STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035283	A. BUILDING _____ B. WING _____	**10/31/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SANTE OF CHANDLER	**825 SOUTH 94TH STREET CHANDLER, AZ 85224**

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

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F 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 (#5) was informed of the risks and benefits of [MEDICAL CONDITION] medications, prior to administration. The deficient practice could result in residents/representatives not being aware of the benefits and risks of taking psychoactive medications. Findings include: Resident #5 was readmitted to the facility on (MONTH) 10, 2019, with [DIAGNOSES REDACTED]. Regarding [MEDICATION NAME]: A physician's orders [REDACTED]. A care plan dated (MONTH) 11, 2019 included the resident used antidepressant medication. The goal was for the resident to be free from discomfort or adverse reactions related to antidepressant therapy through the review date. Interventions included to administer antidepressant medications as ordered and to provide education to the resident and/or family about risks, benefits and the side effects of medications administered. Review of the (MONTH) 2019 Medication Administration Record [REDACTED]. A physician's orders [REDACTED]. The admission Minimum Data Set (MDS) assessment dated (MONTH) 16, 2019 included a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. The assessment also revealed the resident had received an antidepressant for seven days during the look back period. Further review of the (MONTH) 2019 MAR indicated [REDACTED]. However, review of the clinical record revealed no documentation that a consent was obtained from the resident prior to administration of the [MEDICATION NAME] and/or [MEDICATION NAME] from (MONTH) 10 through 16, 2019, nor was there documentation that the resident was informed of the risks and benefits of receiving an antidepressant medication, prior to being administered. Continued review of the clinical record revealed a verbal consent for [MEDICATION NAME] was obtained on (MONTH) 17, 2019. However, the consent did not include the reason for the administration of [MEDICATION NAME] or list the risks and benefits of the medication. The form included the following statement: I have been fully informed about the use of the prescribed psychoactive medication(s) listed below and the benefits, risks, and possible negative outcomes of their use. Per the consent, verbal authorization was given by the resident's family member. Regarding [MEDICATION NAME]: A physician's orders [REDACTED]. Review of the (MONTH) 2019 MAR indicated [REDACTED]. However, review of the clinical record revealed no documentation that a consent was obtained from the resident/resident representative prior to administration of the [MEDICATION NAME] from (MONTH) 19 through 23, 2019, nor was there documentation that the resident was informed of the risks and benefits of receiving the medication prior to being administered. Further review of the clinical record revealed a form dated (MONTH) 24, 2019, where consent for [MEDICATION NAME] was marked, I DO NOT APPROVE the use of this medication. The form did not include the reason for the administration of [MEDICATION NAME] or list the risks and benefits of the medication. The form included, I have been fully informed about the use of the prescribed psychoactive medication(s) listed below and the benefits, risks, and possible negative outcomes of their use. The form was signed by the resident's family member. An interview was conducted on (MONTH) 31, 2019 at 12:36 p.m., with a resource nurse (staff #92). She stated the admission nurse would be responsible for obtaining consent from the resident for admission orders [REDACTED]. She said the process of obtaining consent would include educating the resident and/or family about the new medication, the reason for its use and the side effects. She said the nurse would then have the resident sign the consent form. She said the nurse would need to wait for consent, before administering the medication. An interview was conducted on (MONTH) 31, 2019 at 12:45 p.m., with the Director of Nursing (DON/staff #15). She said if a [MEDICAL CONDITION] medication was ordered for a resident, the nurse would be expected to obtain consent before administration. She said if a resident had taken the medication at home or at the hospital prior to arriving at the facility, the nurse would still need to obtain consent. She said the consent process included explaining the risks, benefits and side effects and allowing the resident to agree or disagree. She said if the resident agreed, they would sign the consent and if they disagreed, the nurse would notify the provider and possibly request to change or discontinue the medication. Review of the facility's [MEDICAL CONDITION] medication documentation and management flow sheet revealed the steps for a new order for a [MEDICAL CONDITION] medication, which included to ensure the order was written with complete parameters and to obtain consent. The flow sheet instructed to document in the record if verbal consent was obtained and to obtain written consent as much as possible. The facility's [MEDICAL CONDITION] medication use policy revealed the facility should involve the resident or the resident's representative in the discussion of the potential non-drug and medication interventions to address the management of behaviors, and the involvement should be documented in the resident's medical record. The policy further included that staff should inform the resident and/or representative of the initiation, reason for use, and the risks associated with the use of [MEDICAL CONDITION] medications.
F 0582 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and the Form Instructions for the Notice of Medicare Non-Coverage (NOMNC) CMS- , the facility failed to ensure the resident's representative signature on the NOMNC form was dated the day the form was signed for one of two sampled residents (#145). The deficient practice could result in NOMNC forms not being accurate. Findings include:

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

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F 0582 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) Resident #145 was admitted on [DATE], with [DIAGNOSES REDACTED]. The resident was discharged on (MONTH) 8, 2019. Review of the admission Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 14 which indicated the resident had intact cognition. Review of the resident's face sheet revealed the resident was his own primary responsible party. Review of a weekly Interdisciplinary Team Meeting (IDT) summary and note dated 9/19/19 at 3:32 p.m., revealed the resident's tentative safe transition date was 9/22/19. The participants listed did not include the resident or the resident's family member. The note included the resident's family member was notified via phone on 9/19/19. The note also included the NOMNC was issued. The note revealed the resident and the resident's family member expressed understanding of and was in agreement with the plan of care. The NOMNC meeting summary and notes dated 9/20/19 at 11:46 a.m., revealed the participants included the resident and the resident's family members x 2. The note included the resident's family member was presented with the NOMNC form and stated that they had also received the information via phone last night (9/19/19). The note also included that the NOMNC form was signed and that the family member was informed that the NOMNC form will be dated 9/19/19 since they were notified via phone on that date regarding the discharge date . A review of the NOMNC CMS- form revealed the Medicare skilled services would end (MONTH) 21, 2019. The NOMNC form included the family member was notified via phone on 9/19/19 at 2:24 p.m. The form also included the family member's signature with the date 9/19/19. Further review of the clinical record revealed no evidence the resident and/or his family member was given a copy the NOMNC form prior to 9/20/19. An interview was conducted with a case manager (staff #149) on 10/30/19 at 08:33 AM. Staff #149 stated that the resident or the resident's representative should be provided a copy of the NOMNC form at least 48 hours prior to the date the Medicare skilled services will end. She stated that the resident's family member was very upset about the discharge and refused to sign the NOMNC form at first. Staff #149 also stated that she was not the case manager for that resident at the time and that the resident's actual case manager was currently out of the country. She stated that she could not comment to the date the NOMNC form was signed. An interview was conducted with the administrator (staff #123) on 10/30/19 at 11:38 AM. The administrator stated that she believes the NOMNC form was presented to the resident's family member on 9/20/19. The administrator also stated that the NOMNC form may have been backdated to 9/19/19 by the case manager because that is when the family member was notified of the NOMNC via phone. The administrator stated that if the form was backdated, she would not consider that to be an acceptable practice. The Form Instructions for the NOMNC CMS- revealed the resident or the resident's representative must sign the signature line and must fill in the date that he or she signed the document.
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 reviews, staff interviews and policy review, the facility failed to ensure two of five sampled residents (#298 and #2) were administered medication as ordered by the physician. The deficient practice of not receiving medications as ordered could result in possible adverse effects. Findings include: -Resident #298 was admitted on [DATE] with [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. A physician's orders [REDACTED]. Review of the (MONTH) 2019 medication administration record (MAR) revealed that [MEDICATION NAME] 650 mg had been given four times for a pain level of 5. During an interview with a Licensed Practical Nurse (LPN/staff #92) on 10/31/19 at 10:00 a.m., the MAR for resident #298 was reviewed. Staff #92 stated the [MEDICATION NAME] should not have been given for a pain level of 5 and that the nurse should have called the doctor. Staff #92 reviewed the clinical record and found no documentation that the physician was notified. In an interview with the acting Director of Nursing/Assistant Director of Nursing (staff #15) on 10/31/19 at 10:55 a.m., staff #15 stated that she assesses the location of pain and uses the pain scale to determine their pain level, offers interventions such as repositioning, ice and gives medication within the parameters, which are set by the physician. At this time, staff #15 reviewed the physician orders [REDACTED]. -Resident #2 was admitted to the facility on (MONTH) 20, 2019, with [DIAGNOSES REDACTED]. An admission Minimum Data Set (MDS) assessment dated (MONTH) 27, 2019, included a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. A physician's orders [REDACTED]. Review of the (MONTH) 2019 MAR revealed that [MEDICATION NAME] was not given to the resident on (MONTH) 22, 2019, with a SBP of 104 and a pulse rate of 73. The MAR also showed documentation that the medication was given to the resident on (MONTH) 27, with a pulse rate of less than 60. An interview was conducted on (MONTH) 31, 2019 at 10:55 a.m. with the Acting Director of Nursing (DON/staff #15), who reviewed the physician's orders [REDACTED]. She stated that the medication should have been given to the resident on (MONTH) 22, as his SBP and pulse were within range. She said that there was not a checkmark, which would indicate that the medication had been given. Regarding (MONTH) 27 when the medication was given for a pulse less than 60, she stated that the medication should not have been given and this was an error. Review of the facility's Administration Medications policy revised in (MONTH) 2012, revealed that medications shall be administered in a safe and timely manner and as prescribed. Medications must be administered in accordance with the orders and the vital signs must be checked if necessary, prior to administering medications.
F 0756 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview and policy review, the facility failed to ensure that recommendations from the pharmacist were acted upon by the physician for one of five sampled residents (#5). The deficient practice could result in residents receiving unnecessary medications. Findings include: Resident #5 was readmitted to the facility on (MONTH) 10, 2019, with [DIAGNOSES REDACTED]. An order dated (MONTH) 10, 2019 included for apixaban (anticoagulant) 5 milligrams (mg) two times a day. Review of a care plan dated (MONTH) 10, 2019, revealed the resident was receiving anticoagulant therapy, with a goal that the resident would be free from discomfort or adverse reactions related to anticoagulant use through the review date. Interventions included a daily skin inspection, and to monitor, document and report to the provider any signs or symptoms of anticoagulant complications such as: blood tinged urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy, bruising, blurred vision, sudden changes in mental status, or significant or sudden changes in vital signs. A pharmacist consultation report dated (MONTH) 12, 2019, included the resident received apixaban and had two or more of the following characteristics: -age greater than or equal to [AGE] years -body weight less that or equal to 60 kilograms (kg) -serum creatinine greater than or equal to 1.5 milligrams per deciliter The report further included a pharmacy recommendation to decrease apixaban to 2.5 mg twice a day with the following rationale: a dose adjustment is recommended when certain patient characteristics are present to reduce the risk of adverse events (bleeding). Per the report, if this therapy is to continue, it is recommended that the prescriber document an assessment of risk versus benefit, indicating it continues to be a valid therapeutic intervention for this individual.

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F 0756 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) Further review of the report revealed that the provider declined the recommendation and signed the report, however the provider did not include a rationale for declining the recommendation. Review of the (MONTH) 2019 Medication Administration Record [REDACTED]. Review of the clinical record revealed no evidence of a risk versus benefits assessment or any documentation by the physician of the rationale for the continued use of apixaban 5 mg twice a day. An interview was conducted on (MONTH) 31, 2019 at 12:45 p.m., with the Director of Nursing (DON/staff #15). She stated the consultant pharmacist reviews residents' medication regimens on admission, monthly and as needed. She stated the pharmacist consultation reports are given to the provider for review. She said if the provider disagreed with the recommendation, they would sign the report and write the reason for declining on the report. She said if the provider did not include a rationale on the report, there might be more information in the provider's progress notes, or the resource nurse would be expected to follow up with the provider. She said the pharmacist might send another report with follow-up questions. She said sometimes the most difficult part of the pharmacist medication reviews was obtaining documentation of a response from the provider in a timely manner. Review of the facility's policy for medication regimen reviews revealed the primary purpose of the medication review was to help the facility maintain each resident's highest practicable level of functioning, by helping them use medications appropriately and prevent or minimize adverse consequences. The consultant pharmacist will provide a written report to physicians for each resident with an identified irregularity. Copies of medication regimen review reports, including physician responses, would be maintained as part of the permanent medical record.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observations, staff interviews and policy and procedures, the facility failed to ensure drinks stored in 1 of 2 nourishment refrigerators were not expired. Expired foods or drinks could pose a health hazard to residents. Findings include: On (MONTH) 29, 2019 at 11:32 a.m., an observation was conducted of the nutrition refrigerator in the front hall that is used to store residents food. The refrigerator contained a small row of apple juice cups and three of the cups were were marked do not use after (MONTH) 10, 2019. An interview was conducted with the food service manager (staff #161) on (MONTH) 31, 2019 at 12:01 p.m. Staff #161 stated that she checks both of the nourishment refrigerators daily each morning. She stated that she must have overlooked checking the expiration dates for the apple juice cups. She said expired juice cups should be disposed on or before their expiration dates. An interview was conducted with the Administrator (staff #123) on (MONTH) 31. 2019 at 12:38 p.m., who stated that it was her expectation that the nourishment refrigerators do not contain expired food or drink items at all times. A facility policy regarding the safe storage of food included that food service staff must discard any perishable foods on or before the use by date.
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and the Form Instructions for the Notice of Medicare Non-Coverage (NOMNC) CMS- , the facility failed to ensure a NOMNC form was accurately dated for one of two sampled residents (#145). The deficient practice could result in residents' clinical records not being accurate. Findings include: Resident #145 was admitted on [DATE], with [DIAGNOSES REDACTED]. The resident was discharged on (MONTH) 8, 2019. Review of the NOMNC meeting summary and notes dated 9/20/19 at 11:46 a.m., revealed the participants included the resident and the resident's family members x 2. The note included the resident's family member was presented with the NOMNC form and stated that they had also received the information via phone last night (9/19/19). The note also included that the NOMNC form was signed and that the family member was informed that the NOMNC form will be dated 9/19/19 since they were notified via phone on that date regarding the discharge date . A review of the NOMNC CMS- form revealed the Medicare skilled services would end (MONTH) 21, 2019. The NOMNC form included the family member was notified via phone on 9/19/19 at 2:24 p.m. The form also included the family member's signature with the date 9/19/19. An interview was conducted with a case manager (staff #149) on (MONTH) 19, 2019 at 08:33 AM. Staff #149 stated that she was not the resident's case manager for the resident and could not comment to the date when the NOMNC form was signed. She stated the case manager who was assigned to the resident was currently out of the country. An interview was conducted with the administrator (staff #123) on 10/30/19 at 11:38 AM. The administrator stated that she believes the NOMNC form was presented to the resident's family member on 9/20/19. The administrator also stated that the NOMNC form may have been backdated to 9/19/19 by the case manager because that is when the family member was notified of the NOMNC via phone. The administrator stated that if the form was backdated, she would not consider that to be an acceptable practice. The Form Instructions for the NOMNC CMS- revealed the resident or the resident's representative must sign the signature line and must fill in the date that he or she signed the document.