STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035105	A. BUILDING _____ B. WING _____	10/15/2018

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SHEA POST ACUTE REHABILITATION CENTER	11150 NORTH 92ND STREET SCOTTSDALE, AZ 85260

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 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **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 policies and procedures were implemented related to an injury of unknown source for one resident (#284). Findings include: Resident #284 was readmitted to the facility on (MONTH) 2, (YEAR), with [DIAGNOSES REDACTED]. The resident was discharged on (MONTH) 1, (YEAR). Review of the end of therapy Minimum Data Set (MDS) assessment dated (MONTH) 23, (YEAR), revealed the resident scored an 8 on the Brief Interview for Mental Status (BIMS), indicating the resident had moderate cognitive impairment. Per the MDS assessment, the resident required extensive assistance for most activities of daily living. A change of condition note dated (MONTH) 31, (YEAR) at 7:32 a.m. revealed the resident was found on the floor of his room, confused and disoriented to time, place, person, and situation. The note included the resident sustained [REDACTED]. A nursing note dated (MONTH) 1, (YEAR) at 12:19 a.m. revealed the resident had a red area on his right forehead, two skin tears to the right arm, and was restless. Per the documentation, the resident was placed in bed after a.m. change of shift and about one hour later was crawling on the floor. Further review revealed the resident was pulling at his Foley catheter and was confused, asking if he had school tomorrow and was attempting to get out of bed. Review of a nursing note dated (MONTH) 1, (YEAR) at 4:01 a.m. revealed the resident had a second abrasion to the right elbow and a bump with redness to the right side of his forehead. The note included the resident was confused and disoriented. A change of condition note dated (MONTH) 1, (YEAR) at 9:41 p.m. revealed the resident was transported to the hospital for a head scan due to a fall, which left a laceration to his right eyebrow. Review of the hospital computed tomography (CT) scan of the brain dated (MONTH) 1, (YEAR) revealed the resident sustained [REDACTED]. However, no evidence was found that an investigation was conducted or that the results of the investigation were submitted to the State Agency. There was also no evidence that the injury of unknown source was reported to the required agencies. An interview was conducted on (MONTH) 12, (YEAR) at 8:30 a.m. with a registered nurse (RN/staff #56). Staff #56 stated that if a resident sustained [REDACTED]. The RN stated that she would notify the Director of Nursing (DON) as soon as possible and that the DON would conduct an investigation and notify the State Agency and the police. During an interview conducted on (MONTH) 12, (YEAR) at 8:40 a.m. with a RN (staff #27), staff #27 stated that for an injury of unknown source, the nurse would review the clinical record to determine what occurred. The RN stated that the DON or Administrator would be notified immediately and the abuse coordinator would conduct an investigation. An interview was conducted on (MONTH) 12, (YEAR) at 9:47 a.m. with the Administrator (staff #122) and the DON (staff #119). The DON stated that if an injury is truly an injury of unknown origin, the injury would be reported to the state agency. The DON stated that the criteria for an injury of unknown source can include when a resident has an unwitnessed fall resulting in a fracture (injury). She stated that the expectation is that an injury of an unknown source would be investigated. During an interview conducted on (MONTH) 12, (YEAR) at 10:43 a.m. with the Director of Nursing (DON/staff #119), she stated that an investigation was not done related to the resident's injury. Review of the facility's policy titled Abuse Prevention revealed that each resident has the right to be free from abuse and neglect. The policy included identifying events such as but not limited to, suspicious bruising of residents, occurrences, patterns, and trends that may constitute abuse. The policy included bruises, skin tears, and injuries of unknown source will be investigated to rule out abuse. Per the policy, all alleged violation or identified events are reported to the Administrator or designee immediately and will be thoroughly investigated. The policy revealed that when an incident or allegation of resident abuse or injury of an unknown source is identified, the administrator/designee will initiate an investigation. The policy also included all alleged violations will be reported within 24 hours to the State Agency, and the follow up results of the investigation will be submitted to the State Agency within the required timeframe per state and federal regulations. However, the regulation requires that all alleged violations involving abuse, neglect and an injury of unknown source be reported to the State Agency within two hours.
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **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 an injury of unknown source was reported to the State Agency for one resident (#284). Findings include: Resident #284 was readmitted to the facility on (MONTH) 2, (YEAR), with [DIAGNOSES REDACTED]. The resident was discharged on (MONTH) 1, (YEAR). A change of condition note dated (MONTH) 31, (YEAR) at 7:32 a.m. revealed the resident was found on the floor of his room, confused and disoriented to time, place, person, and situation. The note included the resident sustained [REDACTED]. A nursing note dated (MONTH) 1, (YEAR) at 12:19 a.m. revealed the resident had a red area on his right forehead, two skin tears to the right arm and was restless. Per documentation, the resident was placed in bed after a.m. change of shift and about one hour later was crawling on the floor. Further review revealed the resident was pulling at his Foley catheter and was confused, asking if he had school tomorrow and attempting to get out of bed. Review of a nursing note dated (MONTH) 1, (YEAR) at 4:01 a.m. revealed the resident had a second abrasion to the right elbow and a bump with redness to the right side of his forehead. The note included the resident was confused and disoriented. A change of condition note dated (MONTH) 1, (YEAR) at 9:41 p.m. revealed the resident was transported to the hospital for a head scan due to a fall, which left a laceration to his right eyebrow. Review of the hospital computed tomography (CT) scan of the brain dated (MONTH) 1, (YEAR) revealed the resident sustained [REDACTED]. No evidence was found that the injury of unknown source was reported to the State Agency. An interview was conducted on (MONTH) 12, (YEAR) at 8:30 a.m. with a registered nurse (RN/staff #56). Staff #56 stated that if a resident sustained [REDACTED]. An interview was conducted on (MONTH) 12, (YEAR) at 9:47 a.m. with the Administrator (staff #122) and the DON (staff #119).

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

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F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) The DON stated that if an injury is truly an injury of unknown origin, the injury would be reported to the State Agency. The DON stated that the criteria for an injury of unknown source can include when a resident has an unwitnessed fall resulting in a fracture (injury). Review of the facility's policy titled Abuse Prevention revealed that when an incident or allegation of resident abuse or injury of an unknown source is identified, the administrator/designee will initiate an investigation. The policy also included that all alleged violations will be reported within 24 hours to the State Agency. However, the regulation requires that all alleged violations involving abuse, neglect and an injury of unknown source be reported to the State Agency within two hours.
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** **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 an injury of unknown source was thoroughly investigated and the results of the investigation were reported to the State Agency for one resident (#284). Findings include: Resident #284 was readmitted to the facility on (MONTH) 2, (YEAR), with [DIAGNOSES REDACTED]. The resident was discharged on (MONTH) 1, (YEAR). A change of condition note dated (MONTH) 31, (YEAR) at 7:32 a.m. revealed the resident was found on the floor of his room and was confused and disoriented to time, place, person, and situation. The note included the resident sustained [REDACTED]. A nursing note dated (MONTH) 1, (YEAR) at 12:19 a.m. revealed the resident had a red area on his right forehead, two skin tears to the right arm, and was restless. Per documentation, the resident was placed in bed after a.m. change of shift and about one hour later was crawling on the floor. Further review revealed the resident was pulling at his Foley catheter and was confused, asking if he had school tomorrow and attempting to get out of bed. Review of a nursing note dated (MONTH) 1, (YEAR) at 4:01 a.m. revealed the resident had a second abrasion to the right elbow and a bump with redness to the right side of his forehead. The note included the resident was confused and disoriented. A change of condition note dated (MONTH) 1, (YEAR) at 9:41 p.m. revealed the resident was transported to the hospital for a head scan due to a fall which left a laceration to his right eyebrow. Review of the hospital computed tomography (CT) scan of the brain dated (MONTH) 1, (YEAR) revealed the resident sustained [REDACTED]. However, no evidence was found that an investigation was conducted regarding the injury of unknown source. An interview was conducted on (MONTH) 12, (YEAR) at 8:30 a.m. with a registered nurse (RN/staff #56). Staff #56 stated that if a resident sustained [REDACTED]. An interview was conducted on (MONTH) 12, (YEAR) at 8:40 a.m. with a RN (staff #27), who stated that for an injury of an unknown source, the DON or Administrator would be notified immediately and the abuse coordinator would conduct an investigation. An interview was conducted on (MONTH) 12, (YEAR) at 9:47 a.m. with the Administrator (staff #122) and the DON (staff #119). The DON stated that the criteria for an injury of unknown source can include when a resident has an unwitnessed fall resulting in a fracture (injury). She stated that the expectation is that an injury of an unknown source would be investigated. During an interview conducted on (MONTH) 12, (YEAR) at 10:43 a.m. with the DON, she stated that there was not an investigation related to the resident's injury. Review of the facility's policy titled Abuse Prevention revealed that each resident has the right to be free from abuse and neglect. The policy included identifying events such as but not limited to, suspicious bruising of residents, occurrences, patterns, and trends that may constitute abuse. The policy included bruises, skin tears, and injuries of unknown source will be investigated to rule out abuse. Per the policy, all alleged violation or identified events will be thoroughly investigated. The policy revealed that when an incident or allegation of resident abuse or injury of an unknown source is identified, the administrator/designee will initiate an investigation.
F 0655 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews and policy review, the facility failed to develop and implement a baseline care plan within 48 hours of admission for one resident (#6) which included the instructions needed to provide effective and person-centered care, and failed to provide a summary of the baseline care plans to the resident/representative. Findings include: Resident #6 was admitted to the facility on (MONTH) 11, (YEAR), with [DIAGNOSES REDACTED]. Regarding a summary of the baseline care plans: Review of the baseline care plans for the resident revealed there were care plans that addressed Hospice services, utilization of a gerichair for comfort when out of bed, bathing and pressure ulcers. The care plans included goals and interventions for each area. However, there was no documentation that a summary of the baseline care plans were provided to the resident/representative. Regarding developing baseline care plans: Review of the physician's admission orders [REDACTED] Review of the physician's orders [REDACTED].>However, review of the baseline care plans revealed there were no care plans that addressed the use of an indwelling urinary catheter, a mood disorder and the use of narcotic pain medication. During an interview conducted with the Director of Nursing (DON/staff #119) on (MONTH) 15, (YEAR), the DON stated that a baseline care plan is to be completed within 48 hours of admission. She stated that the baseline care process is started on admission by the admission nurse and assistant DON. The DON stated that the social worker schedules care conferences and invites the residents and their families to the conferences and that sometimes care conferences are conducted over the telephone. The DON further stated that a form is signed and scanned into the electronic medical record and the resident is given a copy of the baseline care plan summary. A policy titled, Comprehensive Person-Centered Care Planning revealed that the facility will develop and implement a baseline care plan within 48 hours of admission and that the baseline care plan will include the minimum healthcare information necessary to properly care for a resident which includes, but is not limited to physicians orders. The policy included that the facility will provide a written summary of the care plan to the resident or the resident's representative by the time of the completion of the comprehensive care plan.
F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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 and resident interviews, and policies and procedures, the facility failed to ensure services provided met professional standards of quality for seven residents (#s 13, 34, 40, 46, 69, 284 and 484). Findings include: -Resident #34 was admitted on (MONTH) 29, (YEAR), with [DIAGNOSES REDACTED]. Review of the physician's orders [REDACTED]. Cetritzine 10 mg (milligrams) po (by mouth) qd (every day) for seasonal allergies [REDACTED].>[MEDICATION NAME] Powder 17 gm (grams) po qd for bowel care; Multivitamin with minerals 1 po qd as a supplement; [MEDICATION NAME] Chloride ER (extended release) 10 mg po qd for urinary incontinence; [MEDICATION NAME] Nebulization 1 unit inhaled via nebulizer bid (twice a day) for congestion and shortness of breath; [MEDICATION NAME] Suspension 1 mg inhaled bid for shortness of breath;

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F 0658

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

(continued... from page 2)
Med Pass 2.0 4 oz (ounces) bid as a dietary supplement;
[MEDICATION NAME] 2.5 mg po bid for [MEDICAL CONDITION];
[MEDICATION NAME] 50 mg po q 8 hours for pain; and
Tylenol 325 mg 2 po tid (three times a day) for pain.
A review of the resident's care plan revealed that the resident had [MEDICAL CONDITION] and chronic pain, and that medications were to be administered as ordered.
Review of the Medication Administration Record (MAR) for (MONTH) (YEAR) revealed the following: 3 occasions with no documentation that the Cetritzine, [MEDICATION NAME], Multivitamin with minerals, [MEDICATION NAME] was administered; 5 occasions with no documentation that the [MEDICATION NAME] was administered; 6 occasions with no documentation that the Tylenol was administered;16 occasions with no documentation that the Med Pass was administered; and 20 occasions with no documentation that the [MEDICATION NAME] was administered.
Review of the MAR for (MONTH) (YEAR) revealed the following: 3 occasions with no documentation that the [MEDICATION NAME] was administered; 5 occasions with no documentation that the Med Pass was administered; and 8 occasions with no documentation that the [MEDICATION NAME] was administered.
Review of the MAR for (MONTH) (YEAR) revealed the following: 9 occasions with no documentation that the Med Pass was administered; 12 occasions with no documentation that the [MEDICATION NAME] was administered.
-Resident #40 was admitted (MONTH) 8, (YEAR) and readmitted on (MONTH) 6, (YEAR), with [DIAGNOSES REDACTED].
Review of the physician's orders [REDACTED].
Multivitamin with minerals 1 po qd as a supplement;
Nuplazid 17 mg 2 po qd for [MEDICAL CONDITIONS];
[MEDICATION NAME] 25 mg po qd for depression;
Vitamin B1 100 gm po qd as a dietary supplement;
[MEDICATION NAME] 2 mg po bid for muscle spasms;
[MEDICATION NAME]-Salmeterol Aerosol 250/50 mcg (micrograms) 1 puff inhaled bid for wheezing;
Med Pass 2 oz po bid as a dietary supplement;
[MEDICATION NAME] Sodium DR (delayed release) 500 mg po tid for mood disorder;
Pregabalin 50 mg po q 8 hours for [MEDICAL CONDITION];
[MEDICATION NAME]-[MEDICATION NAME] 25/100 mg 1 po q 6 hours for [MEDICAL CONDITION]; and
[MEDICATION NAME] Nebulization 3 ml (milliliters) inhaled via nebulizer every 2 hours for shortness of breath and wheezing.
A review of the resident's clinical record revealed care plans for chronic pain and [MEDICAL CONDITION] and related symptoms. The care plans included the medications were to be administered per orders.
Review of the MAR for (MONTH) (YEAR) revealed the following: 1 occasion with no documentation that the Multivitamin with minerals, Nuplazid, [MEDICATION NAME], Vitamin B1, [MEDICATION NAME], and [MEDICATION NAME]-Salmeterol was administered; 3 occasions with no documentation that the Med Pass was administered; 5 occasions with no documentation that the [MEDICATION NAME]-[MEDICATION NAME] was administered; 17 occasions with no documentation that the Pregabalin and [MEDICATION NAME] was administered; and 19 occasions with no documentation that the [MEDICATION NAME] was administered.
Review of the MAR for (MONTH) (YEAR) revealed the following: 2 occasions with no documentation that the Med Pass was administered; 4 occasions with no documentation that the [MEDICATION NAME]-[MEDICATION NAME] was administered; 11 occasions with no documentation that the [MEDICATION NAME] was administered; 12 occasions with no documentation that the [MEDICATION NAME] was administered; and 13 occasions with no documentation that the Pregabalin was administered.
Review of the MAR for (MONTH) (YEAR) revealed the following: one occasion with no documentation that the [MEDICATION NAME]-[MEDICATION NAME] was administered; 4 occasions with no documentation that the Med Pass was administered; and 7 occasions with no documentation that the [MEDICATION NAME], and Pregabalin was administered.
An interview was conducted with a LPN (Licensed Practical Nurse/staff #31) on (MONTH) 14, (YEAR) at 12:00 p.m. Staff #31 stated that the nurse is to document administrations of medications in the EMAR (Electronic Medication Administration Record). Staff #31 stated the undocumented medications will flag the nurse for documentation, but does not freeze up the EMAR and that the nurses can leave at the end of their shift without completing the documentation. Staff #31 stated that the nurses are to sign a sheet of paper at the end of their shift to state their documentation was complete at the end of the shift. The LPN stated the sheet is given to the DON (Director of Nursing) for review. Staff #31 further stated the on-coming nurse is to audit the previous shifts MAR for documentation and remind the previous shift nurse to complete the documentation before leaving. The LPN stated that this does not always happen.
An interview was conducted with the DON (staff #119) on (MONTH) 15, (YEAR) at 12:14 p.m. Staff #119 stated that nurses are to sign off at the end of their shift that they have completed their documentation on the MAR and TAR (Treatment Administration Record). After reviewing the (MONTH) (YEAR) MAR for resident #34, staff #119 stated that obviously it was not being done. Staff #119 further stated that no nursing administrative staff were auditing the MARs and TARS. The DON stated that she had delegated the auditing to the nurses.
-Resident #13 was admitted on (MONTH) 9, (YEAR) with [DIAGNOSES REDACTED].
A review of the annual Minimum Data Set assessment dated (MONTH) 23, (YEAR) revealed the resident had a Brief Interview for Mental Status (BIMS) score of 8, which indicated the resident had moderate cognitive impairment. The MDS assessment also revealed the resident received scheduled and as needed (PRN) pain medication and that she reported she had occasional pain at a level 4 which did not limit her day to day activities or sleep.
A review of the resident's care plan revealed that the resident had pain related to generalized pain and muscle spasms with interventions that included to administer pain medications as ordered.
A review of the physician's orders [REDACTED].
[MEDICATION NAME] Tablet 10 mg 1 tablet by mouth every 8 hours for muscle spasms ordered (MONTH) 26, (YEAR).
[MEDICATION NAME] Capsule 300 milligrams (mg) 1 capsule by mouth every 8 hours for muscle spasms ordered (MONTH) 26, (YEAR) and discontinued on (MONTH) 10, (YEAR).
[MEDICATION NAME] Capsule 300 mg 1 capsule by mouth two times a day for muscle spasms ordered (MONTH) 10, (YEAR).
A review of the Medication Administration Record (MAR) for (MONTH) (YEAR) revealed 17 occasions with no documentation that [MEDICATION NAME] and [MEDICATION NAME] was administered;
A review of the MAR for (MONTH) (YEAR) revealed 19 occasions with no documentation that [MEDICATION NAME] and [MEDICATION NAME] was administered.
A review of the MAR for (MONTH) (YEAR) revealed 17 occasions with no documentation that [MEDICATION NAME] and [MEDICATION NAME] was administered.
A review of the MAR for (MONTH) (YEAR) revealed 8 occasions with no documentation that [MEDICATION NAME] was administered and 6 occasions with no documentation that [MEDICATION NAME] was administered.
Review of the Progress Notes from (MONTH) 1, (YEAR) through (MONTH) 14, (YEAR) revealed no documentation regarding the [MEDICATION NAME] or [MEDICATION NAME] administration.
During an interview conducted on (MONTH) 11, (YEAR) at 9:45 a.m., resident #13 stated that occasionally she does not receive her regularly scheduled medications; however, she was unable to state a specific instance of which medication she did not receive or a specific date or time.
An interview was conducted on (MONTH) 15, (YEAR) at 12:03 PM with a Licensed Practical Nurse (LPN/staff #31). The LPN stated that the nurses are not supposed to leave blanks on the MAR and that it is possible to close the MAR without documenting. She also stated that the nurses are supposed to audit their documentation at the change of shift and sign a sheet every day that states that they have completed all MAR documentation for their shift.
In an interview on (MONTH) 15, (YEAR) at 1:34 p.m., staff #119 stated that the nurses are not supposed to leave blanks on the MAR. She stated that the nurses are responsible for auditing their documentation at the change of shift and that they are to sign a sheet every day that states that they have completed all MAR documentation for their shift.
-Resident #69 was admitted on (MONTH) 12, (YEAR), with [DIAGNOSES REDACTED].
A quarterly MDS assessment dated (MONTH) 24, (YEAR) revealed the resident had a BIMS score of 14, which indicated the resident was cognitively intact. The MDS assessment also indicated the resident had frequent pain, received scheduled pain medication, and received antidepressant and narcotic medications.
Review of the care plans revealed the resident has chronic pain related to [MEDICAL CONDITION] and chronic wounds. An

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F 0658

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

(continued... from page 3)
intervention was to administer medication as ordered.
Review of the physician's orders [REDACTED].
Review of the Medication Administration Record (MAR) for (MONTH) (YEAR) revealed the following: 5 occasions with no documentation that the [MEDICATION NAME] was administered; 5 occasions with no documentation that the Baclophen was administered; and 12 occasions with no documentation that the [MEDICATION NAME] was administered.
Review of the (MONTH) (YEAR) MAR revealed there were 4 occasions with no documentation that the [MEDICATION NAME] was
administered.
A review of the (MONTH) (YEAR) MAR revealed the following: 3 occasions with no documentation that the [MEDICATION NAME] was
administered; 3 occasions with no documentation that the Baclophen was administered; and 3 occasions with no documentation that the [MEDICATION NAME] was administered.
Regarding the antidepressant medication:
Review of the (MONTH) (YEAR) physician orders [REDACTED].
A care plan included the resident received an antidepressant medication related to depression, as evidenced by self isolation, sadness and inability to sleep. An approach included to give the antidepressant medication as ordered by the physician.
Review of the (MONTH) (YEAR) MAR revealed the resident was not administered [MEDICATION NAME] from (MONTH) 19, through 29,
(YEAR). The documentation included that the medication was unavailable, pending refill.
In addition, there was no clinical record documentation that the physician was notified.
An interview was conducted on (MONTH) 12, (YEAR) at 2:26 p.m., with a Registered Nurse (staff #60). Staff #60 stated if a medication is missing the nurse reorder it on the pharmacy website. Staff #60 said that one the website it will show if the medication has been reordered or if the order is pending. Staff #60 stated that if the medication does not come in a few days, then the pharmacy should be called to see what is going on. Staff #60 said that if a medication is not given, the reason should be written in the notes on the MAR.
An interview was conducted on (MONTH) 12, (YEAR) at 2:45 p.m. with the Director of Nursing (DON/staff #119). The DON stated that according to their policy, if a medication hasn't come within 24 hours, the nurse is expected to notify her. Staff #119 said then an investigation is done to find out why the medication is not here. She stated the physician should be notified if a significant medication is missed.
-Resident #46 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED].
Regarding the Medication Administration Record (MAR):
Review of the recapitulation of physicians orders dated (MONTH) (YEAR), revealed an order for [REDACTED].
A review of the (MONTH) (YEAR) MAR revealed no documentation that the [MEDICATION NAME] was administered on (MONTH) 2, 5,
17, and 30, (YEAR).
An interview was conducted on 10/11/2018 at 10:47 AM with a Licensed Practical Nurse (LPN/staff #56). She stated that after the resident has taken the medication, it is documented in the electronic MAR. The LPN stated that if it is not documented, this indicates that either the nurse forgot to document or that the medication was not given for some reason. She stated that if the medication is not administered, the nurse should document why. She also stated that if it is not documented, then it was not done. The LPN stated that each nurse is responsible to audit her own documentation.
During an interview conducted on 10/11/18 at 13:01 p.m., staff #119 stated that her expectation is that all medications administered are to be documented. She also stated that she was unable to state why [MEDICATION NAME] was not given on the 4 days in August.
The facility's policy titled Administration of Drugs revealed that only licensed nurses or other lawfully authorized staff members may prepare, administer, and record the administration of medications. The policy also included that all current drugs and dosage schedules must be recorded on the electronic medication administration record and that if a medication is withheld, refused, or given at other than the scheduled time, the documentation will be reflected in the clinical record, and if a medication is unavailable and is not administered at the scheduled time, the documentation will be reflected in the clinical record. The policy also lists the 7 rights of medication administration which includes the right documentation: document the administration or refusal of the medication after the administration or attempt and note any concerns. The policy included physician notification and other information regarding unavailable medication will be documented accordingly.
A review of the facility's policy titled Pain Management revealed medications received, refused, and the response to the medication will be documented on the MAR.
Regarding the skin assessments:
Review of the recapitulation of physician's orders [REDACTED].
A review of the Treatment Administration Review (TAR) from (MONTH) 13, (YEAR) through the first week of (MONTH) (YEAR) revealed the skin assessments were initialed as being done every Monday.
However, further review of the clinical record revealed there was no documentation that weekly skin assessments were completed from (MONTH) 18, (YEAR) through (MONTH) 8, (YEAR). A weekly skin assessment was completed on [DATE], (YEAR),
after the missing assessments were brought to the nurses' attention.
An interview was conducted on 10/11/18 at 10:47 a.m., with a LPN (staff #56). The LPN stated that the weekly skin evaluations are documented in the electronic record under assessments. She stated that she did not know why there were no weekly skin evaluations in the electronic record from late (MONTH) to early (MONTH) (YEAR).
During an interview conducted with the wound nurse (staff #68) on 10/11/18 at 11:31 a.m., she stated that the weekly skin evaluations are under assessments in the electronic record. The wound nurse stated that the TAR is initialed to indicate that the skin evaluations are completed. She agreed that there was no documentation that the skin evaluations had been completed from late (MONTH) through the first week of (MONTH) (YEAR).
An interview was conducted with the Assistant Director of Nursing (ADON/staff#12) on 10/12/18 at 2:10 p.m. She stated that the procedure for the weekly skin assessments is for the wound nurse to remind each nurse daily of the individual residents that have a weekly skin assessment due on that day. She stated that the nurse is to complete the assessment and initial it on the TAR. The ADON stated that the information from the skin assessment is to be documented in the electronic record under assessments and that the TAR is to be initialed. The ADON also stated that there may have been a miscommunication over the past months that the nurses believed the skin assessments were already completed. She stated that it was an oversight that the documentation was not caught on review.
The facility's policy regarding wound management included that the purpose of the policy is to prevent the residents from developing skin ulcers or other skin issues. The policy included to complete a weekly head to toe assessment with follow up as applicable. The policy also included that all skin assessments and treatments should to be documented in the clinical record at the time they are administered.
-Resident #284 was readmitted to the facility on (MONTH) 2, (YEAR), with [DIAGNOSES REDACTED]. The resident was discharged
(MONTH) 1, (YEAR).
Review of the physician's orders [REDACTED].
A nurse practitioner progress note dated (MONTH) 30, (YEAR) revealed the resident was awake, pleasantly confused, pupils were equal, round, reactive to light, and accommodation.
A change of condition note dated (MONTH) 31, (YEAR) at 7:32 a.m. revealed the resident was found on the floor of his room, confused, and disoriented to time, place, person, and situation. The note included the resident sustained [REDACTED]. The note further included vital signs were taken and neuro checks were initiated.
A nursing note dated (MONTH) 1, (YEAR) at 12:19 a.m. revealed the resident had a red area on his right forehead, two skin tears to the right arm, and was restless. Per documentation, the resident was placed in bed after a.m. change of shift and about one hour later was crawling on the floor. Further review revealed the resident was pulling at his Foley catheter, confused, asking if he had school tomorrow, and attempting to get out of bed. The note included the neuro checks were within normal limits.
Review of a nursing note dated (MONTH) 1, (YEAR) at 4:01 a.m. revealed the resident had a second abrasion to the right elbow and a bump with redness to the right side of his forehead. The note included the resident was confused and disoriented.
A review of the resident's neurological observation sheet dated (MONTH) 31, (YEAR) at 4:15 a.m. through (MONTH) 1, (YEAR) to 4:15 a.m. revealed the resident's vital signs were taken 12 times. Further review of the neurological observation sheet

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	035105	A. BUILDING _____ B. WING _____	**10/15/2018**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) revealed no documentation the resident's level of consciousness, hand grasps, and pupillary reactions were assessed and no documentation whether or not the physician was notified. Review of the physician's orders [REDACTED]. A change of condition note dated (MONTH) 1, (YEAR) at 9:41 p.m. revealed the resident was transported to the hospital for a head scan due to a fall which left a laceration to the resident's right eyebrow. An interview was conducted on (MONTH) 11, (YEAR) at 9:27 a.m. with a registered nurse (staff #27/RN). The RN stated that if a resident is found on the floor or crawling on the floor it is a fall. Staff #27 stated that once a fall has occurred, the resident is assessed for injuries, asked what happened, vital signs are taken, the physician is notified, and an incident report is initiated. Staff #27 stated that if the resident is unable to communicate what happened, neuro checks would be initiated. The RN stated the resident would be monitored every 15 minutes for one hour, every 30 minutes for one hour, and then every hour for 4 hours. Staff #27 stated that if a resident is on blood thinners, the resident would be sent out to the emergency room immediately because the resident could have a bleed. An interview was conducted on (MONTH) 11, (YEAR) at 9:45 a.m. with a licensed practical nurse (LPN/staff #31). Staff #31 stated that if a resident was found on the floor, the nurse would immediately assess the resident, take vital signs, and that if the fall was unwitnessed, neuro checks including pupils equal, round, reactive to light, and accommodation (PERRLA) would be assessed every 15 minutes for 1 hour. Staff #31 further stated that the physician and the family would be notified immediately. The LPN stated that for a resident being administered blood thinners, there could be a potential for the resident to bleed out. During an interview conducted on (MONTH) 11, (YEAR) at 12:36 p.m. with a RN (staff #79), the RN stated that if a resident had a fall and was unable to verbalize what happened, neuro checks would be assessed every 15 minutes, every 30 minutes, and then every 1 hour. Staff #79 stated that if the resident is receiving anticoagulants, the resident is at risk for developing a bleed. The RN stated the physician would be notified. An interview was conducted on (MONTH) 11, (YEAR) at 12:40 p.m. with staff #119. She stated that if a resident sustained [REDACTED]. She further stated that if the resident is on anticoagulants, the physician is notified and the physician's orders [REDACTED]. She stated that the fall occurred at 4 a.m. and that the physician and the DON were notified at 7:30 a.m. The DON stated that the neuro check sheet corresponded to the fall on (MONTH) 31, (YEAR) at approximately 4 a.m. and that the vital signs were taken at regular intervals, but that the neuro checks were not completed. The facility's policy titled Neurological Evaluation revealed it is the policy of the facility to gather accurate nursing data necessary for a comprehensive neurological evaluation. The policy included that any resident having a injury involving the head or an unobserved fall will have neuro checks and vital sign taken. The policy also included all incidents involving trauma to the head will result in a comprehensive neurological evaluation for a minimum of forty-eight hours. -Resident #484 was admitted on [DATE] on hospice services, with [DIAGNOSES REDACTED]. Review of a physician's orders [REDACTED]. A review of the Medication Administration Record (MAR) revealed that the resident received the medication on 10/9/18 and 10/10/18. The dosage on the MAR was 10 mg. During an observation conducted on (MONTH) 10, (YEAR) at 9:00 a.m. of the medication cart on the resident's hall, a bottle of rivaroxaban was observed with a pharmacy label with the resident's name on it. However, the bottle contained 15 mg tablets, instead of 10 mg tablets. An interview was conducted with a Registered Nurse (RN/staff# 27) on (MONTH) 10, (YEAR) at 9:15 AM. The nurse stated that the medication was delivered by hospice two days ago and that it was a home medication used by the resident. The nurse said that this is the only rivaroxaban medication in the facility for this resident and that he had given the resident this medication today and on (MONTH) 9. He said that he should have checked the medication for the correct dose prior to administering it as the dosage in the bottle is different than the physician's orders [REDACTED]. A second interview was conducted with staff #27 on (MONTH) 11, (YEAR) at 11:37 AM. He stated that it is the nurse's responsibility to check that the right dose of medication is being administered to the resident. An interview was conducted with staff #119 on (MONTH) 12, (YEAR) at 11:30 a.m The DON said that the staff are expected to check for all rights of medication administration including that it is the right dose prior to administration the medication. The facility's policy regarding administration of medication included that medications must be administered in accordance with the written orders of the attending physician. The policy also included that orders will be accurately implemented and that the seven rights of medication administration are followed in order to ensure safety and accuracy of administration. This includes that medications are administered according to the dose prescribed.
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 observations, clinical record reviews, resident and staff interviews, and policy review, the facility failed to ensure that one resident (#6) received the necessary care and services to prevent and promote the healing of an unstageable pressure ulcer, and failed to complete a timely assessment of a pressure ulcer for one resident (#13). Findings include: -Resident #6 was admitted on (MONTH) 11, (YEAR), with [DIAGNOSES REDACTED]. Review of the admission orders [REDACTED]. An admission Minimum Data Set (MDS) assessment dated (MONTH) 18, (YEAR), revealed the resident had a Brief Interview for Mental Status (BIMS) score of 6, which indicated severe cognitive impairment. The MDS included the resident required extensive assistance with bed mobility and transfers. The MDS also included that the resident was at risk for pressure ulcers and had two pressure ulcers which were present on admission and was not on a turning and repositioning program. A care plan identified that the resident had two stage 2 pressure ulcers on the buttocks. Interventions included to administer treatments as ordered, assess/record/monitor wound healing, measure length, width, and depth where possible, assess and document status of wound perimeter, wound bed and healing progress, report improvements and declines to the MD, float heels, notify nurse immediately of any new areas of skin breakdown, weekly head to toe skin assessments and for wound care team to follow. A Braden Scale for Predicting Pressure Ulcer Risk dated (MONTH) 3, (YEAR) included the resident was at high risk for developing pressure ulcers. Review of the clinical record including the weekly skin assessments revealed there was no documentation that the resident had a pressure ulcer to the right foot from admission through (MONTH) 16, (YEAR). There was also no documentation that the resident's heels were floated as care planned from admission through (MONTH) 16, (YEAR). Review of the CNA (Certified Nursing Assistant) ADL (activities of daily living) documentation regarding turning and repositioning revealed there were several notations that it was not applicable to turn and reposition the resident every two hours, and there were multiple shifts with no documentation that the resident was turned and repositioned every 2 hours from admission through (MONTH) 16, (YEAR). Review of a wound care physician's note dated (MONTH) 17, (YEAR), revealed the resident's right lateral dorsal foot had a superficial ulceration which exposed the dermis and had thin slough, with a scant amount of serous drainage. The note did not include any measurements of the wound. This was the first documentation of the right lateral dorsal foot wound. The plan included for Xeroform and a bordered gauze to the right lateral foot daily. However, review of the physician orders [REDACTED]. In addition, there was no documentation that any wound treatments were provided from (MONTH) 17 through 25, (YEAR). The next assessment of the right lateral dorsal foot wound was completed on (MONTH) 26, (YEAR), which was nine days after the previous assessment (on (MONTH) 17). Per the physician's note dated (MONTH) 26, (YEAR), the right foot had a superficial ulceration which exposed the dermis and had thin slough, with a scant amount of serous drainage. The assessment did not include any measurements of the wound. The plan was to monitor closely, as the resident can not turn himself. The note also included for Xeroform and bordered gauze to the right lateral foot daily. A physician's orders [REDACTED]. The order included to cleanse the right lateral dorsal foot with normal saline, cover with [MEDICATION NAME] and bordered gauze every Tuesday, Thursday and Saturday. The next assessment of the right foot pressure ulcer was not completed until 12 days later on (MONTH) 8, (YEAR), by the

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F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 5) physician. The physician note included that the right plantar forefoot ulcer began as a bulla and was unstageable. There were no measurements and there was no description of the unstageable pressure ulcer. The plan was to apply [MEDICATION NAME] and gauze to the right plantar forefoot ulcer. Review of a Weekly Skin Evaluation dated (MONTH) 8, (YEAR) revealed the resident had a right plantar forefoot bulla, which measured 4 cm x 3 cm. This is the first documentation of any measurements of the pressure ulcer to the right foot. A Weekly Skin Evaluation dated (MONTH) 10, (YEAR) included the right plantar foot pressure ulcer measured 0.9 cm x 1.3 cm, with black eschar and was unstageable. Review of the Pressure Ulcer Weekly documentation which was completed by the wound nurse dated (MONTH) 13, (YEAR), revealed the right medial foot wound was unstageable with slough and black/brown eschar. The pressure ulcer measured 2.0 cm by 3.0 cm with a no exudate, no odor, wound edges were attached and the surrounding tissue was normal. The documentation included the pressure ulcer was dressed with [MEDICATION NAME] soaked gauze and covered with [MEDICATION NAME], and wrapped in Kerlix. The documentation further noted that the pressure ulcer was not present on admission. This was the first documentation by the wound nurse regarding the right foot wound, which was more than three weeks after the pressure ulcer was discovered. A wound care physician note dated (MONTH) 15, (YEAR) included the right plantar forefoot ulcer began as a bulla and was unstageable. The plan was to apply [MEDICATION NAME] and gauze to the right foot ulcer. A review of the clinical record for the period of (MONTH) 15, (YEAR) through (MONTH) 23, (YEAR) revealed weekly wound care physicians notes, which addressed the right foot wound and frequent modifications of the treatment orders. The wound care physician's note dated (MONTH) 28, (YEAR) indicated the non-healing right plantar forefoot ulceration was debrided at the bedside, which exposed peiosteum on the wound bed. The plan was to continue iodosorb gel and gauze to the right plantar forefoot ulceration, turn every two hours, and continue to mobilize patient out of bed as tolerated. A review of the Licensed Nurse Pressure Ulcer Weekly documentation dated (MONTH) 30, (YEAR), indicated that the right foot wound had slough, was unstageable and measured 1.1 by 1.2 cm with no depth. The wound also had a small amount of serosanguinous exudate and the wound edges were fibrotic and calloused, and the tissue surrounding the wound was normal. Further review of the clinical record revealed the right foot wound continued to be assessed weekly and treatments were provided through (MONTH) (YEAR). A quarterly MDS assessment dated (MONTH) 1, (YEAR) revealed a BIMS score of 7, which indicated severe cognitive impairment. The MDS included the resident required extensive assistance with bed mobility and transfers, and that he had one stage 4 pressure ulcer that was not present on admission. The MDS noted that the resident was not on a turning and positioning program. A review of the (MONTH) 4, (YEAR) Pressure Ulcer Weekly assessment revealed the right foot pressure ulcer was a stage 4 and measured 0.3 cm by 0.3 cm with a depth of 0.3 cm, with no undermining. The wound bed had granulation tissue, and had a small amount of serosanguinous exudate, no odor, and the wound edges were fibrotic and calloused, and the surrounding tissue was normal. A wound care observation was conducted with the wound nurse (Registered Nurse/staff #68) on (MONTH) 10, (YEAR) at 2:00 p.m. The resident was lying on his back with his heals floated, by a foam bridge across the foot of the bed. Staff #68 performed the dressing change in accordance with the current physician's orders [REDACTED]. Staff #68 stated that the wound presented as a stage 4 pressure ulcer with red granulation tissue. During an interview with staff #68 on (MONTH) 10, (YEAR) at 2:05 p.m., the RN stated that this wound began when the resident was in a shorter bed, and his foot would rest against the footboard. The RN stated that the wound started as a small black eschar covered area. Staff #68 said that she had been on leave around the time that this wound developed and that she had been following it weekly since her return. An interview was conducted with the Director of Nursing (DON/staff #119) on (MONTH) 15, (YEAR) at 1:34 p.m. The DON stated that she expects that who ever discovers a new wound would notify the wound nurse and the charge nurse, and the wound nurse would assess the wound and put orders in place. She stated that any nurse can notify the physician. The DON stated that documentation should include describing the wound bed and measuring the wound, and that the physician should be notified of any new wounds. -Resident 13 was admitted on (MONTH) 9, (YEAR), with [DIAGNOSES REDACTED]. A review of the annual MDS assessment dated (MONTH) 23, (YEAR), revealed the resident had a BIMS score of 8, which indicated moderate cognitive impairment. The MDS included that the resident required extensive assistance with bed mobility, transfers, dressing, toileting and personal hygiene, and was frequently incontinent of urine and bowel. The MDS further revealed the resident was at risk for pressure sores, and had no pressure sores currently. A pressure reducing device was in place for the bed, but no pressure reducing device for the chair, and was not on a turning or positioning schedule. Review of a care plan revealed the resident was at risk for developing pressure ulcers related to incontinence of bowel and bladder and decreased functional mobility. A goal included the resident would be free from injury. Interventions included assist with toileting and/or offer incontinent care on rounds and as needed, keep skin clean and dry, monitor/document location, size, and treatment of [REDACTED]. The care plan further noted that the resident had refused placement of a low air loss mattress. physician's orders [REDACTED]. According to the corresponding MARs, the barrier cream was applied. A review of the clinical record and the Weekly Skin Evaluations from (MONTH) 24, (YEAR) through (MONTH) 7, (YEAR), revealed the resident did not have any skin breakdown or pressure sores. A physician's orders [REDACTED]. Despite having a physician's orders [REDACTED]. There was no documentation of any measurements of the sacral area pressure ulcer, no description of the wound bed and surrounding skin, or if there was any drainage or odor. There was also no staging of the pressure ulcer. In an interview on (MONTH) 9, (YEAR) at 4:41 p.m., resident #13 stated that she had a sore on her tailbone, which developed since she was admitted to the facility. She stated that the nursing assistants had been putting a salve on it but it hurt, so they changed the salve. Review of the Licensed Nurse Weekly Skin Evaluation dated (MONTH) 10, (YEAR), revealed documentation of a stage II pressure ulcer on the sacrum which measured 0.5 cm by 0.3 cm with 0 cm depth, with a pink wound bed and no peri wound skin issues. Wound care provided per MD orders. This was the first assessment of the pressure ulcer on the sacrum, which was completed two days after the physician ordered treatment. A wound treatment observation was conducted with the wound nurse (staff #68) and a Certified Nursing Assistant (CNA/staff #1) on (MONTH) 11, (YEAR) at 10:00 a.m. Staff #68 stated the wound measured 0.3 by 0.3 cm with no measurable depth, and described the wound bed as pink, with healing tissue. Staff #68 stated that the pressure ulcer was a stage II. A review of the Licensed Nurse Skin Pressure Ulcer Weekly Review dated (MONTH) 11, (YEAR) revealed it was the initial evaluation of a stage II pressure ulcer on the sacrum that was not present on admission. The wound measured 0.3 cm by 0.3 cm with no depth, and had a pink wound bed with defined edges and normal surrounding skin. The treatment included for [MEDICATION NAME] covered with foam. In an interview conducted with staff #1 on (MONTH) 15, (YEAR) at 11:13 a.m., staff #1 stated that to prevent pressure ulcers for resident #13, she changed her brief often and applied barrier cream to protect the skin. She stated that she helps the resident turn and change position and that the resident is able to use the bar to pull herself to her side. Staff #1 also stated that the resident developed the pressure sore about a week ago and that she was the CNA who discovered it and reported it to the nurse and the wound nurse. Another interview was conducted with staff #68 on (MONTH) 15, (YEAR) at 12:09 p.m. Staff #68 stated the unit nurses are responsible to document the wound appearance and initiate the standing orders for wound care and they may describe the wound. She said that the wound nurses are the only ones who may stage a wound. Staff #68 stated the wound nurse is responsible to assess the wound, to follow standing orders for wound care, add the resident to the wound rounds list, and update the care plan. She stated every wound should receive an assessment, care orders, and is added to the rounding list by the next day. A review of a policy titled, Wound Management revealed a resident who enters the facility without pressure ulcers does not develop pressure ulcers unless the individual's clinical condition or other factors demonstrate that a developed pressure

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F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 6) ulcer was unavoidable and a resident having pressure ulcers receives necessary treatment and services to promote healing, prevent infection, and prevent new, avoidable sores from developing. The policy included to provide care and services to promote the prevention of pressure ulcers, promote the healing of pressure ulcers that are present and prevent the development of additional pressure ulcers. The policy further stated that nursing staff are responsible to implement approaches as appropriate and consistent with the resident's care plan, which include stabilizing, reducing or removing any existing underlying risks, reposition the resident, and use pressure relieving/reducing and redistributing devices (including, but not limited to, low air loss mattresses, wedges, pillows, etc.), monitor the impact of interventions and modify interventions as appropriate based on any identified changes in condition.
F 0688 **Level of harm -** Minimal harm or potential for actual harm **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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interviews, review of clinical records, facility records, and policy, the facility failed to ensure two residents (#182 and #26) with limited range of motion received appropriate treatment and services to increase their range of motion and/or prevent further decrease in their range of motion. Findings include: -Resident #182 was admitted on (MONTH) 10, (YEAR) with [DIAGNOSES REDACTED]. An Initial Admission Record dated (MONTH) 10, (YEAR) revealed the resident's bilateral hand grips were equal and that there were no contractures present. The record included there were no limitations in range of motion in the resident's hands and no loss in the resident's ability to move his hands voluntarily. A physician's orders [REDACTED]. An OT (Occupational Therapy) evaluation dated (MONTH) 11, (YEAR) included short-term goals that the resident was to have a splint wearing schedule established to avoid further contracture of the left hand and wrist. The evaluation included an RNA program will be established for the left upper extremity to avoid further contracture. An admission MDS (Minimum Data Set) assessment dated (MONTH) 17, (YEAR) revealed the resident had a BIMS (Brief Interview for Mental Status) score of 10, which indicated the resident had moderately impaired cognition. The MDS assessment also included that the resident had impaired functional limitation in range of motion on one side and was receiving OT services. Review of the daily skilled documentation dated (MONTH) 29 through (MONTH) 31, (YEAR) revealed the resident had decreased grasp and movement of the upper left extremity and was receiving OT services. An OT discharge summary dated (MONTH) 24, (YEAR) revealed the resident had completed OT services. The summary included the therapy goals had been met which included establishment of a splint wearing schedule to avoid further contracture of the left hand and wrist. The summary also included the resident was independent with range of motion for the left hand in a resting hand splint and that the goals had been met for donning and doffing the left hand splint. The discharge summary further included recommendations to establish a restorative splint and brace program and for the resident to be able to tolerate splinting daily. Further review of the clinical record revealed no documentation that RNA services were provided to the resident as recommended by OT. An interview was conducted on (MONTH) 9, (YEAR) at 2:56 p.m. with the resident. During the interview, the resident demonstrated that he was unable to fully open his left hand; the fingers of the hand remained slightly bent when he attempted to open his hand. The resident was not observed to have a splint on the left hand. The resident stated that the splint was in a drawer in his room and that the staff only sometimes applied the splint. During an interview conducted with a LPN (Licensed Practical Nurse/staff #56) on (MONTH) 11, (YEAR) at 12:53 p.m., the nurse stated that the resident was unable to use his left hand and that his fingers were not contracted. The nurse stated that the resident had received RNA (Restorative Nursing Assistant) services who she believed had placed splints on the resident's hands, but that the resident no longer used the splints. During an interview conducted with the RNA (staff #13) on (MONTH) 11, (YEAR) at 1:00 p.m., the RNA stated that the resident was not currently receiving RNA services and had not received RNA services in the past. The RNA stated that there had been a discussion with the therapy staff regarding RNA services for the resident but that he had not heard any more about it. An interview was conducted on (MONTH) 11, (YEAR) at 1:15 p.m. with the Director of Rehab Services (staff #21). The Director stated that the resident completed OT services and that the resident had functional ROM (Range of Motion) of the left hand. The Director stated that OT services included the use of a resting hand splint and that at the time the resident was discharged from therapy services, RNA was recommended. The Director stated that he did not know why the resident had not received the RNA services that had been recommended. The Director also stated that when RNA services are recommended by the therapy staff, a form is completed for the recommended services and provided to the RNA staff, who then initiates the services. An interview was conducted on (MONTH) 11, (YEAR) at 1:51 p.m. with staff #13. Staff #13 stated that he never received a referral for this resident to receive RNA services, and that the splint for the resident's left hand was in the resident's drawer in his room. An interview was conducted on (MONTH) 11, (YEAR) at 2:40 p.m. with the Director of Nursing (DON/staff #119). The DON stated that when RNA services are recommended for a resident by the therapist, a referral form is completed and provided to the RN[NAME] The DON stated the RNA then initiates an RNA schedule for the resident based on the therapist's recommendation. Staff #119 stated that the RNA staff are responsible for applying and removing hand splints. The DON agreed that the recommendation for RNA services had not been communicated to the RNA staff. -Resident #26 was admitted to the facility on (MONTH) 30, (YEAR), with [DIAGNOSES REDACTED]. Review of the quarterly Minimum Data Set (MDS) assessment dated (MONTH) 13, (YEAR), revealed the resident was moderately cognitively impaired and required extensive assistance from staff for his activities of daily living. Review of the physician's orders [REDACTED]. arm to aid in contracture reduction. The order also included for the resident to receive restorative range of motion to the right upper and lower extremities. The care plan regarding activities of daily living revealed the resident had right upper extremity and right lower extremity contractures. The care plan goal was that the resident would demonstrate the appropriate use of adaptive devices to increase ability. The intervention included nursing rehabilitation would apply rolled towels and perform range of motion to the right upper and lower extremities daily. Review of the Restorative Nursing Assistant (RNA) documentation from (MONTH) 1, (YEAR) through (MONTH) 31, (YEAR), revealed no documentation for 35 days that range of motion was provided or that rolled towels were used daily and no documentation from (MONTH) 1, (YEAR) through (MONTH) 10, (YEAR) for 49 days. Observations of the resident were conducted on (MONTH) 9, (YEAR) at 2:19 PM and (MONTH) 10, (YEAR) at 8:25 AM. The resident was observed seated in his wheelchair with no rolled towels present in his right hand or under his right arm. Review of an Occupational Therapy (OT) evaluation dated (MONTH) 10, (YEAR), revealed the resident was referred to OT from RNA due to decreased right upper extremity range of motion. An interview was conducted on (MONTH) 11, (YEAR) at 12:08 PM with the RNA (staff #13). He stated the RNA is responsible for providing and documenting the range of motion and rolled towel treatments. He stated that if the resident refused, he would document the refusal. He further stated that the rolled towel should be used in the resident's right hand at all times. The RNA stated the larger rolled towel under the resident's right arm was only supposed to be used when the resident was lying down in bed. An observation was conducted on (MONTH) 11, (YEAR) at 1:26 PM of the resident lying in his bed. No rolled towel was observed in the resident's right hand or under his right arm. Observations were conducted on (MONTH) 12, (YEAR) at 10:07 AM and at 1:52 PM. Both times the resident was observed seated in his wheelchair with no rolled towels present in his right hand or under his right arm. During an interview conducted on (MONTH) 12, (YEAR) at 11:05 AM with an Occupational Therapist (staff #21), he stated that the resident's range of motion was evaluated on (MONTH) 10, (YEAR). He stated that the degree of the resident's extension

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F 0688 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 7) in his right arm and right hand was greater than the range that would be needed to fit a rolled towel in his hand or under his arm. He stated that based on the evaluation, the resident's contractures had not worsened beyond the range of what a rolled towel would provide. An interview was conducted on (MONTH) 12, (YEAR) at 11:38 AM with the Director of Nursing (DON/staff #119). She stated that she is responsible for adding restorative interventions to the resident's care plan. The DON stated that interventions in the care plan automatically transfer to the RNA to view, perform, and document in the electronic record. She stated that the RNA is the one that would provide the restorative nursing treatments and document the treatment. The DON stated that she was not aware the RNA services were not being provided daily, and that currently no one is auditing the RNA documentation to ensure that treatments are provided as ordered. The facility's restorative care policy revealed a policy statement that restorative care will be provided to each resident according to his/her individual needs. The policy also included that residents will receive services to attain and maintain the highest possible mental/physical functional status and psychosocial well-being defined by the comprehensive assessment and plan of care. The policy further included that a resident's restorative care requires close intervention and follow-through by a licensed nursing staff or designee.
F 0695 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, staff interviews, and policy and procedures, the facility failed to ensure that one resident (#44) received oxygen as ordered by the physician. Findings include: Resident #44 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of a physicians order dated 5/15/2018 revealed the resident was to receive oxygen at 2 liters via nasal cannula as needed for shortness of breath, respiratory distress, cyanosis, or labored breathing. Review of the current respiratory care plan initiated 5/15/2018 revealed that the resident had [MEDICAL CONDITION] and [MEDICAL CONDITION] related to smoking and uses oxygen therapy related to [MEDICAL CONDITIONS] and ineffective gas exchange. The goal for the care plan was that the resident will display optimal breathing patterns daily. One of the interventions was to give oxygen therapy as ordered by the physician. A quarterly Minimum Data Set (MDS) assessment dated [DATE] included that the resident had a Brief Interview for Mental Status (BIMS) score of 5, which indicated severe cognitive impairment. The MDS assessment also included that the resident was receiving oxygen therapy. Review of physician progress notes [REDACTED]. During multiple observations of the resident conducted on 10/9/2018 at 2:15 p.m., 10/10/2018 at 9:15 a.m. and 2:15 p.m. and 10/11/2018 at 8:29 a.m., the resident had a nasal cannula on and the oxygen was running at 3 liters, instead of 2 liters as ordered. An interview was conducted on 10/11/2018 at 8:48 AM with a Licensed Practical Nurse (LPN/staff# 31). The nurse stated that when she has a resident in her section who is on oxygen she would check to see that the oxygen is being administered as per the physician's orders [REDACTED]. During an interview with a Registered Nurse (RN/staff#47) on 10/11/2018 at 3:15 p.m., she checked the resident's oxygen concentrator and said that the resident was on 3 liters of oxygen. She then checked the physician's orders [REDACTED]. She stated that the resident should not be on 3 liters of oxygen and that the resident was getting the incorrect amount of oxygen. An interview was conducted on 10/12/2018 at 11:30 a.m. with the Director of Nursing (DON/staff #119). She stated that she expects that the nurses will administer oxygen at the rate that is ordered by the physician. According to facility policy, oxygen therapy is administered by licensed nurses as ordered by the physician.
F 0697 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide safe, appropriate pain management for a resident who requires such services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record reviews, resident and staff interviews and policy review, the facility failed to ensure pain management was provided to one resident (#13) consistent with professional standards of practice and the resident's goals and preferences. Findings include: Resident #13 was admitted on (MONTH) 9, (YEAR) and readmitted on (MONTH) 26, (YEAR), with [DIAGNOSES REDACTED]. The annual Minimum Data Set (MDS) assessment dated (MONTH) 23, (YEAR) revealed a Brief Interview for Mental Status (BIMS) score of 8, which indicated moderate cognitive impairment. The assessment included the resident received scheduled pain medication and as needed pain medication and that she occasionally reported her pain level at a 4 which did not interfere with day to day activities or sleep. The assessment also included that the resident had not received non-medication interventions for pain. A review of the care plan revealed the resident had generalized pain and muscle spasms. The goals were the resident would voice level of comfort and would have no discomfort related to side effects. Interventions included pain medications as ordered, pain assessment every shift, and activities of choice for distraction. A review of the physician's orders [REDACTED]. -[MEDICATION NAME] 10 milligrams (mg) by mouth every 8 hours for muscle spasms ordered on (MONTH) 26, (YEAR). -[MEDICATION NAME] 300 mg by mouth every 8 hours for muscle spasms ordered on (MONTH) 26, (YEAR) and discontinued on (MONTH) 10, (YEAR). -[MEDICATION NAME] 300 mg by mouth twice daily for muscle spasms ordered on (MONTH) 10, (YEAR). -[MEDICATION NAME] 325 mg 2 tablet by mouth every 6 hours as needed for a pain level of 1-3 ordered on (MONTH) 1, (YEAR). -[MEDICATION NAME] 15 mg by mouth every 6 hours as needed for a pain level of 4-10 ordered on (MONTH) 1, (YEAR). Review of the Medication Administration Records (MAR) and progress notes from (MONTH) (YEAR) until (MONTH) (YEAR) revealed there were multiple times with no documentation that the [MEDICATION NAME] and [MEDICATION NAME] were administered or that the resident had refused. Further review of the clinical record revealed the resident rated her pain at a level of 4 on multiple occasions, however, there was no documentation that non pharmalogical interventions were offered or that pain medication was administered. During an observation conducted on (MONTH) 9, (YEAR) at 4:20 p.m., the resident asked a Licensed Practical Nurse (LPN/staff #78) for pain medication for a pain level of 12. The resident told the nurse that she had requested [MEDICATION NAME] at 1:30 p.m. and had not received it. Staff #78 stated that she was unaware of the request from the previous shift, but she would get the pain medication right away. Staff #78 was observed to administer [MEDICATION NAME] at 4:26 p.m. to the resident. A review of the MAR and progress notes for (MONTH) 9, (YEAR) revealed the only time [MEDICATION NAME] was documented as administered was at 4:26 p.m. An interview was conducted with the resident on (MONTH) 9, (YEAR) at 4:40 p.m. The resident stated that she has waited for hours to receive pain medication. During another interview with the resident on (MONTH) 11, (YEAR) at 9:45 a.m., the resident stated that occasionally she does not receive her regularly scheduled medications; however, she was unable to state a specific instance of which medication she did not receive or a specific date or time. A follow up interview was conducted with the resident on (MONTH) 12, (YEAR) at 1:01 p.m. The resident stated that often she has waited 2 hours for pain medication after requesting it. She said the pain medication relieves her pain, but that sometimes it can take up to an hour for relief. She stated that she may have to request the pain medication sooner, because of the wait. During an interview conducted with the resident on (MONTH) 15, (YEAR) at 9:45 a.m., the resident stated that she continues to wait up to 3-4 hours for pain medication. An interview was conducted with a Certified Nursing Assistant (staff #1) on (MONTH) 15, (YEAR) at 11:13 a.m. The CNA stated that when the resident complains of pain, she reports it to the nurse. During an interview conducted with the Director of Nursing (DON/staff #119) on (MONTH) 15, (YEAR) at 1:34 p.m., the DON

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	035105	A. BUILDING _____ B. WING _____	10/15/2018

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SHEA POST ACUTE REHABILITATION CENTER	11150 NORTH 92ND STREET SCOTTSDALE, AZ 85260

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F 0697 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 8) stated that she expects the nurses to follow the physician's orders [REDACTED]. The facility's policy titled Pain Management revealed the resident's pain is assessed and managed by an interdisciplinary team who work together to achieve the highest practicable outcome. The policy included the facility will assist each resident with pain by developing and implementing a plan, using pharmacologic and/or non-pharmacologic interventions to manage the pain and/or try to prevent the pain consistent with the resident's goals. The policy also included medications received, refused, and response to medication will be documented on the Medication Administration Record (MAR). The policy further revealed to monitor pain status and treatment effects on a regular basis, e.g., during routine medication passes.
F 0757 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and review of policy and procedure, the facility failed to ensure one resident's (38) drug regimen was free of unnecessary drugs, by failing to ensure that pain medication was administered as physician ordered. Findings include: Resident #38 was admitted to the facility on (MONTH) 17, (YEAR) with [DIAGNOSES REDACTED]. Review of a pain care plan dated (MONTH) 8, (YEAR), revealed the resident had acute and chronic pain related to depression, an abdominal surgical site and back pain. Interventions included to administer pain medications as ordered and monitor and document for side effects and effectiveness. The admission Minimum Data Assessment (MDS) dated (MONTH) 27, (YEAR) revealed that the resident scored 14 on the Brief Interview for Mental Status (BIMS) indicating the resident was cognitively intact. The assessment also noted that the resident had received opioids during all days of the 7-day look-back period and he indicated that he had occasional pain. Review of the (MONTH) (YEAR) recapitulation of physician orders [REDACTED]. -[MEDICATION NAME] (a pain medication) 650 milligrams (mg) every 6 hours as needed for pain levels of 1 through 3. -[MEDICATION NAME] (an opioid pain medication) 4 mg every 4 hours as needed for pain levels of 4 through 10. A review of the Medication Administration Record [REDACTED]. Review of the nursing notes for (MONTH) 1 through 11, (YEAR) revealed no documentation as to why the [MEDICATION NAME] was administered for pain levels of 3 instead of the [MEDICATION NAME]. An interview was conducted with a Licensed Practical Nurse (LPN/staff# 44) on (MONTH) 12, (YEAR) at 11:15 AM. The nurse stated that when a resident complains of pain, she would asses the resident by asking what level the pain is and then check the physician's orders [REDACTED]. She said that she would administer the medication that corresponds to the resident's pain level as per the physician's orders [REDACTED]. In an interview with the Director of Nursing (DON/staff#119) on (MONTH) 12, (YEAR) at 11:30 AM, she stated that she expects that the nurses will follow the physician orders [REDACTED]. She said they should not administer medications outside of these orders. Review of facility policy for administration of drugs revealed that medications must be administered in accordance with the written orders of the attending physician. The policy further noted that when as needed medications are administered, the nurse must record the justification or reason the medication is given.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** Based on observations, staff interviews and policy review, the facility failed to ensure that expired medications were discarded and that one insulin vial was dated when opened. Findings include: A medication storage observation was conducted on (MONTH) 10, (YEAR) at 9:00 a.m., on the skilled unit. The following items were observed in medication cart #1: one anoro ellipta aerosol powder breath inhaler 62.5-25 mcg/Inh with an expiration date of 10/2017; one bottle of Xarelto (anticoagulant) 15 mg which included pharmacy labeled directions to discard by 5/17/2016 and one vial of Humalog insulin was opened but was not dated. An interview was conducted with a registered nurse (RN/staff #27) on (MONTH) 10, (YEAR) at 9:15 a.m. The RN stated that these were the resident's home medications which were delivered by hospice 2 days ago. When asked if they had Xarelto and the inhaler medication to use for this resident that were not expired, staff #27 replied they did not. He stated that he will follow up with hospice to get more medication. Staff #27 said that he gave the resident the two medications yesterday and today from the expired bottles. Regarding the undated insulin vial, staff #27 stated that he did not know when the vial was opened. He stated the open date should be written on it. He said insulin is good for 28 days after it is opened, but there is no way to tell if 28 days have passed, since there was no open date on the vial. An interview was conducted with a licensed practical nurse (LPN/staff #31) on (MONTH) 11, (YEAR) at 8:48 a.m. Staff #31 stated that the nurse who is administering medications needs to be checking for expiration dates. Another interview was conducted with staff #27 on (MONTH) 11, (YEAR) at 11:37 a.m. Staff #27 stated that the nurse administering medications is the one responsible to ensure that medications are not expired. An interview was conducted with a pharmacy consultant (staff #126) on (MONTH) 12, (YEAR) at 11:00 a.m. He stated that medications loose about 60-70% of their potency after the expiration date. He stated that expired medications should not be administered. An interview was conducted on (MONTH) 12, (YEAR) at 11:30 a.m., with the Director of nursing (DON/staff #119), the Administrator (staff #122) and a RN consultant (staff #124). The DON stated that she expects the nurses to check for expiration dates, prior to administering medications. She also stated that when a multi use vial like insulin is opened, it has to be dated. The DON said it is the responsibility of the nurse to check the med cart for expired medications. A policy titled, Medication Access and storage included that any outdated, contaminated or deteriorated medications and those in containers that are cracked, soiled or without secure closures are immediately removed from stock, and disposed of according to procedures for medication destruction. The policy also included that any opened vial without an open date will be discarded immediately and replaced with a new vial.
F 0867 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.** Based on concerns identified during the survey, staff interview and policy and procedures, the Quality Assessment and Assurance (QAA) committee failed too develop and implement appropriate plans of action to correct identified quality deficiencies regarding clinical record documentation. Findings include: During the survey, concerns were identified regarding multiple occasions when there was no documentation on the Medication Administration Records (MARs) that medications were administered to several residents in July, August, (MONTH) and (MONTH) (YEAR). During an interview conducted on (MONTH) 15, (YEAR) at 3:45 p.m. with the Administrator (staff #122) and the Director of Nursing (staff #119), both stated that the committee identifies concerns brought forth by facility staff, residents, and families, as well as concerns from on-going monitoring of pressure ulcers, falls, and infections. Regarding the pervasive lack of nursing documentation for the administration of medications, staff #119 stated she was aware of the issue and had attempted to implement interventions such as, nursing staff signing sheets at the end of their shift to state that their documentation was complete and by having the on-coming nurses audit the previous shift's documentation on the MARs for

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F 0867 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 9) completeness. Staff #119 stated this was just an informal intervention with no actual goal or tracking to ensure the interventions were successful. Staff #119 said that it had not become a formal QAA plan of action. Review of the facility's policy regarding QAA and QAPI (Quality Assurance and Performance Improvement) revealed that QAA and QAPI are data-driven and are a proactive approach to quality improvement. All staff and residents are involved in continuously identifying opportunities for improvement. Gaps in systems are addressed through planned interventions with a goal of improving the overall quality of the life and quality of care and services delivered to nursing home residents.