| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER<br>**035117** | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING ______<br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br>**09/19/2019** |
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| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| **PAYSON CARE CENTER** | **107 EAST LONE PINE DRIVE<br>PAYSON, AZ 85541** |

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) |
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| F 0578<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | **Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on clinical record reviews, staff interviews, and policy review, the facility failed to ensure advance directives were accurately documented for 2 of 20 sampled residents (#35 and #74). Failing to have accurate documentation for advanced directives could result in performing emergency treatment against residents' wishes.<br>Findings include:<br>-Resident #35 was admitted to the facility on (MONTH) 6, (YEAR) with [DIAGNOSES REDACTED].<br>Review of the clinical record revealed a FULL CODE Cardiopulmonary Resuscitation Advance Directive Statement dated (MONTH) 6, (YEAR) signed by the resident and a Registered Nurse.<br>A physician order dated (MONTH) 6, (YEAR) revealed documentation that the resident was a 'DO NOT RESUSCITATE status.<br>The care plan regarding Advance Directives dated (MONTH) 5, 2019 revealed Resident has Advance Directives- DNR- Do Not Resuscitate. The goal was the resident's Advance Directives will be honored. Interventions included Resident has signed Do Not Resuscitate (DNR).<br>A review of the face sheet dated (MONTH) 18, 2019 revealed Advance Directive. Do Not Resuscitate.<br>An interview was conducted with the Social Services Assistant (staff #78) on (MONTH) 18, 2019 at 8:26 a.m. Staff #78 stated that when a resident is admitted the resident and/or the family are asked what their advance directive wishes are and that either a Full Code form or DNR form is placed in the resident's clinical record.<br>An interview was conducted with a Licensed Practical Nurse (LPN/staff #4) on (MONTH) 18, 2019 at 8:30 a.m. Staff #4 stated she would refer to her 24 hour report to determine the resident's advance directive wishes. The LPN stated that the 24 hour report revealed the resident is a full code but that the resident's electronic clinical record revealed the resident is a DNR.<br>An interview was conducted with the Director of Nursing (DON/staff #41) on (MONTH) 18, 2019 at 8:40 a.m. Staff #41 stated that she could not provide a copy of the 24 hour report as it was not a facility form. Staff #41 stated that licensed nurses should refer to the resident's clinical record regarding advance directive wishes. Staff #41 stated that the resident's advance directive status is updated periodically in the resident's clinical record and there may be a DNR form that did not get placed in the resident's clinical record. The DON further stated that the resident's advance directives needed to be clarified because of the discrepancy in the clinical record.<br>-Resident #74 was admitted to the facility on (MONTH) 22, (YEAR) with [DIAGNOSES REDACTED].<br>Review of the clinical record revealed an Advance Directive Statement signed by the resident with no date and signed by a witness dated (MONTH) 22, (YEAR) that the resident was a DNR status.<br>Review of physician's orders revealed an order dated (MONTH) 8, (YEAR) that the resident was a DNR.<br>Review of the care management progress note dated (MONTH) 10, 2019 revealed the resident requested to change her advance directive from a DNR to a full code and that the resident signed the new advance directive form. The note also included medical records were notified to make changes on the face sheets.<br>Continued review of the clinical record revealed an Advance Directive Statement that the resident was a full code status signed by the resident dated (MONTH) 11, 2019 and signed by the witness, social service worker, dated (MONTH) 10, 2019.<br>However, review of the advance directives care plan revised (MONTH) 12, 2019 revealed the resident was a DNR. The goal was the resident's advance directives will be honored. Interventions included the code status will be reviewed on a quarterly basis and as needed.<br>Review of the electronic clinical record dashboard and the face sheet revealed the resident was a DNR.<br>Further review of the clinical record revealed no physician order that the resident was a full code status.<br>During an interview conducted with a LPN (staff #3) on (MONTH) 18, 2019 at 11:00 AM, the LPN stated that if a resident was unresponsive, without pulse or respirations, she would call for assistance and check the clinical record for advance directive and would check the dashboard in the electronic clinical record to determine whether or not to initiate CPR. The LPN also stated that if there was a discrepancy, she would follow the advance directive signed by the resident.<br>In an interview conducted with the social worker (SW/staff #77) on (MONTH) 18, 2019 at 11:26 AM, the SW stated that when someone changes their advance directive, she documents the request, have the resident complete and sign a new advance directive statement, and notifies the nurse the resident changed their advance directive so that the nurse can obtain a physician order to reflect the change.<br>An interview was conducted with the Minimum Data Status (MDS) coordinator (staff #45) on (MONTH) 19, 2019 at 8:10 AM. The MDS coordinator stated that care plan conferences with the resident in attendance includes a review of the resident's code status. She said if the resident requests a change in code status, the advance directive statement is updated and the provider is called for a new advance directive order. Staff #45 stated that there was a delay in updating the order and care plan for resident #74 due to missed communication.<br>The facility's policy regarding Advance Directives effective (MONTH) 21, 2019 revealed residents have the right to self-determination regarding their medical care, including the right to execute an advance directive. An advance directive is a written document prepared by the resident which directs how medical decisions are to be made should he/she lose the ability to make decisions. Social Services should review the advance directive information for accuracy quarterly and as needed with the resident or legal representative and document the findings in the progress note. With written reversals, the physician is notified and the plan is permanently adjusted. The policy included the physician must give an order for [REDACTED].> |
| F 0600<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on clinical record reviews, resident and staff interviews, and policy review, the facility failed to ensure that one of two sampled residents (#2) was free from verbal abuse by another resident (#71). The deficient practice could result in further incidents of resident to resident abuse.<br>Findings include: |

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 0600<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | (continued... from page 1)<br>-Resident #2 was admitted to the facility on (MONTH) 16, (YEAR) with [DIAGNOSES REDACTED].<br>A review of the quarterly MDS (Minimum Data Set) assessment dated (MONTH) 13, 2019 revealed the resident's BIMS (Brief Interview for Mental Status) score was a 15 indicating the resident had intact cognition.<br>-Resident #71 was readmitted to the facility on (MONTH) 31, (YEAR) with [DIAGNOSES REDACTED].<br>A review of the quarterly MDS assessment dated (MONTH) 3, 2019 revealed a BIMS score of 15 which indicated the resident had intact cognition.<br>Review of an Activity Participation Note dated (MONTH) 8, 2019 written by the activity director (staff #71) revealed Late entry: On Thursday (MONTH) 4, during the 4th of (MONTH) party, (resident #71) asked for a third helping of food. Not all of the residents had been served so (staff member's name) asked him to wait until all of the other residents had been served. It appeared to this writer, that because he wanted more food, and because he did not believe (staff member's name), he got angry, became belligerent and called her a liar and a 'b----.' This writer was serving food to others, but overheard this conversation as (resident #71) became loud. A second incident occurred at the same party with (resident #71). He raised his voice and began yelling at another resident (resident #2) and stated 'You should never eat in front of people, you are disgusting to watch. You should just leave.' The other resident (#2) appeared to be hurt, embarrassed and he did leave the party.<br>An interview was conducted with the activity director (staff #71) on (MONTH) 17, 2019 at 1:36 p.m. Staff #71 stated that resident #2 had a [MEDICAL CONDITION] and was non-verbal. Staff #71 stated that resident #71 saw resident #2 eating and became upset and said the way resident #2 ate was disgusting. Staff #71 stated that resident #2 stopped eating, got up and walked out of the dining room. Staff #71 stated she told resident #2 to come back to the party and that nothing was wrong with the way he was eating. Staff #71 stated resident #2 was embarrassed and his feelings were hurt. Staff #71 further stated that she knew that resident #2's feelings were hurt but she did not think of the situation as abuse because it was verbal and not physical.<br>An interview was conducted with the administrator (staff #129) on (MONTH) 17, 2019 at 2:18 p.m. Staff #129 stated that he was not notified about this incident and that it should have been reported to him immediately.<br>An interview was conducted with resident #2 and his roommate on (MONTH) 17, 2019 at 2:37 p.m. The roommate stated that he was at the party with resident #2 and that resident #71 stated to resident #2 that he needed to take his tongue and stick it in his hole (referring to his [MEDICAL CONDITION] stoma). The roommate stated that resident #2's tongue comes out when he eats and resident #71 stated we do not need to see that kind of stuff around here. Resident #2 shook his head affirmatively to the roommate's statement. The roommate stated that he told resident #71 that he was really rude and what he said was unacceptable. The roommate stated that resident #71 told him to mind his own business. Resident #2 stated that it made him feel sad and mad. Resident #2 further stated that he left the party and did not come back.<br>Review of the facility's policy Protection of Residents: Reducing the Threat of Abuse and Neglect dated (MONTH) (YEAR) revealed each resident has the right to be free from abuse. Residents must not be subjected to abuse by anyone. It is the policy and practice of this facility that all residents will be protected from all types of abuse. The policy also included .Verbal Abuse-The use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents . |
| F 0607<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **Develop and implement policies and procedures to prevent abuse, neglect, and theft.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on clinical record review, staff interviews, and policy review, the facility failed to implement their policy regarding reporting and investigating an allegation of abuse involving two residents (#2 and #71). The deficient practice could result in further incidents of resident to resident abuse not being reported and investigated.<br>Findings include:<br>-Resident #2 was admitted to the facility on (MONTH) 16, (YEAR) with [DIAGNOSES REDACTED].<br>A review of the quarterly MDS (Minimum Data Set) assessment dated (MONTH) 13, 2019 revealed the resident's BIMS (Brief Interview for Mental Status) score was a 15 indicating the resident had intact cognition.<br>-Resident #71 was readmitted to the facility on (MONTH) 31, (YEAR) with [DIAGNOSES REDACTED].<br>A review of the quarterly MDS assessment dated (MONTH) 3, 2019 revealed a BIMS score of 15 which indicated the resident had intact cognition.<br>A review of an Activity Participation Note dated (MONTH) 8, 2019 written by the activity director (staff #71) revealed Late entry: On Thursday (MONTH) 4, during the 4th of (MONTH) party, (resident #71) asked for a third helping of food. Not all of the residents had been served so (staff member's name) asked him to wait until all of the other residents had been served. It appeared to this writer, that because he wanted more food, and because he did not believe (staff member's name), he got angry, became belligerent and called her a liar and a 'b----.' This writer was serving food to others, but overheard this conversation as (resident #71) became loud. A second incident occurred at the same party with (resident #71). He raised his voice and began yelling at another resident (resident #2) and stated 'You should never eat in front of people, you are disgusting to watch. You should just leave.' The other resident (#2) appeared to be hurt, embarrassed and he did leave the party.<br>Further review of the clinical record revealed no evidence that the incident was reported to the administrator or the State Survey Agency or investigated by the facility.<br>An interview was conducted with the activity director (staff#71) on (MONTH) 17, 2019 at 1:36 p.m. Staff #71 stated that she did not think of the situation as abuse because it was verbal and not physical. Staff #71 stated that she did not report the incident because it occurred on a holiday. Staff #71 stated that although she did not document it, she reported the incident four days later to the former director of nursing.<br>An interview was conducted with the administrator (staff #129) on (MONTH) 17, 2019 at 2:18 p.m. Staff #129 stated that if a staff member witnessed resident to resident abuse that it should be reported to himself or the director of nursing within 15 minutes. Staff #129 stated that he would then report the incident to the State Survey Agency within the required time frame of two hours. Staff #129 stated that he was not notified of this incident and that he expected staff to report something like this to him immediately.<br>Review of the facility's policy Protection of Residents: Reducing the Threat of Abuse and Neglect, dated (MONTH) (YEAR), revealed .All associates are mandated to immediately report suspected resident abuse and/or neglect to their immediate supervisor and/or facility representative .The incident will be reported immediately to the administrator and the director of nursing .Facilities must ensure that all alleged violations involving abuse .are reported immediately, but not later than 2 hours after the allegation is made .to the administrator of the facility and to other officials (including the State Survey Agency) .It is the policy of this facility that reports of abuse are promptly and thoroughly investigated . The policy also revealed when an incident or suspected incident of resident abuse is reported, the administrator/designee will investigate the occurrence. The policy included if the investigation is being conducted by the designee, the administrator will be consulted daily concerning the progress of the investigation. |
| F 0609<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on clinical record reviews, staff interviews, and policy review, the facility failed to ensure an allegation of verbal abuse involving two residents (#2 and #71) was reported to the administrator and the State Survey Agency. The deficient practice could result in further incidents of resident to resident abuse not being reported as required.<br>Findings include:<br>-Resident #2 was admitted to the facility on (MONTH) 16, (YEAR) with [DIAGNOSES REDACTED].<br>A review of the quarterly MDS (Minimum Data Set) assessment dated (MONTH) 13, 2019 revealed the resident's BIMS (Brief Interview for Mental Status) score was a 15 indicating the resident had intact cognition.<br>-Resident #71 was readmitted to the facility on (MONTH) 31, (YEAR) with [DIAGNOSES REDACTED].<br>A review of the quarterly MDS assessment dated (MONTH) 3, 2019 revealed a BIMS score of 15 which indicated the resident had |

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| F 0609<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | (continued... from page 2)<br>intact cognition.<br>A review of an Activity Participation Note dated (MONTH) 8, 2019 written by the activity director (staff #71) revealed Late entry: On Thursday (MONTH) 4, during the 4th of (MONTH) party, (resident #71) asked for a third helping of food. Not all of the residents had been served so (staff member's name) asked him to wait until all of the other residents had been served. It appeared to this writer, that because he wanted more food, and because he did not believe (staff member's name), he got angry, became belligerent and called her a liar and a 'b----.' This writer was serving food to others, but overheard this conversation as (resident #71) became loud. A second incident occurred at the same party with (resident #71). He raised his voice and began yelling at another resident (resident #2) and stated 'You should never eat in front of people, you are disgusting to watch. You should just leave.' The other resident (#2) appeared to be hurt, embarrassed and he did leave the party.<br>Further review of the clinical record revealed no evidence that the incident was reported to the administrator or the State Survey Agency.<br>An interview was conducted with the activity director (staff#71) on (MONTH) 17, 2019 at 1:36 p.m. Staff #71 stated that she did not think of the situation as abuse because it was verbal and not physical. Staff #71 stated that she did not report the incident because it occurred on a holiday. Staff #71 stated that although she did not document it, she reported the incident four days later to the former director of nursing.<br>An interview was conducted with the administrator (staff #129) on (MONTH) 17, 2019 at 2:18 p.m. Staff #129 stated that he was not notified of the incident and that it should have been reported to him immediately so that he could have reported the incident to the State Survey Agency within two hours.<br>Review of the facility's policy Protection of Residents: Reducing the Threat of Abuse and Neglect, dated (MONTH) (YEAR), revealed .All associates are mandated to immediately report suspected resident abuse and/or neglect to their immediate supervisor and/or facility representative .The incident will be reported immediately to the administrator and the director of nursing .Facilities must ensure that all alleged violations involving abuse .are reported immediately, but not later than 2 hours after the allegation is made .to the administrator of the facility and to other officials (including the State Survey Agency) . |
| F 0610<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **Respond appropriately to all alleged violations.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on clinical record reviews, staff interview, and policy review, the facility failed to ensure a thorough investigation was conducted for an allegation of abuse involving two residents (#2 and #71). The deficient practice could result in incidents of resident to resident abuse not being investigated.<br>Findings include:<br>-Resident #2 was admitted to the facility on (MONTH) 16, (YEAR) with [DIAGNOSES REDACTED].<br>A review of the quarterly MDS (Minimum Data Set) assessment dated (MONTH) 13, 2019 revealed the resident's BIMS (Brief Interview for Mental Status) score was a 15 indicating the resident had intact cognition.<br>-Resident #71 was readmitted to the facility on (MONTH) 31, (YEAR) with [DIAGNOSES REDACTED].<br>A review of the quarterly MDS assessment dated (MONTH) 3, 2019 revealed a BIMS score of 15 which indicated the resident had intact cognition.<br>A review of an Activity Participation Note dated (MONTH) 8, 2019 revealed Late entry: On Thursday (MONTH) 4, during the 4th of (MONTH) party, (resident #71) asked for a third helping of food. Not all of the residents had been served so (staff member's name) asked him to wait until all of the other residents had been served. It appeared to this writer, that because he wanted more food, and because he did not believe (staff member's name), he got angry, became belligerent and called her a liar and a 'b----.' This writer was serving food to others, but overheard this conversation as (resident #71) became loud. A second incident occurred at the same party with (resident #71). He raised his voice and began yelling at another resident (resident #2) and stated 'You should never eat in front of people, you are disgusting to watch. You should just leave.' The other resident (#2) appeared to be hurt, embarrassed and he did leave the party.<br>Further review of the clinical record revealed no evidence that the facility conducted an investigation of this incident.<br>An interview was conducted with the administrator (staff #129) on (MONTH) 17, 2019 at 2:18 p.m. Staff #129 stated that he was not notified of the incident involving resident #2 and resident #71 and that therefore the incident of resident to resident verbal abuse was not investigated by the facility.<br>Review of the facility's policy Protection of Residents: Reducing the Threat of Abuse and Neglect, dated (MONTH) (YEAR), revealed .It is the policy of this facility that reports of abuse are promptly and thoroughly investigated . The policy also revealed when an incident or suspected incident of resident abuse is reported, the administrator/designee will investigate the occurrence. The policy included if the investigation is being conducted by the designee, the administrator will be consulted daily concerning the progress of the investigation. |
| F 0641<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | **Ensure each resident receives an accurate assessment.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on clinical record review, staff interviews, and the Resident Assessment Instrument (RAI), the facility failed to ensure Minimum Data Set (MDS) assessments were accurate for 2 of 20 sampled residents (#82 and #76). The deficient practice could result in inaccurate discharge tracking information and inaccurate crucial factors for care planning decisions.<br>Findings include:<br>-Resident #82 was admitted to the facility on (MONTH) 16, 2019 with [DIAGNOSES REDACTED].<br>Review of a nursing note dated (MONTH) 5, 2019 revealed the resident had been discharged to an assisted living facility.<br>However, review of the discharge MDS assessment dated (MONTH) 5, 2019 revealed the resident had been discharged to a psychiatric hospital.<br>An interview was conducted with the MDS Coordinator (staff #45) on (MONTH) 19, 2019 at 1:10 p.m. Staff #45 stated the MDS assessment coding was inaccurate because the resident was discharged to an assisted living facility and not a psychiatric hospital. She stated she was unsure of how the inaccuracy occurred. She also stated that the MDS assessment needed to be coded accurately.<br>During an interview conducted with the Director of Nursing on (MONTH) 19, 2019 at 1:15 p.m., she stated it was important for the MDS assessment to be accurate for every resident. The DON stated they did not have a specific policy for MDS assessment that they use the RAI manual.<br>The RAI manual instructs to review the clinical record including the discharge plan and discharge orders for documentation of a resident's location and code the discharge location.<br>-Resident #76 was admitted to the facility on (MONTH) 26, (YEAR) with [DIAGNOSES REDACTED].<br>A review of the nursing progress note dated (MONTH) 27, (YEAR) revealed the resident was alert, confused, and unable to follow direction.<br>A review of the provider's initial history and physical dated (MONTH) 27, (YEAR) revealed the resident was a poor historian.<br>Review of the baseline care plan dated (MONTH) 27, (YEAR) revealed the resident had short and long term memory impairment. Interventions included allowing extra time to respond to questions and to face and speak clearly when communicating with the resident.<br>However, review of the admission Minimum Data Set (MDS) assessment dated (MONTH) 2, 2019 revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact.<br>During an interview conducted with the MDS Coordinator (staff #45) on (MONTH) 19, 2019 at 11:36 AM, the MDS Coordinator stated that the BIMS score on the admission assessment is incorrect. She stated that she was unable to find any documentation in the clinical record that supports the BIMS score of 15. Staff #45 also stated that this error could have a negative impact on the care plan.<br>The RAI manual instructs an attempt to conduct the BIMS should be conducted with all residents. Cognitive patterns are crucial factors in many care planning decisions. The RAI manual revealed the importance of accurately completing and submitting the MDS assessment cannot be over emphasized. The MDS assessment is the basis for the development of an individualized care plan. |

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| F 0641<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | (continued... from page 3) |
| F 0658<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | **Ensure services provided by the nursing facility meet professional standards of quality.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on clinical record review, staff interviews, and policy review, the facility failed to ensure services provided met professional standards of quality by failing to clarify the dosage of a medication for one of five sampled residents (#71). The deficient practice could result in residents being administered incorrect dosages of medications.<br>Findings include:<br>Resident #71 was readmitted to the facility on (MONTH) 31, (YEAR) with [DIAGNOSES REDACTED].<br>Review of the clinical record revealed a physician's orders [REDACTED]. Give 1 capsule by mouth two times a day for anxiety.<br>Further review of the physician's orders [REDACTED].<br>A review of the (MONTH) 2019 Medication Administration Record [REDACTED].<br>An interview was conducted with a Licensed Practical Nurse (LPN/staff #4) on (MONTH) 18, 2019 at 8:30 a.m. Staff #4 stated that the dosage of the medication was not documented on the physician order [REDACTED]. The LPN further stated that she would clarify the dose with the resident's physician before it was administered again.<br>An interview was conducted with the Director of Nursing (DON/staff #41) on (MONTH) 18, 2019 at 9:47 a.m. The DON stated that the order should have been clarified before it was administered to the resident.<br>Review of the facility's policy Administration of Medications, dated (MONTH) 24, 2019, revealed a physician order [REDACTED]. The policy also included the nurse must clarify any order that is incomplete or unclear. |

| F 0684<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | **Provide appropriate treatment and care according to orders, resident's preferences and goals.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on clinical record review and staff and resident interviews, the facility failed to ensure that one sampled resident (#65) received treatment and care in accordance with professional standards of practice relating to bowel status. The deficient practice could result in residents with diarrhea not being treated.<br>Findings Include:<br>Resident #65 was admitted to the facility on (MONTH) 30, 2019 with [DIAGNOSES REDACTED].<br>Review of the nursing admission/readmission note signed (MONTH) 31, 2019 revealed the resident was alert and oriented to person, place, time, and situation and was pleasant and cooperative. The note included the resident had burning/itching and redness to the perianal area related to [MEDICAL CONDITIONS] diarrhea. The note also revealed the resident was started on an antibiotic at the hospital for [MEDICAL CONDITION] and will finish the antibiotics at the facility.<br>Review of the clinical record revealed physician orders dated (MONTH) 31, 2019 for [MEDICATION NAME] (antibiotic) suspension 125 milligrams (mg) by mouth every 6 hours for history [MEDICAL CONDITION] and [MEDICAL CONDITION] until (MONTH) 6, 2019,<br>Lactobacillus (antidiarrheal agent) one capsule by mouth two times a day for antibiotic treatment, and strict isolation for [MEDICAL CONDITION] and contact isolation [MEDICAL CONDITION].<br>The nursing skilled progress note dated (MONTH) 31, 2019 revealed the resident was on strict precautions for [MEDICAL CONDITION]. The note included the resident was the only resident in the room. The note also included the resident needed one person assistance for bed mobility, transfers and activities of daily living (ADLs).<br>Review of the admission Minimum Data Set (MDS) assessment dated (MONTH) 6, 2019 revealed a Brief Interview for Mental Status (BIMS) score of 10, which indicated the resident had moderate impaired cognition. The assessment also included the resident was occasionally incontinent of bowel.<br>The Medication Administration Record [REDACTED].<br>Review of the care plan initiated (MONTH) 12, 2019 revealed the resident had occasional bowel incontinence. The goal was that the resident would have no skin breakdown related to bowel incontinence. Interventions included checking the resident every two hours and assisting with toileting as needed, observing pattern of incontinence and initiating toileting schedule if indicated, and providing pericare after each incontinent episode and as needed.<br>Review of the provider progress note dated (MONTH) 14, 2019 revealed the resident was no longer having loose stools and that the resident had been taken off of contact precautions.<br>The health status progress note dated (MONTH) 14, 2019 revealed the resident had not had loose stools for 3 days and the strict isolation precautions had been discontinued.<br>The task documentation for bowel movements revealed boxes to check if the resident had formed, loose, hard, or putty like stools. The task documentation revealed the resident had loose stools on (MONTH) 21, 2019.<br>A skin/wound note dated (MONTH) 28, 2019 revealed a wound culture was obtained and there were new orders for [MEDICATION NAME] and [MEDICATION NAME] for 10 days.<br>Physician orders dated (MONTH) 28, 2019 revealed for [MEDICATION NAME] (antibiotic) 100 mg by mouth twice a day for infection for 10 days and [MEDICATION NAME] (antibiotic) 500 mg by mouth three times a day for infection for 10 days.<br>The MAR for (MONTH) 2019 revealed the resident continued to receive the Lactobacillus for antibiotic treatment.<br>The task documentation for bowel movements revealed the resident had loose stools on (MONTH) 29, 2019 and (MONTH) 1-3, 2019.<br>The clinical record revealed the resident was sent to the hospital on (MONTH) 3, 2019 related to a fall injury.<br>Review of a discharge MDS assessment dated (MONTH) 3, 2019 revealed the resident was frequently incontinent of bowel.<br>The resident was readmitted to the facility on (MONTH) 7, 2019 with [DIAGNOSES REDACTED].<br>Readmission physician orders did not include antibiotics or Lactobacillus.<br>Review of an admission/re-admission collection tool dated (MONTH) 7, 2019 revealed the box for bowel incontinence was checked but the box for diarrhea was not checked.<br>The nursing progress notes from (MONTH) 9-11, 2019 revealed the resident was incontinent of bowel but did not include the resident was having diarrhea/loose stools.<br>Review of the task documentation for bowel movements revealed the resident had loose stools on (MONTH) 11, 2019.<br>The wound physician progress notes [REDACTED].<br>Physician orders dated (MONTH) 11, 2019 revealed for isolation precautions [MEDICAL CONDITION] and [MEDICATION NAME]<br>(antibiotic) 1 gram intravenously every 24 hours for 21 days, pharmacy to follow [MEDICATION NAME] trough levels and adjust dose as needed.<br>Review of the nursing progress notes from (MONTH) 12 to 18, 2019 revealed the resident was incontinent of bowel but did not include the resident was having diarrhea.<br>The task documentation for bowel movements revealed the resident had loose stools on (MONTH) 13-14, 16-17, and 19, 2019.<br>Review of the clinical record including the Order Summary Report for active physician's orders as of (MONTH) 19, 2019 revealed no documentation the diarrhea/loose stools were being addressed.<br>An interview was conducted with resident #65 on (MONTH) 16, 2019 at 3:28 p.m. He stated that he had been having a problem with diarrhea. He stated that he had a diarrhea bowel movement today.<br>Another interview was conducted with the resident on (MONTH) 19, 2019 at 8:47 a.m. He stated that the diarrhea had become kind of a constant thing and that it was happening daily. The resident stated that he told staff that he was having a problem with diarrhea. He stated that he did not know who or when he spoke with staff regarding the diarrhea.<br>An interview was conducted with a Certified Nursing Assistant (CNA/staff #106) on (MONTH) 19, 2019 at 8:50 a.m. She stated that if a resident is constantly having loose stools that she would let the nurse know and keep the nurse updated. She stated that resident #65 has diarrhea and that his stools has always been loose. The CNA stated that she notified the nurse that resident #65 was having loose stools.<br>An interview was conducted with a Registered Nurse (RN/staff #91) on (MONTH) 19, 2019 at 9:17 a.m. She stated that if she was notified that a resident was having loose stools she would document it, notify the practitioner, consult with dietary, and assess the consistency of the stools to rule out a blockage. The RN stated that she had not been notified by the CNA or the resident that the resident was having loose stools. She also stated that the resident had not requested any medication for loose stools. She stated that she would expect the CNA to let her know if a resident is having constant loose stools so that she could visualize the stool. The RN stated she would notify the physician and dietary if the loose stools continued over three days so that interventions could be implemented to resolve the loose stools. |
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER<br>**035117** | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING ______<br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br>**09/19/2019** |
|---|---|---|---|

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **PAYSON CARE CENTER** | **107 EAST LONE PINE DRIVE<br>PAYSON, AZ 85541** |

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F 0684

**Level of harm -** Minimal harm or potential for actual harm

**Residents Affected -** Some

(continued... from page 4)
During an interview conducted with the Director of Nursing (DON/staff #41) on (MONTH) 19, 2019 at 1:43 p.m., the DON stated that if a resident was having constant diarrhea, she would expect the CNA to report it to the nurse. She stated that the nurse would then be expected to assess the stools and document it. The DON stated that if the nurse determines that the resident is having constant diarrhea, the nurse would need to notify the provider. She stated that having constant loose stools/diarrhea would put the resident at risk for skin breakdown, dehydration, altered nutrition, and weakness.

F 0686

**Level of harm -** 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 clinical record review, observation, staff interviews, and policy review, the facility failed to ensure one of three sample residents (#65) was provided necessary treatment and services consistent with professional standards of practice regarding pressure ulcers. The deficient practice could result in the development of pressure ulcers, wound complications and delayed identification of new skin issues.
Findings include:
Resident #65 was admitted to the facility on (MONTH) 30, 2019, with [DIAGNOSES REDACTED].
Review of the nursing admission/readmission note dated (MONTH) 30, 2019 revealed the resident was alert and oriented to person, place, time, and situation and was pleasant and cooperative. The note included the resident was status [REDACTED]. The note included the resident stated that he had not ambulated in approximately 3 months.
Review of an admission/readmission collection tool signed (MONTH) 31, 2019, revealed the resident had no feeling at all to the lower legs and is status [REDACTED]. The Tool included the resident had intermittent burning and tingling in the lower legs, heels, and toes and that there was a tiny scab at the tip of the remaining metatarsal of the left toe(s) but did not include what toes remained. The tool also included pressure ulcer(s) was a risk alert.
However, review of the Braden Scale for predicting pressure ulcer risk signed (MONTH) 31, 2019 revealed a score of 16 which indicated the resident was at mild risk for pressure ulcers.
A care plan initiated (MONTH) 31, 2019 revealed the resident was at risk for break in skin integrity related to a history of pressure ulcers to the heels/toes, [MEDICAL CONDITION], and being wheelchair bound. The goal was that the resident would maintain intact skin. Interventions included floating the heels while in bed and/or boots and weekly skin checks.
Review of the clinical record revealed physician admission orders [REDACTED].
Nursing skilled progress notes dated (MONTH) 1, 4, 5, and 6, 2019 revealed the resident's heels were soft and boggy and there was a dry scab to the right great toe. The note included the resident declined major position changes.
Review of the admission Minimum Data Set (MDS) assessment dated (MONTH) 6, 2019 revealed a Brief Interview for Mental Status (BIMS) score of 10 which indicated the resident had moderate impaired cognition. The assessment included the resident required extensive assistance with bed mobility, toileting, and hygiene and had only transferred from the bed 1-2 times. The assessment also included the resident was at risk for pressure ulcers and had pressure reduction in place to the chair and bed.
Review of the pressure ulcer Care Area Assessment (CAA) for the MDS assessment revealed weekly skin checks were ongoing and that a care plan would ensure measures were in place for prevention of complications due to decreased mobility.
The nursing skilled progress notes dated (MONTH) 8 and 12, 2019 revealed the resident declined major position changes and that the resident's heels were soft and boggy
A nursing skilled progress note dated (MONTH) 13, 2019 revealed the resident was able to ambulate in halls, cooperates as able with PT (physical therapy)/OT (occupational therapy), and that nursing continued to encourage and educate.
The nursing skilled progress notes dated (MONTH) 16 and 17, 2019 revealed the resident was able to ambulate in the hall.
The weekly skin integrity data collection tools conducted between (MONTH) 6, 2019 and (MONTH) 23, 2019 revealed the resident's skin was intact.
However, review of the clinical record from (MONTH) 31, 2019 to (MONTH) 25, 2019, revealed no evidence the heels were floated and/or that boots were in place as indicated in the care plan.
A nursing progress note dated (MONTH) 26 2019 revealed the wound care nurse was notified the resident had an open area to his left and right foot so that the wound nurse could obtain orders. The note included the resident was aware of the open areas. The note also included the foot board was removed since the resident slides in bed. The note did not include location, description, or measurements of the wounds to the feet.
The physician orders [REDACTED].
Review of the Treatment Administration Record (TAR) dated (MONTH) 2019 revealed the treatment for [REDACTED].
The nursing skilled progress note dated (MONTH) 27, 2019 revealed the bilateral feet dressing were clean, dry and intact. The note included the wound nurse was following and to see the wound notes for details.
Review of the Wound Observation Tool dated (MONTH) 27, 2019 revealed the resident acquired a right foot unstageable/deep tissue injury pressure ulcer on (MONTH) 26, 2019. The right foot 2nd to 5th toes are amputated and the ulcer is located on the lateral aspect of the amputated site. The wound measured 1 centimeter (cm) by 1 cm, no drainage, and no signs of infection, no pain, and was dark purple to black discoloration with skin intact. The current treatment plan is [MEDICATION NAME] gauze daily. The Tool included the ulcer may have been caused by the resident's feet against the foot board and that the footboard was removed. The Tool included the resident reported no feeling in his feet. The Tool revealed preventative measures included pressure reduction mattress, pressure reduction cushion in wheelchair, pillows to elevate bilateral lower extremities to float heels, and reposition every two hours.
Review of a Wound Observation Tool dated (MONTH) 27, 2019 revealed the resident acquired an unstageable pressure ulcer to the plantar surface of the left foot on (MONTH) 26, 2019. The wound measured 2.5 cm by 2 cm, had 100% slough, a small amount of serous drainage, no signs of infection, and no pain. The current treatment plan is [MEDICATION NAME] Ag daily. The Tool revealed preventative measures included pressure reduction mattress, pressure reduction cushion in wheelchair, pillows to elevate and float heels, and reposition every two hours. The Tool also included the resident rests his feet against the foot board; the foot board was removed from the bed, and to educate the resident on pressure relief and positioning.
Further review of the clinical record revealed no progress note for (MONTH) 28, 2019.
A care plan initiated (MONTH) 28, 2019 revealed the resident had an unstageable pressure ulcer to the right foot and a stage 4 pressure ulcer to the left foot related to history of ulcers and immobility. The goal was that the pressure ulcers will show signs of healing and remain free from infection. Interventions included educating the resident/family/caregivers as to causes of skin breakdown, transfer/positioning requirements, importance of taking care during ambulating/mobility, good nutrition and frequent repositioning and treatments as ordered.
A nutrition/dietary progress note dated (MONTH) 28, 2019 revealed the resident's nutrition intake by mouth was 25-50% and that the resident was likely not meeting increased needs for wound healing. The [MEDICATION NAME] was low at 3. The note included a recommendation will be made to increase ensure to three times a day and for prosource twice a day for wound healing.
The wound physician progress notes [REDACTED]. The note included the unstageable right foot ulcer located to the lateral aspect of the foot had black eschar and was without odor. The note included the wounds to the left and the right feet were debrided.
A skin/wound progress note dated (MONTH) 28, 2019 revealed the wound care physician saw the resident. The note revealed the left plantar wound was debrided and that the bone was exposed after debridement. The right foot wound was also debrided. A wound culture was obtained by the physician and the physician wrote new orders for treatment and for [MEDICATION NAME] and Keflex for 10 days. The note did not include measurements or descriptions of the wounds.
Review of the physician's orders [REDACTED]., cover with dry 4 X 4 gauze, wrap with Kerlix and change daily and to cleanse the right foot unstageable pressure ulcer with wound cleanser, apply [MEDICATION NAME] gel, cover with [MEDICATION NAME] Ag dressing, cover with 4 X 4 gauze, wrap with [MEDICATION NAME], and change three times a week on Monday, Wednesday, and Friday.
The TAR for (MONTH) 2019 revealed the treatment was provided to the left foot on (MONTH) 29 and 30. The TAR contained no documentation that the treatment was provided on (MONTH) 31.
The (MONTH) 2019 TAR revealed the treatment was provided to the right foot on Friday, (MONTH) 30 as ordered.
The nursing skilled progress note dated (MONTH) 2, 2019 revealed the resident was taking antibiotics [MEDICAL CONDITION] in

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| F 0686<br><br>**Level of harm -** Actual harm<br><br>**Residents Affected -** Few | (continued... from page 5)<br>the left foot wound and was on contact precautions [MEDICAL CONDITION].<br>Review of the clinical record revealed the resident was sent to the hospital on (MONTH) 3, 2019 related to a fall injury.<br>The resident was readmitted to the facility on (MONTH) 7, 2019 with [DIAGNOSES REDACTED].<br>Review of the physician admission orders [REDACTED].<br>The Braden Scale for predicting pressure ulcer risk and risk factors with an effective date of (MONTH) 7, 2019 revealed a score of 13 which indicated the resident was at moderate risk for pressure ulcers.<br>Continued review of the clinical record revealed no documentation that a thorough assessment of the left and right feet pressure ulcers was conducted upon admission.<br>Review of the admission/readmission collection tool regarding the skin condition signed by the nurse on (MONTH) 9, 2019 revealed the resident had open area/wound. The documentation included the left foot was healing from amputated toes and that the dressing was clean, dry, and intact. The assessment did not include any information about the right foot.<br>Review of the TAR for (MONTH) 2019 revealed the left foot pressure ulcer treatment from the previous admission (July 30, 2019) was provided to the resident on (MONTH) 8 and 9.<br>Continued review of the (MONTH) 2019 TAR revealed the right foot pressure ulcer treatment from the previous admission (July 30, 2019) was provided to the resident on Monday, (MONTH) 9.<br>The care plan regarding pressure ulcers was revised (MONTH) 9, 2019 to include the intervention to remove the footboard from the bed so that the resident does not rest/push his feet on it.<br>Review of the physician's orders [REDACTED]. Cleanse the right foot unstageable ulcer with wound cleanser, apply silver foam dressing, pad with 4 x 4 gauze, wrap with rolled gauze, and change every three days.<br>The physician order [REDACTED].<br>Review of the TAR for (MONTH) 2019 revealed the treatment was provided as ordered to the right and left foot.<br>The (MONTH) 2019 TAR also revealed documentation that the waffle boots to bilateral feet were on at all times while in bed from (MONTH) 10-19, 2019.<br>Review of the clinical record from the readmission on (MONTH) 7, 2019, revealed no thorough assessment of the left foot wound until (MONTH) 11, 2019 and no thorough assessment of the right foot until (MONTH) 12, 2019.<br>Review of the wound observation tool dated (MONTH) 11, 2019 revealed documentation this was the first observation and that the stage 4 left foot plantar pressure ulcer measured 1.7 cm x 1 cm, 100% slough, a very small piece of bone was present in the wound bed, small amount of serous drainage, no tunneling or undermining, and no signs or symptoms of infection.<br>Treatment was provided as ordered. The documentation revealed preventative measures included pressure reduction mattress, waffle boots to bilateral feet, pressure reduction cushion in wheelchair, and that the foot board was removed.<br>The comments section of the wound observation tool included that prior to admission to the hospital the left foot wound had granulation and now has 100% slough and that no redness was noted. The resident [MEDICAL CONDITION] in the wound and is on contact precautions. The wound care physician is to see the resident today (September 11, 2019). Waffle boots were placed to bilateral feet. The comment section included the resident needs extensive assistance with 1-2 staff for ADL care, bed mobility, and transfers.<br>Review of the wound physician progress notes [REDACTED].<br>Review of physician's orders [REDACTED].<br>Review of the wound observation tool dated (MONTH) 12, 2019 revealed documentation this was the first observation and that the right foot unstageable pressure ulcer measured 1 cm x 1 cm, 100% slough, small amount serous drainage, no tunneling and/or undermining, and no signs or symptoms of infection. Included was pressure reduction mattress, pressure reduction cushion in wheelchair, waffle boots to bilateral feet, and foot board removed as preventative measures.<br>The comments section of the wound observation tool revealed the right foot pressure ulcer had dark brown eschar with no redness (conflicting information regarding wound bed) and a small amount of serous drainage. The resident saw the wound doctor yesterday (September 11, 2019) who debrided the wounds and changed the treatment. The comments included waffle boots to bilateral feet and foot board on bed removed.<br>Review of the care plan regarding pressure ulcers revealed the interventions were updated (MONTH) 13, 2019 to include waffle boots to bilateral feet while in bed and pressure reduction mattress on the bed.<br>Continued review of the clinical record from the readmission on (MONTH) 7, 2019, revealed a complete weekly skin assessment was not conducted until (MONTH) 17, 2019 on the weekly skin integrity data collection form.<br>Review of the care plan regarding skin integrity revealed the interventions were revised on (MONTH) 17, 2019 to include pressure reducing mattress and alternating air mattress.<br>An observation of the right and left foot pressure ulcer treatment was conducted on (MONTH) 18, 2019 at 12:42 p.m. with two wound nurses (Licensed Practical Nurse (LPN)/staff #96 ) and (staff #8). The right foot pressure ulcer measured 1cm x 1.2 cm x utd (unable to determine), had 50% dark eschar, 20-30 % slough, small amount granulation, no odor and the peri wound was intact. The left foot pressure ulcer measured 1.4 cm x 1 cm x 0.3 cm, slough removed, scant amount serosanguinous drainage, red granulation, and peri wound intact. Treatment was provided as ordered to the right and left foot pressure ulcers.<br>An interview was conducted with a Registered Nurse (RN/staff #91) on (MONTH) 19, 2019 at 9:17 a.m. She stated that the nurse is to do a head to toe skin assessment within two hours of admission/re-admission and then weekly and as needed after that. She stated that if the resident is admitted with wounds the dressings should be adjusted enough to visualize and assess the wound unless there is a provider order to leave the dressing in place, the assessment/description of any wounds present should be documented in the admission nursing assessment, and the nurse should notify the wound nurse that the resident has wounds. She stated that if the wounds were present on admission/re-admission there should not be 4 to 5 days between admission/re-admission and documentation of wound assessments. She stated that a head to toe skin assessment completed over seven days from the prior assessment would be late.<br>An interview was conducted with the wound nurse (LPN/staff #96) on (MONTH) 19, 2019 at 1:05 p.m. She stated skin assessments are to be conducted weekly. The wound nurse stated that if weekly skin assessments are late, new skin issues may be missed and/or there could be a delay in notification and treatment of [REDACTED]. The wound nurse stated that the wound observation tool is done once a week and that she does the staging of wounds. She stated that the wound assessments on resident #65 did not meet expectation as there was no documentation of an assessment of the wounds until 4 and 5 days after the re-admission. She stated that by not doing an initial assessment, they would not be able to identify if the wounds had changed or worsened.<br>During an interview conducted with the Director of Nursing (DON/staff #41) on (MONTH) 19, 2019 at 1:43 p.m., the DON stated the expectation is that the admission nurse completes the skin status which would include any wounds on the admission/readmission collection tool. She stated that the 4 and 5 day delay of wound assessments increased the risk of unidentified wound deterioration that could have been present on admission. She stated that the nursing staff is expected to do a head to toe skin assessment on admission and weekly thereafter. The DON further stated that the skin assessment conducted on (MONTH) 17, 2019 was late which could increase the risk of missing new skin issues.<br>Review of the facility's policy for pressure ulcer/injury prevention and management revealed that a comprehensive skin assessment on admission and re-admission may identify pre-existing signs of possible deep tissue damage already present. The policy stated that a skin assessment should be performed weekly by a licensed nurse. Measures to protect the resident against the adverse effects of external mechanical forces, such as pressure, friction, and shear are implemented in the plan of care: .heel protection/suspension should be implemented while the resident is in bed . |
| F 0688<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | **Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on clinical record review, resident and staff interviews, and policy review, the facility failed to provide treatment and services to prevent further reduction in range of motion (ROM) for one of two sampled residents (#17). The deficient practice could result in residents not being provided treatment and services to increase, maintain, or prevent further decrease in ROM. |

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| F 0688<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | (continued... from page 6)<br>Findings include:<br>Resident #17 was readmitted to the facility on (MONTH) 1, (YEAR) with [DIAGNOSES REDACTED].<br>A review of an Occupational Therapy Evaluation and Plan of Treatment dated (MONTH) 4, 2019 revealed the long term goal was for education/training to be completed for resident and staff for appropriate splinting/bracing and for contracture management.<br>Review of an Occupational Therapy Discharge Summary dated (MONTH) 28, 2019 revealed .Use of palm guard and built up palm guard to increase digit extension. Unable to use resting splint due to current contracture. Continue with RNA (restorative nursing assistant) .<br>Review of the care plan initiated (MONTH) 23, 2019 revealed the resident has [MEDICAL CONDITION] and that her ability to communicate is impaired but that she is able to communicate most needs. The goal was that the resident will communicate needs, wants using head nods, gestures, and pointing. Interventions included framing questions in yes/no format and giving the resident adequate time to communicate needs and wants in an unhurried and un-rushed atmosphere.<br>Review of a Rehabilitation Services Multidisciplinary Screening Tool dated (MONTH) 29, 2019 revealed the resident was on level 1 maintenance for active range of motion, passive range of motion, splinting/braces, and omnicycle.<br>A review of the care plan initiated (MONTH) 30, 2019 revealed the resident has an ADL (activities of daily living) self-care performance deficit related to musculoskeletal impairment and stroke. The goal was the resident will maintain current level of function in ADL's. Interventions included the resident has contractures of the right hand, provide skin care to keep clean and prevent skin breakdown and Nursing rehabilitation/restorative: Splint/Brace Program #1. Placement of palm guard and hand hygiene.<br>Review of a Rehabilitation Services Multidisciplinary Screening Tool dated (MONTH) 29, 2019 revealed the resident was receiving restorative services but did not indicate what services were provided to the resident.<br>Review of the quarterly MDS (Minimum Data Set) assessment dated (MONTH) 12, 2019 revealed a BIMS (Brief Interview for Mental Status) score of 13 which indicated the resident had intact cognition. The assessment also included that passive/active ROM and a splint or brace assistance was not performed in the last 7 days.<br>An interview was conducted with the resident on (MONTH) 16, 2019 at 11:22 a.m. A splint or hand roll was not observed in her right hand. When asked if staff assisted her with range of motion for her contracted right hand, the resident shook her head no.<br>Another interview was conducted with the resident on (MONTH) 18, 2019 at 3:51 p.m. When asked if staff had attempted range of motion to extend the fingers on her right hand, the resident shook her head no. When asked if staff had ever placed a hand roll or brace in her right hand the resident shook her head no. When asked if she wanted staff to provide range of motion for her right hand the resident shook her head yes. Again no splint or hand roll was observed in the resident's right hand.<br>An interview was conducted with the Director of Therapy (staff #68) on (MONTH) 19, 2019 at 9:21 a.m. Staff #68 stated that the resident was on a restorative program for hand hygiene, range of motion, and contracture prevention.<br>An interview was conducted with a Restorative Nursing Assistant (RNA/staff #104) on (MONTH) 19, 2019 at 9:30 a.m. Staff #104 stated that she believed the resident was still on the restorative nursing caseload. Staff #104 stated that the resident uses an omnicycle three times a week and never refuses to participate. Staff #104 stated that range of motion is provided to her right hand and that the resident wore a hand splint. Staff #104 stated that restorative nursing usually put the hand splint on the resident's right hand three times a week and nursing probably took it off at night. Staff #104 stated that they document in the computer when the resident participated in restorative nursing however she was unable to provide evidence of that. Staff #104 stated that the resident is not scheduled for restorative nursing on any particular day just as long as she participated three times a week. Staff #104 stated that range of motion is provided to the resident three times a week and a splint is put on the resident's right hand.<br>Another interview was conducted with the resident on (MONTH) 19, 2019 at 9:50 a.m. A splint or hand roll was not observed in her right hand. When asked if staff had ever placed the hand roll in her right hand that staff #104 had located at the back of one of her dresser drawers, the resident shook her head no and then shook her head yes. When asked if staff placed the hand roll in her right hand three times a week, the resident shook her head no.<br>An interview was conducted with a Certified Nursing Assistant (CNA/staff #109) on (MONTH) 19, 2019 at 9:59 a.m. Staff #109 stated that he never applied a splint or hand roll to the resident's right hand and did not document when he performed range of motion to the resident's right hand during care.<br>An interview was conducted the Restorative Nurse (staff #45) on (MONTH) 19, 2019 at 10:33 a.m. Staff #45 stated that the splint and palm guard with hand hygiene was put on the resident's care plan on (MONTH) 9, 2019. Staff #45 stated that since the resident was on a level 1 restorative order, there was no physician's order. Staff #45 stated that since there was not a physician order for [REDACTED].<br>Review of the facility's policy Restorative Nursing revealed The facility is responsible for providing maintenance and restorative programs as indicated by the resident's comprehensive assessment to achieve and maintain the highest practicable outcome .Restorative Nursing Functions can be within one of the following categories: Range of Motion (Active and Passive. Splint or brace assistance .The trained CNA will document provided techniques per the restorative care plan in the medical record .Restorative Nursing does not require a physician order . |