staff #142 did not stop performing the skin assessment and did not assess the resident's pain. An interview was conducted with the resident on (MONTH) 1, 2019 at 12: 50 p.m. The resident stated when the staff was looking at her skin earlier that morning she stated, It hurt my bottom. An interview was conducted with a Licensed Practical Nurse (LPN/staff #44) on (MONTH) 2, 2019 at 9:29 a.m. Staff #44 stated if a resident complains of pain and does not have a PRN pain medication, the physician must be called. Staff #44 further stated if a resident is having a treatment done and complains or shows pain, the nurse should stop the treatment and tell the resident that they will try and get something for the pain. An interview was conducted with a CNA (staff #145) on (MONTH) 2, 2019 at 10:38 a.m. She stated if a resident complains of pain while she is giving care, she has to stop the care because of the pain. She said that she has to tell the nurse right away if a resident has pain. An interview was conducted with the Assistant Director of Nursing (staff #144) on (MONTH) 2, 2019 at 2:25 p.m. Staff #144 stated the facility does not have standing orders for PRN pain medications and if a resident complains of pain during a treatment, the pain needs to be assessed. Staff #144 also stated the resident now has a PRN Tylenol for complaints of pain.Another interview was conducted with resident #169 on (MONTH) 2, 2019 at 3:32 p.m. She stated during the skin observation done on (MONTH) 1, 2019 with staff #142, she said It hurt, it hurt real bad and they (staff) kept on. An interview was conducted with staff #142 on (MONTH) 3, 2019 at 10:30 a.m. Staff #142 stated he did not recall if the resident had been voicing pain or discomfort during the skin observation that was conducted on (MONTH) 1. A physician's orders [REDACTED]. assess pain; 2. reposition; 3. quiet environment; 4. one to one; 5. encourage to express feelings. According to a facility policy related to pain management, the following was included: It is the policy of this facility to provide an environment and programs that assist each resident to attain or maintain the resident's highest practicable physical, mental, and psychosocial well being. Residents are provided and receive the care and services needed according to established practice guidelines. Resident pain is assessed and managed by the interdisciplinary team who work together to achieve the highest practical outcome. Purpose: The facility assists each resident with pain to maintain or achieve the highest practicable level of well being and functioning by: 1) screening to determine if the resident has been or is experiencing pain. 2) Comprehensively assessing the pain. 3) Identifying circumstances when pain is antiapartheid 4) Developing and implementing a plan, using pharmacological and/or non-pharmacological interventions to mange the pain and/or try to prevent the pain consistent with the resident's goals. Assessment: The resident will be assessed for pain upon

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035174	A. BUILDING _____ B. WING _____	**10/03/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PARK AVENUE HEALTH AND REHABILITATION CENTER	**2001 NORTH PARK AVENUE TUCSON, AZ 85719**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0697 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 4) development of new symptoms of acute or chronic pain that had not been previously assessed.