| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **035231** | A. BUILDING _____ B. WING _____ | **05/30/2019** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **SIERRA WINDS** | **17300 NORTH 88TH AVE PEORIA, AZ 85382** |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) |
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| F 0623<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on closed clinical record reviews, staff interviews, facility documentation and policy review, the facility failed to ensure copy of notices of facility transfers and discharges were sent to the Ombudsman for two residents (#3 and #9).<br>Findings include:<br>-Resident #3 was admitted to the facility on (MONTH) 5, 2019, with [DIAGNOSES REDACTED].<br>A physician's history and physical note dated (MONTH) 6, 2019 included the resident was transferred from the hospital to the facility on (MONTH) 5, 2019 for rehabilitation services.<br>Review of the clinical record revealed the resident fell from a Hoyer lift and hit her head and back on (MONTH) 12, 2019. The x-ray results included suspicious for lumbar 1 and possibly lumbar 3 compression fracture.<br>A physician's orders [REDACTED].<br>Review of the transfer form dated (MONTH) 12, 2019 revealed the resident was sent to hospital, due to a fall with major injury.<br>Review of the Discharge and Transfer Log for (MONTH) 2019 provided by the social services assistant (staff #20), revealed that resident #3 was not on the list of discharges or transfers.<br>Further review of the closed clinical record revealed no evidence that the Ombudsman was provided a copy of the notice of discharge and/or transfer for resident #3.<br>In an interview with the social services director (staff #63) conducted on (MONTH) 30, 2019 at 10:10 a.m., she stated the Ombudsman is informed of facility discharges and transfers through an email sent to the Ombudsman on a quarterly basis.<br>A review of the email correspondences sent to the Ombudsman was conducted with staff #63 on (MONTH) 30, 2019 at 10:20 a.m. Staff #63 stated that according to the documentation, the discharges and transfers for (MONTH) and (MONTH) 2019 were sent to the Ombudsman on (MONTH) 7, 2019. She stated the copy of the discharges and transfers for (MONTH) and (MONTH) have not been sent to the Ombudsman yet. She said these together with the (MONTH) discharges and transfers will be sent to the Ombudsman in (MONTH) 2019. She stated she used to inform the Ombudsman on a monthly basis, but there is a new Ombudsman for the facility and the new Ombudsman wanted these copies sent every quarter.<br>During an interview with the Administrator (staff #110) conducted on (MONTH) 30, 2019 at 11:00 a.m., she stated that staff #63 and #20 are sending notification of discharges and transfers to the Ombudsman every quarter because that's what the Ombudsman instructed them to do. However, she stated that facility policy was to send the notice on a monthly basis. Staff acknowledged that she was unaware that the discharges and transfers for (MONTH) and (MONTH) 2019 were not sent to the Ombudsman yet.<br>In another interview with staff #110 conducted on (MONTH) 30, 2019 at 12:35 p.m., she stated that she was not aware of why or when the Ombudsman changed the frequency regarding the notification of discharges and transfers from monthly to quarterly.<br>-Resident (#9) was admitted to the facility on (MONTH) 26, (YEAR), with [DIAGNOSES REDACTED].<br>Review of the clinical record revealed the resident had a change of condition on (MONTH) 19, (YEAR).<br>According to the Situation Background Assessment Request (SBAR) Tool for physician/nurse communication dated (MONTH) 19, (YEAR), the resident's physician and medical power of attorney were notified of the resident's stroke like symptoms.<br>Review of the facility Resident Transfer Form dated (MONTH) 19, (YEAR) revealed the transfer was approved by the primary physician and the resident was transferred to the hospital.<br>Further review of the closed clinical record revealed no evidence that the Ombudsman was provided a copy of the notice of discharge and/or transfer of resident #9.<br>An interview was conducted on (MONTH) 30, 2019 at 12:47 p.m. with the Social Services Director (staff #63), who stated that she was not able to verify that the Ombudsman was notified regarding resident #9's transfer to the hospital in (MONTH) (YEAR), because her email doesn't hold that many emails. She stated that the first Friday of every month, she is going to start faxing the Ombudsman the resident transfers and will keep a copy of the fax confirmation showing the fax was received.<br>A second interview was conducted on (MONTH) 30, 2019, with staff #63, who stated that she had contacted the Ombudsman to request a copy of the Discharge and Transfer Log, which she had emailed to the Ombudsman in (MONTH) (YEAR). Staff #63 provided a copy of the log, however, resident #9 was not on the log for discharges or transfers. Staff #63 reviewed the list and agreed that the Ombudsman was not notified about the hospital transfer for resident #9.<br>On (MONTH) 30, 2019 at 12:52 p.m., the Administrator (staff #110) was interviewed and stated that the facility does not have policy on when to notify the Ombudsman of discharges and/or transfers. She stated the facility is following the CMS (Centers for Medicare and Medicaid Services) regulation on notification of the Ombudsman. |
| F 0686<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | **Provide appropriate pressure ulcer care and prevent new ulcers from developing.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on clinical record review, resident and staff interviews and policy review, the facility failed to provide the necessary treatment and services to promote healing of two pressure ulcers, which were present upon admission for one sampled resident (#317). The deficient practice could result in care not being provided and worsening of the pressure ulcers.<br>Finding include:<br>Resident #317 was admitted (MONTH) 23, 2019 for a 5 day hospice respite stay, with [DIAGNOSES REDACTED].<br>A Nursing Evaluation dated (MONTH) 23, 2019 included that friction and shear were identified as a problem, as the resident requires moderate to maximum assistance with moving. The resident slides down in the bed or chair requiring frequent repositioning with maximum assistance. The evaluation also included the resident was assessed to be at moderate risk for development of a pressure ulcer and had pressure related wounds. The wounds were identified as follows: [MEDICAL CONDITION] area on buttock which measured 3.5 cm (centimeters) x 3.0 cm with no depth, drainage or odor and the left heel which was [MEDICAL CONDITION] measured 1.0 cm x 1.0 cm., with no depth, drainage or odor.<br>Physician admission orders [REDACTED].<br>There was no physician's order for any treatment to the left heel pressure ulcer.<br>Review of a nutrition care plan revealed the resident was at nutritional risk. One of the interventions was to monitor skin for changes in condition. |

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

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| F 0686<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | (continued... from page 1)<br>Further review of the resident's care plans revealed there was no care plan developed which addressed the pressure ulcers to the buttocks and left heel. There were also no interventions on any care plans regarding the care and treatment for [REDACTED].<br>A dietary note dated (MONTH) 24, (YEAR) at 1:52 p.m., revealed the resident had pressure areas on admission.<br>A nursing note dated (MONTH) 26, 2019 at 1:51 a.m. documented the resident had redness to the left heel and wears a boot, and had redness on the buttocks on both sides, under the coccyx bone.<br>Review of the TAR (Treatment Administration Record) for (MONTH) 2019, revealed the order to apply barrier cream twice a day was not included. The TAR only included the order for the barrier cream as needed. Further review revealed there was no documentation on the TAR that the barrier cream had been applied.<br>There was no further clinical record documentation regarding the redness on the resident's left heel or buttocks, nor any orders regarding the boot that the resident had on the left foot.<br>An interview was conducted with resident #317 on (MONTH) 28, 2019 at 9:31 a.m. The resident stated that he had sacral wounds which were not being checked enough. The resident stated that his bed was too short, so he keeps sliding down and his feet press against the foot board. The resident stated that he could not pull himself up, as the sheets were rough and do not allow him to move easily in bed. The resident was observed in bed with the head of the bed slightly raised, and the resident had slid down in bed and his feet were pressing against the foot board of the bed.<br>On (MONTH) 29, 2019 at 9:06 a.m., an interview was conducted with a LPN (Licensed Practical Nurse/staff #59), who stated that she had provided cares to resident #317. Staff #59 stated that she had removed the boot from the resident's left foot and would have to look at her notes regarding any skin assessments, however, no notes were located.<br>An interview was conducted on (MONTH) 29, 2019 at 9:15 a.m., with a LPN (staff #80), who stated that she had done the admission for resident #317, and that the physician's orders should have been obtained regarding the boot on the resident's left foot and orders for treatment. Staff #80 said the admitting nurse or any of the nurses can initiate and update a resident's care plan and based on the initial evaluation of the resident, the care plan should have reflected care and treatment for [REDACTED].<br>During an interview with the DON (Director of Nursing/staff #52) on (MONTH) 29, 2019 at 9:44 a.m., staff #52 stated that any of the nurses can create and revise care plans. Staff #52 said the nurses should have identified the need for an order regarding the care of the resident's left foot and instructions regarding the boot.<br>An interview was conducted with a RN (Registered Nurse/Supervisor/staff #16) on (MONTH) 29, 2019 at 9:57 a.m. Staff #16 stated that care plans can be developed and revised by any nurse during the admission process or upon identification of an issue, such as skin breakdown. Staff #16 stated that since the resident was on hospice respite, the nurse should have called hospice regarding orders and then the orders would have been entered just as any other physician's order.<br>Another interview was conducted with staff #16 on (MONTH) 29, 2019 at 12:40 p.m. Regarding the orders for the barrier cream, staff #16 stated that when the order was entered into the electronic record it was entered incorrectly, and as a result the order did not populate onto the TAR. Staff #16 said that since the order for barrier cream twice a day did not appear on the TAR, nursing staff did not document the administration of the cream.<br>Review of the policy regarding Pressure Ulcer Prevention and Treatment revealed that resident's will receive services to prevent new pressure ulcers and receive the necessary treatment to promote healing of pressure ulcers. At the time of admission, all risk factors are identified and care plan interventions are developed to mitigate the risk as much as medically possible. An initial care plan is developed based on the risk factors and score.<br>The policy further included that resident's with pressure ulcers will be assessed as to location, stage, size and shape, depth, surrounding tissue, drainage, wound bed, wound edges and related pain. The initial status is to be documented in the EMR (electronic medical record) visual evaluation form. The physician would be notified and treatment is initiated, as ordered. For residents who are identified as moderate risk, the resident is to be checked during care for reddened areas, especially over bony prominence, check for [MEDICAL CONDITION] and evaluate and document any abnormalities. |
| F 0732<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **Post nurse staffing information every day.**<br><br>Based on observations, staff interviews, facility documentation and policy review, the facility failed to ensure the posted daily nurse staffing information was accurate.<br>Findings include:<br>During an observation on (MONTH) 28, 2019 at 8:04 a.m., the nurse staffing information was posted on a bulletin board in a resident hallway. However, the posted staffing information had a date of (MONTH) 24, 2019, which was 4 days prior.<br>An interview was conducted with the Director of Nursing (staff #52) on (MONTH) 28, 2019 at 8:05 a.m. Staff #52 looked at the posted nurse staffing information and stated the date was inaccurate and therefore; the posting was incorrect.<br>An interview was conducted with the Administrator (staff #110) on (MONTH) 30, 2019 at 12:20 p.m. Staff #110 stated the usual procedure was for the weekend supervisor to be responsible to make sure the nurse staffing information was accurate and posted on a daily basis. Staff #110 stated the staffing information had not been completed and posted from (MONTH) 24 through 27, 2019.<br>A facility policy regarding the posting of 24 hour licensed and unlicensed direct care staff included the following: Licensed and unlicensed staff directly responsible for care of the residents, and the facility census data will be posted daily in a public area. The facility census and staff responsible for direct resident care will be posted in a visible place on each unit by the Staffing Coordinator for the next day. The Staffing Coordinator, unit clerks and nursing staff will be responsible to update the posting as soon as possible. |
| F 0812<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.**<br><br>Based on observations, staff interviews and policy review, the facility failed to ensure expired food items in the kitchen were discarded and not readily available for resident use. The deficient practice could result in residents receiving expired food items, resulting in possible food borne illnesses.<br>Findings include:<br>During the initial kitchen observation conducted on (MONTH) 28, 2019 at 8:12 a.m. with the executive chef (staff #108), there were five sealed, unopened bottles of organic coconut oil located on the second shelf of the storage rack in the dry storage area. These bottles had a date of 13 (MONTH) 19 written on the top part of the lids.<br>An interview with staff #108 was conducted immediately following the observation. He stated that the date on the lid may be the manufacturing dates. However, he further stated that he was not sure about this.<br>In an interview with the Director of Food Services (staff #107) conducted on (MONTH) 28, 2019 at 10:55 a.m., she stated the date written on the top part of the lid of the bottles of coconut oil was the expiration date. She stated the expiration date is more of a quality issue than a safety issue for this food item.<br>An interview with the dietary manager (staff #94 was conducted on (MONTH) 30, 2019 at 12:18 p.m. She stated the bottles of coconut oil were purchased for a resident activity that involved the creation of essential oils. However, she stated she does not know why it was even in the kitchen. She stated the date on the lid of the bottles is the expiration date. She also said that each dietary staff including the manager and the chef are responsible for checking and discarding expired food items in the kitchen on a daily basis. She also said the dietician who visits the facility on a monthly basis should also check for expired items in the kitchen.<br>Review of the Food and Supply Storage policy revealed that foods past the use by, sell by, best by or enjoy by date should be discarded. The policy included to discard food when past the expiration date. The policy also included for the use of manufacturer's expiration date for product storage. |