STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035144	A. BUILDING _____ B. WING _____	**07/25/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PEORIA POST ACUTE AND REHABILITATION	**13215 NORTH 94TH DRIVE PEORIA, AZ 85381**

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 0552 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that residents are fully informed and understand their health status, care and treatments.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policy review, the facility failed to ensure one of five sampled residents (#69) and/or their representative were informed of the risks and benefits of a [MEDICAL CONDITION] medication prior to administration. The deficient practice can result in residents and/or residents' representatives not being aware of the benefits and the risks of taking psychoactive medications. Findings include: Resident #69 was admitted to the facility on (MONTH) 26, 2019, with [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. A care plan dated (MONTH) 13, 2019 included the resident had an anxiety disorder. The goal was for the resident to show decreased episodes of anxiety through the review date. Interventions included giving antianxiety medication as ordered, monitoring for side effects, monitoring/recording occurrence of target behavior symptoms, and implementing non-pharmacological interventions. The quarterly Minimum Data Set assessment dated (MONTH) 3, 2019 revealed the resident scored a 4 on the Brief Interview for Mental Status, indicating severe cognitive impairment. Review of the (MONTH) and (MONTH) 2019 Medication Administration Records revealed the resident was administered [MEDICATION NAME] 0.5 mg on a regular basis. However, review of the clinical record revealed no documentation that consent was obtained for the [MEDICAL CONDITION] medication in (MONTH) or (MONTH) 2019 from the resident's representative prior to administering, nor was there documentation that the resident's representative was informed of the risks and benefits of receiving an antianxiety medication before being administered. Further review of the clinical record revealed a verbal consent for [MEDICAL CONDITION] medication was obtained on (MONTH) 14, 2019. The documentation included for the administration of [MEDICATION NAME] to decrease anxiety, as evidenced by restlessness. The form included the risks and benefits of the medication. Per the consent, verbal authorization was given by the resident's family member/Power of Attorney. An interview was conducted on (MONTH) 25, 2019 at 9:46 a.m. with a Licensed Practical Nurse (LPN/staff #90). She stated that prior to administration of a [MEDICAL CONDITION] medication; the process is to obtain informed consent. The LPN stated the nurses are able to obtain verbal consent over the phone, but sometimes consents are overlooked, which was possibly the case for resident #69. On (MONTH) 25, 2019 at 10:08 a.m., an interview was conducted with the Director of Nursing (DON/staff #159). The DON stated that her expectation is for the nurses to input the physician's orders [REDACTED]. A facility's policy titled Psychoactive Medication revealed the use of psychoactive medication must first be explained to the resident, family member or legal representative. Consent is to be obtained either from the resident or responsible party if the resident is unable. A verbal consent may be obtained if no responsible person is available. The policy included that the facility must explain in the context of the individual resident's condition and circumstances, the potential risks and benefits of all options under consideration and explain the potential negative outcomes of psychoactive medication.
F 0608 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop and implement policies and procedures to ensure (1) employees report any suspicion of a crime against any resident, according to timelines; (2) post the notice of employee rights; and (3) prohibit and prevent retaliation for reporting.** Based on observations and staff interviews, the facility failed to develop and implement a policy to ensure a notice of employee rights about reporting suspicion of crimes was posted in a conspicuous place. The deficient practice could result in employees not knowing their rights. Findings include: An interview was conducted on (MONTH) 25, 2019 at 9:06 a.m. with a Certified Nursing Assistant (CNA/staff #22). The CNA stated that she has not seen a posting in the facility regarding employees' rights to report suspicion of a crime without fear of retaliation. On (MONTH) 25, 2019 at 9:29 a.m., an interview was conducted with the Administrator (staff #160). The Administrator stated that when employees are hired, they receive information about reporting suspicion of a crime without fear of retaliation in their packets. He stated that he was not aware of this information being posted in the facility. Human Resources (staff #164) joined the interview. Staff #164 stated that she receives notices to post from the Resources department. She stated that the notice of employee rights about reporting a suspicion of a crime should be posted in the hallway where the employees clock in for work. At this time, observations of the employee break room and the hallway where the employees clock in for work were conducted with the Administrator and staff #164. No notice of employee rights about reporting a suspicion of a crime was observed posted. Later that day, staff #164 stated that they do not have a policy about posting a notice of employees' rights regarding reporting a suspicion of a crime in a conspicuous place.
F 0755 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, and policy review, the facility failed to ensure their system of medication records enabled accurate reconciliation and accounting for all controlled medications. The deficient practice could result in misappropriation of residents' medications.

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

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F 0755 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) Findings Include: -During an observation conducted on (MONTH) 24, 2019 at 3:11 p.m. with the Charge Nurse/ Registered Nurse (RN/staff #94) of the medication cart on the 200 odd hall, 12 medication cards for a resident that had expired were observed wrapped in the reconciliation sheets separate from the rest of the controlled medications inside the locked drawer. The wrapped medication cards included a card of 25 [MEDICATION NAME] (opioid) 5 milligram tablets. Following this observation, an interview was conducted with staff #94. Staff #94 stated that the medication cards wrapped in the reconciliation sheets are medications of residents that have been discharged or have had their orders changed. She stated that the discontinued controlled medications stay in the locked drawer in the medication carts until they are destroyed or given to the Director of Nursing (DON). Staff #94 further stated that wrapped medications are not reconciled at shift change with the other controlled medications. She stated that the wrapped medications are counted by two nurses when they are removed from the active medications and put aside for destruction and again at the time of destruction. Staff #94 further stated that the discontinued medications are only in the medication carts for a short time. -An observation was conducted of the medication cart on the 200 even hall on (MONTH) 24, 2019 at 3:20 p.m. with a RN (staff #31). Within the separately locked drawer of the medication cart, 14 medications cards wrapped in the reconciliation sheets were observed separated from the other controlled medications. Following this observation, an interview was conducted with staff #31. Staff #31 stated that the discontinued controlled medications stored in the locked drawer in the medication cart are waiting to be destroyed, are not reconciled at shift change. During an interview conducted with a RN (staff #5) on (MONTH) 24, 2019 at 3:30 p.m., the RN stated that only the active controlled medications are reconciled at shift change. She stated that once controlled medications are discontinued, they are stored in the medication cart until they are removed for destruction. -An observation was conducted of the #2 medication cart on the 400 hall on (MONTH) 24, 2019 at 3:41 p.m. with a RN (staff #147). 10 medication cards wrapped in reconciliation sheets were observed in the separately locked drawer of the medication cart separate from the other controlled medications. Following this observation, an interview was conducted with staff #147. Staff #147 stated that the discontinued controlled medications are not reconciled between shifts while waiting for destruction. An interview was conducted with a Licensed Practical Nurse (LPN/staff #144) on (MONTH) 25, 2019 at 9:32 a.m. The LPN stated that the discontinued controlled medications are picked up a couple of times a week, when the nurse let the designated staff know that there are discontinued narcotics. During another interview conducted with the charge nurse (RN/staff #94) on (MONTH) 25, 2019 at 9:41 a.m., the charge nurse stated that the amount of time a discontinued controlled medication remain in the medication cart depends on how many discontinued controlled medications the nurse has stored in the cart and when the nurse is able to notify the DON that controlled medications need to be removed from the cart. Staff #94 stated that the discontinued controlled medications are removed from the medication carts a couple of times a month. An interview was conducted with the DON (staff #159) on (MONTH) 25, 2019 at 9:50 a.m. She stated that discontinued controlled medications remain in the locked narcotic drawer in the medication carts until they are removed by two nurses and placed under double lock in her office for destruction. The DON stated that there is no set schedule for removal of discontinued controlled medications from the medication carts. The DON also stated the expectation is that all controlled medications, active and discontinued, in the medication carts should be reconciled at shift change according to facility policy. She further stated that by not reconciling the discontinued controlled medications at shift change increases the risk for drug diversion. Review of the facility's policy for Controlled Medications revealed the Director of Nursing Services and the consultant pharmacist will maintain the facility's compliance with federal and state laws and regulations in the handling of controlled medications. The policy also revealed that at each shift change, a physical inventory of all controlled medications is conducted by two licensed nurses and is documented on an audit record.
F 0770 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide timely, quality laboratory services/tests to meet the needs of residents.** Based on facility documentation review, manufacturer's user's guide, staff interviews and policy review, the facility failed to ensure calibration of glucometer machines on 4 of 6 medication carts was performed daily and/or weekly. The deficient practice could result in blood sugar readings that are not accurate. Findings include: Review of the facility's Blood Glucose Monitoring: Daily Quality Control Records revealed the following: Hall 300: January 2019 record was missing 4 days of testing Hall 400: October (YEAR) record was missing 9 days of testing November (YEAR) was missing 10 days of testing December (YEAR) was missing 11 days of testing January 2019 was missing 16 days of testing February 2019 was missing 21 days of testing, no testing the week of (MONTH) 10-16 March 2019 was missing 4 days of testing April 2019 was missing 7 days of testing May 2019 was missing 12 days of testing June 2019 was missing 12 days of testing July 2019 was missing 5 days of testing Hall 500: October (YEAR) was missing 12 days of testing November (YEAR) was missing 10 days of testing December (YEAR) was missing 10 days of testing January 2019 was missing 16 days of testing, no testing the week of (MONTH) 27-February 2 February 2019 was missing 22 days of testing, no testing the week of (MONTH) 10-16 March 2019 was missing 4 days of testing April 2019 was missing 9 days of testing May 2019 was missing 12 days of testing June 2019 was missing 15 days of testing, no testing the week of (MONTH) 23-29 July 2019 was missing 9 days of testing Hall 600: March 2019 was missing 19 days of testing, no testing the weeks of (MONTH) 3-9 and 10-16 April 2019 was missing 18 days of testing, no testing the week of (MONTH) 21-27 May 2019 was missing 25 days of testing, no testing the week of (MONTH) 26-June 1 June 2019 was missing 18 days of testing July 2019 was missing 7 days of testing An interview was conducted with the Assistant Director of Nursing (ADON/staff #61) on (MONTH) 24, 2019 at 1:49 p.m. The ADON stated that the quality control testing is supposed to be performed daily on the glucometers. She stated that the testing ensures they are getting accurate blood sugar readings and that insulin dependent residents are receiving accurate dosages of insulin. After reviewing the glucose monitoring records for hall 400 and 500, the ADON stated quality control monitoring was not performed daily. An interview was conducted with the Director of Nursing (DON/staff #159) on (MONTH) 25, 2019 at 8:41 am. The DON stated her expectation is that glucometer quality control testing be performed every night on the night shift on every glucometer being used. She stated that the incomplete quality control testing forms did not meet her expectation. The DON stated that not performing the glucometer quality control testing daily could result in blood sugar readings that are not accurate, which would put residents at risk for high/low blood sugars, receiving incorrect dosages of insulin, and hospitalization .

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F 0770 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) Review of the facility's policy on Blood Glucose Monitoring instructed to refer to the Manufacturer's Specific Equipment Instructions for care and use of the blood glucose monitor. Review of the Manufacturer's user's guide for the glucometers revealed the purpose of the control solution testing is to validate that the glucometer is working properly with the test strips. The policy also revealed that control solution testing should be performed when using the meter for the first time, using a new package of blood glucose control strips, and at least once a week to verify that the meter and test strips are working properly together.