STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035241	A. BUILDING ______ B. WING _____	**08/23/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SOUTH MOUNTAIN POST ACUTE	**8008 S. JESSE OWENS PARKWAY PHOENIX, AZ 85042**

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 0550 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** Based on observations, resident and staff interviews and policy review, the facility failed to ensure that multiple residents were treated with dignity and respect, by failing to ensure that staff knocked on resident room doors prior to entering. The deficient practice could result in resident's rights not being honored. Findings include: -During an interview conducted on (MONTH) 19, 2019 at 8:22 a.m. with a resident, a staff member was observed to walk into the resident's room, without knocking or asking if she could come into the room. At this time, the resident stated that staff do not always knock before entering the room or ask if it is alright to come in. A second interview was conducted on (MONTH) 19, 2019 at 10:15 a.m., with this same resident. During the interview, a certified nursing assistant (CNA/staff #134) was observed to enter the resident's room without knocking, and without asking permission. Staff #134 told the resident that she had contacted maintenance to come and fix the call light and then left the room. After a few minutes, staff #134 reentered the room, again without knocking or asking permission to enter. The resident's roommate was also in the room at this time. An interview was conducted on (MONTH) 19, 2019 at 9:14 a.m. with another resident. During the interview, two CNA's were observed entering the resident's room without knocking or asking permission to enter. The two CNA's then donned gloves and stated that they needed to get the resident ready for an appointment. The resident's roommate was also in the room. Another observation was conducted on (MONTH) 22, 2019 at 12:40 p.m. A CNA (staff #134) was observed walking into a resident's room (the same resident from the (MONTH) 19 observations at 8:22 a.m. and 10:15 a.m.) without knocking or asking permission to enter. At this time, the resident had a visitor and the resident's roommate was also in the room. During the observation, a case manager (staff #126) was observed standing in the doorway and said hello to the residents and then entered the room, without knocking or asking permission to enter. An interview was conducted on (MONTH) 22, 2019 at 1:35 p.m. with staff #134, who stated that prior to entering a resident's room she knocks on the door even if the door is open and then introduces herself. She said it is different working on the long-term care unit, because she knows the residents, so she knocks and then asks the residents how she can help them. She said that in the morning on (MONTH) 19, she remembered that she did not knock when she entered the resident's room to get her ready for an appointment, because she had just been told at the last moment that the resident needed to be ready for an appointment. She also remembered going into the resident's room on (MONTH) 22, 2019 at approximately 12:40 p.m., and said that she did not knock when entering the room, because the resident already knew that she was coming to lay her down. -An interview was conducted with a CNA (staff #47) on (MONTH) 22, 2019 at 11:46 a.m. She stated that staff are to knock and announce themselves before entering a resident's room. She said that she receives training on treating residents with respect and dignity at least yearly. An observation was conducted on (MONTH) 22, 2019 at 12:07 p.m. on the 100 hall. Staff #150 (Assistant Director of Nursing) was observed to enter two resident's rooms without knocking or announcing herself. There was one resident in the first room and two residents in the second room. An interview was conducted with staff #150 on (MONTH) 22, 2019 at 12:45 p.m. She stated that if she did not knock/identify herself before entering the resident's rooms, she did not follow the expectations of the facility. She stated the facility provides training on treating residents with dignity and respect at least annually. She stated the training included resident privacy and that staff are to knock on a resident door and identify themselves, prior to entering their room. An interview was conducted with the Executive Director (staff #148) on (MONTH) 22, 2019 at 2:44 p.m. He stated that staff receive training on resident rights, including treating residents with dignity and respect on hire, at the skills fair which is two times a year and at monthly staff meetings. He said the expectation is that when a staff member enters a resident room, the resident would be notified by a knock or a verbal announcement, with a resident response. He stated that staff should not just walk into a room without some kind of verbal or physical representation that alerts the resident that someone is entering the room. He said the observations of staff entering a resident's room unannounced did not meet his expectations. Review of a facility policy regarding Resident's Rights, Dignity and Respect revised (MONTH) (YEAR), revealed that all residents are to be treated with kindness, dignity and respect. The policy included that staff members shall knock before entering a resident's room.
F 0645 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**PASARR screening for Mental disorders or Intellectual Disabilities** **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 Preadmission Screening and Resident Review (PASARR) Level II review was conducted within 40 calendar days of admission for two sampled residents (#9 and #53) who were found to require more than 30 days of nursing facility care. The deficient practice could result in a delay of residents receiving the level of services they require. Findings include: -Resident #9 was admitted to the facility on (MONTH) 13, 2019, with [DIAGNOSES REDACTED]. Review of the clinical record revealed a PASARR Level I signed (MONTH) 9, 2019 that a referral was not necessary for a PASARR Level II. Review of the physician orders [REDACTED]. Review of the care plan initiated (MONTH) 13, 2019, revealed the resident wished to be discharged home. Interventions included making arrangements with required community resources to support independence post-discharge. Review of the admission Social Services assessment dated (MONTH) 20, 2019, now revealed the discharge plan was long-term care placement in the facility. However, once it was determined the resident would require care for more than 30 days, a second PASARR Level I that included a referral was needed for a PASARR Level II determination was not completed until (MONTH) 5, 2019. -Resident #53 was admitted to the facility on (MONTH) 18, 2019 with [DIAGNOSES REDACTED]. Review of a PASARR level I signed (MONTH) 17, 2019, revealed under the section does the resident have a serious mental illness a [DIAGNOSES REDACTED]. Review of a physician order [REDACTED]. Review of the admission Social Services assessment dated (MONTH) 25, 2019, now revealed the resident's discharge plan was

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0645

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Few

(continued... from page 1)
long-term care placement in the facility.
However, continued review of the clinical record revealed a second PASRR Level I was not completed until (MONTH) 1, 2019 which included a referral was necessary for a PASARR Level II.
An interview was conducted on (MONTH) 21, 2019 at 12:50 p.m. with the Social Services manager (staff #111) who stated that the PASARR Level I screening must be completed prior to a resident's admission to the facility. She stated that the PASARR Level I screening for resident #9 did not require a PASARR Level II review because the resident's stay was to be less than 30 days. She stated the resident was admitted for therapy, a short term stay. Staff #111 stated resident #9 [DIAGNOSES REDACTED]. The Social Services manager further stated that she was late requesting the resident's PASARR Level II evaluation.
A second interview was conducted on (MONTH) 22, 2019 at 9:46 a.m. with staff #111. She stated that a progress note dated (MONTH) 19, 2019, revealed resident #53's discharge plan was changed to long-term care.
An interview was conducted on (MONTH) 22, 2019 at 12:50 p.m. with the Executive Director (staff #148). He said that the PASARR Level II review requests have been sent to the state-designated authority; but that he was not aware the requests were made late.
Review of the facility's policy regarding PASARR, revised on (MONTH) (YEAR) revealed it is the policy of the facility to ensure that each resident is properly screened with the PASARR specified by the state. The policy included that based upon the PASARR assessment; the facility will ensure a proper referral is made to the appropriate state agencies for the provision of specialized services to residents with mental illness and/or developmental disabilities.

F 0684

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide appropriate treatment and care according to orders, resident's preferences and goals.
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on clinical record reviews, staff interviews and policy and procedures, the facility failed to ensure that care and services met professional standards of practice, by failing to ensure that physician orders [REDACTED].#352 and #32). The deficient practice could result in residents not receiving medications as ordered, and delays in identifying and treating skin conditions.
Findings include:
-Resident #352 was admitted on (MONTH) 6, 2019, with [DIAGNOSES REDACTED].
A physician's orders [REDACTED].
A chronic pain care plan related to status [REDACTED]. The goal was for the resident to not have an interruption in normal activities due to pain. Interventions included to administer [MEDICATION NAME] medication per orders and give 1/2 hour before treatments or care, and to follow the pain scale for medicating as ordered.
Review of the admission Minimum Data Set (MDS) assessment dated (MONTH) 13, 2019 revealed the resident scored a 12 on the Brief Interview for Mental Status (BIMS) assessment, indicating she had moderate cognitive impairment. Section J revealed the resident experienced occasional pain of 6/10 on a pain scale.
Review of the (MONTH) 2019 Medication Administration Record [REDACTED].
During an interview conducted on (MONTH) 23, 2019 at 8:58 a.m., the Director of Nursing (DON/staff #149) stated that if there's a parameter on the order, her expectation is to follow it. She said it is the facility policy to administer medications within the parameters of the doctor's order.
-Resident #32 was admitted to the facility on (MONTH) 21, (YEAR), with [DIAGNOSES REDACTED].
Review of a quarterly MDS assessment dated (MONTH) 19, 2019, revealed that resident #32 had a BIMS score of 15, which indicated intact cognition. The MDS included that the resident received as needed pain medication, had occasional pain at a 4 on a scale of 1-10 and received an opioid on 5 days of the look back period.
Regarding pain parameters not being followed:
Review of the physician's orders [REDACTED].
A care plan revealed the resident posed a risk for alteration in comfort level as evidenced by acute/chronic pain, with an intervention to administer [MEDICATION NAME] medication per orders.
According to the MAR for (MONTH) 2019, the resident received [MEDICATION NAME] outside of the physician ordered parameters
as follows: on (MONTH) 3, 4, 12, 17, 18, 19, 24 and 25 for a pain level of 9.
The (MONTH) 2019 MAR indicated [REDACTED].
The (MONTH) MAR indicated [REDACTED].
Regarding the skin evaluations:
Review of the physician's orders [REDACTED].
A care plan included the resident was at risk for alteration in skin integrity and had a history of [REDACTED]. An intervention was to follow facility policies/protocols for the prevention/treatment of [REDACTED].
Review of the Treatment Administration Record (TAR) for (MONTH) 2019 revealed the order for weekly skin assessments to be done. The documentation showed that a nurse signed that the weekly skin evaluations were completed on (MONTH) 3 and 24, 2019.
However, review of the resident's clinical record revealed no evidence that the weekly skin evaluations UDA had been completed, or documentation that any skin assessments had been completed for the week of (MONTH) 3 and (MONTH) 24, 2019.
Review of the TAR for (MONTH) 2019 revealed the nurse documented other/see the nurses notes for the weekly skin evaluation for (MONTH) 8 and (MONTH) 22, 2019, and the nurse signed that the weekly skin assessment was completed on (MONTH) 29.
However, review of the clinical record including the nursing notes revealed there were no skin evaluations which were completed for the weeks of (MONTH) 8, (MONTH) 22 or (MONTH) 29, 2019.
Review of the TAR for (MONTH) 2019 revealed a nurse signed that the weekly skin evaluation was completed for (MONTH) 5, 2019.However, there was no clinical record documentation that a skin evaluation was completed for the week of (MONTH) 5, 2019.
An interview was conducted with a LPN (staff #145) on (MONTH) 21, 2019 at 11:09 a.m. She stated the physicians orders must be followed as written and that if the order includes parameters, the nurse must follow the parameters. Regarding the skin assessments, the nurse stated that skin assessments are required weekly and they are documented in the electronic record. She stated that if a resident refused to have a skin assessment done there would not be a UDA/weekly skin assessment, but there should be a nurses note.
An interview was conducted with a LPN (staff #99) on (MONTH) 21, 2019 at 12:55 p.m. She stated that she is expected to follow the physician's orders [REDACTED].
An interview was conducted with the DON on (MONTH) 23, 2019 at 8:59 a.m. She stated that her expectation for the nurses is to follow the parameters as ordered, when administering medication. She stated that she reviewed the MARs for resident #32 and the nurses were not following the physician ordered parameters for pain medications. She stated that she would expect the nurse to communicate the resident's preferences to the provider to see if the nurse can go outside the parameter to give the medication at that time, and that there should be documentation of the communication with the provider. She stated that she expects accuracy regarding nurse's documentation. She also stated the nurses are to follow the order for the weekly skin assessments. She said the nurse should review the resident's skin and if any acute changes, the nurse would trigger the daily assessment. She stated that she expects the nurses to complete the electronic skin assessment form or a progress note and document the results of the skin assessment. She stated when the nurse signs the Certified Nursing Assistant's (CNA) shower sheets it also indicates the nurse assessed the resident's skin. She stated that nursing did not meet expectations for documentation of weekly skin assessments as far as the UDA/skin assessment was concerned for resident #32.
An interview was conducted with a CNA (staff #134) on (MONTH) 23, 2019 at 9:29 a.m. She stated that she does a shower sheet on each resident after the shower is completed. She stated that she documents on the shower sheet anything she notices on the resident's skin and gives the form to the nurse to sign, and then turns the form in. She stated the nurse is not in the shower with the resident and the CNA and that the nurse does not look at the resident's skin before signing the shower sheet. She stated that the form contains the CNAs observation and that the nurses complete their own assessment/form and does not document on the CNA's form.

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F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) An interview was conducted with a LPN (staff #36) on (MONTH) 23, 2019 at 9:34 a.m. She stated that she signs the CNA's shower sheet to make sure that the shower was provided, and that there are no skin breakdown issues. She stated that if the CNA had found a skin issue, she would follow up and assess the resident. She stated that her signature on the CNA shower sheet does not indicate that she assessed the skin. She stated when she assesses the resident's skin, she initials it on the TAR and completes the UDA/skin assessment to document the assessment. She stated the CNA shower sheet is not proof that the nurse assessed the resident's skin. Review of the Skin Inspection, Shower Day policy revealed to identify any pertinent skin issues during routine inspections of residents at shower/bath times. The policy included the CNA will document all skin issues that he/she observes on the resident as the shower, tub or bed bath is given. The policy noted that the CNA will document these skin issues using the skin assessment shower forms, which must be completed at the time of the shower, must have the signature of the CNA completing the form, and must be given to the licensed nurse immediately following the completion of the form. The nurse will review the form and sign off on it. Review of the Wound Management policy revealed the facility will provide care and services to promote the prevention of pressure ulcer development. The policy noted that the nurse is expected to complete a weekly head to toe skin assessment with follow up as applicable. A policy titled, Physician order [REDACTED]. The policy stated that it was the policy of the facility to accurately implement orders, in addition to medication orders in accordance with the resident's plan of care. A policy regarding Documentation and Charting of Pain Medication included to provide a complete account of the resident's care, treatment, response to care, as well as the progress of the resident's care and a record of the physical and mental status of the residents and the elements of quality medical nursing care. The policy included that documentation pertaining to medication administration should include accurate administration of pain medication as ordered.
F 0690 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews and review of policies and procedures, the facility failed to ensure that one resident (#32) who was incontinent was thoroughly assessed and provided treatment and services, in order to achieve or maintain as much normal bladder/bowel function as possible. The deficient practice could result in a lack of interventions to address residents with incontinence. Findings include: Resident #32 was admitted to the facility on (MONTH) 21, (YEAR), with [DIAGNOSES REDACTED]. An annual Minimum Data Set (MDS) assessment dated (MONTH) 25, 2019 included the resident had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS included the resident was occasionally incontinent of urine and frequently incontinent of bowel. The Care Area Assessment (CAA) included the resident had occasional bladder incontinence with factors contributing to transitory urinary incontinence that included psychological or psychiatric problems, pain, restricted mobility, urinary urgency, depression and opioid and sedative use. The MDS indicated the urinary status would be included on the care plan with an overall objective of minimizing risks and that no referral to another discipline was warranted. Review of a care plan revealed the resident had episodes of bowel and bladder incontinence. Interventions were to use disposable briefs/change as needed and incontinent checks as required. However, a Bowel and Bladder evaluation dated (MONTH) 20, 2019 included documentation that the resident was continent and that the evaluation did not need to be completed. Therefore, there was no further assessment of the resident's incontinence status and the resident was not assessed for potential interventions. Review of the nursing monthly summary dated (MONTH) 18, 2019 revealed documentation that the resident was incontinent of bladder. A quarterly MDS assessment dated (MONTH) 19, 2019 revealed the resident had a BIMS score of 15, which indicated cognition was intact. The MDS included also the resident was frequently incontinent of bowel and bladder. Accordance to the bladder and bowel continence daily documentation, the resident was incontinent of bladder over 30 times and bowel over 20 times between (MONTH) 18, 2019 and (MONTH) 18, 2019. However, the nursing monthly summary dated (MONTH) 18, 2019 documented the resident was continent of bladder. Another Bowel and Bladder evaluation dated (MONTH) 20, 2019 included the resident was continent and that the evaluation did not need to be completed. Therefore, no further assessment of the resident's incontinence status was completed and the resident was not assessed for potential interventions. Review of the bladder continence daily documentation from (MONTH) 18, 2019 through (MONTH) 18, 2019, revealed the resident was incontinent of bladder over 30 times. However, review of the nursing monthly summary dated (MONTH) 18, 2019 revealed documentation that the resident was continent of bladder. An observation of the resident was conducted on (MONTH) 19, 2019 at 1:35 p.m. The resident had no observable soiling or odors and was assisted promptly by staff. An observation of the resident was conducted on (MONTH) 21, 2019 at 8:34 a.m. The resident had no observable soiling or odors present. An interview was conducted with a Certified Nursing Assistant (CNA/staff #147) on (MONTH) 21, 2019 at 8:59 a.m. She stated the resident has incontinence in the morning, but otherwise usually uses the urinal. She stated the resident also has some accidents at night. An interview was conducted with a Licensed Practical Nurse (LPN/staff #145) on (MONTH) 21, 2019 at 11:00 a.m. She stated that she thinks the resident is continent on the day shift, as she gives him the urinal and the aides take him to the bathroom. She stated the Bowel and Bladder evaluation is done by nursing through working with the resident and talking with the CNAs to find out if the resident is continent or not. After reviewing the daily bowel and bladder documentation in the electronic record, staff #145 stated that the Bowel and Bladder evaluation dated (MONTH) 20, 2019 was not accurate when the resident was marked as continent. She stated if the evaluation would have been done accurately the assessment would have been completed and the resident would have been further assessed for possible interventions. An interview was conducted with the Director of Nursing (DON/staff #149) on (MONTH) 23, 2019 at 8:59 a.m. She stated the Bowel and Bladder evaluations are done on admission and then quarterly. She stated the purpose of the evaluation was to see if the resident had a significant change in continence and would benefit from a bowel and bladder program. She stated for it to be filled out correctly, the nurse evaluates the resident and talks with the CNA, and then follows through with the assessment results. She said the nurses had been provided bowel and bladder education. Review of the policy for Activities of Daily Living (ADL) revealed that residents are given the appropriate treatment and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with a written plan of care. The policy regarding Bowel and Bladder assessment revealed that a bowel and bladder assessment will be completed within the first fourteen days of admission, after an elimination pattern has been identified, quarterly and when a significant change occurs. The policy included the purpose of the bowel and bladder assessment is to offer a structured, goal oriented approach with the intent that the resident attains the highest level of independence in bowel and/or bladder continence and that the program will focus on the resident's ability to improve continence independently. The policy stated that the interdisciplinary team would identify if the resident is a candidate for the bowel and bladder retraining program.
F 0757 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record reviews, staff interviews and policy and procedures, the facility failed to ensure that two resident's (#18 and #32) were free of unnecesary drugs. The deficient practice could result in residents being administered medications that are unnecessary and possibly experiencing adverse effects.

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F 0757 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 3)

Findings include:
-Resident #18 was admitted on (MONTH) 3, (YEAR), with [DIAGNOSES REDACTED].
The quarterly Minimum Data Set (MDS) assessment dated (MONTH) 4, 2019 revealed the resident scored a 13 on the Brief Interview for Mental Status (BIMS), indicating intact cognition.
A hypertension care plan dated (MONTH) 4, 2019 included a goal for the resident to remain free of complications related to hypertension. Interventions were to give antihypertensive medications as ordered, monitor for side effects such as orthostatic [MEDICAL CONDITION] and effectiveness, and obtain blood pressure readings.
Review of the physician's orders [REDACTED].
-[MEDICATION NAME] (antihypertensive) 20 milligrams (mg) 1 tablet in the morning for hypertension; hold for systolic blood pressure (SBP) below 120
-Carvedilol (antihypertensive) 12.5 mg 1 tablet two times daily for hypertension; hold if SBP is less than 100 or a heart rate of less than 60
Review of the (MONTH) 2019 Medication Administration Record [REDACTED].
Review of the (MONTH) 2019 MAR indicated [REDACTED]
-Carvedilol 12.5 mg was administered on (MONTH) 10 for a heart rate of 53 and on (MONTH) 13 for a heart rate of 51
-[MEDICATION NAME] 20 mg was administered on (MONTH) 17 for a blood pressure of 117/72
Review of the (MONTH) 2019 MAR indicated [REDACTED]
Review of the (MONTH) 2019 MAR indicated [REDACTED]
-[MEDICATION NAME] 20 mg was administered on (MONTH) 24 for a blood pressure of 116/63.
-Carvedilol 12.5 mg was administered on (MONTH) 19 on two separate occasions, both for a heart rate of 58; on (MONTH) 22 for a heart rate of 59; and on (MONTH) 29 for a heart rate of 58.
Review of the (MONTH) 2019 MAR indicated [REDACTED].
An interview was conducted on (MONTH) 22, 2019 at 9:24 a.m. with a Licensed Practical Nurse (LPN/staff #22). She stated that administering an antihypertensive medication to a resident with a blood pressure or pulse rate that was below the ordered parameters, might drop the apical pulse or blood pressure to an unsafe level. She said her process for administering an antihypertensive medication is to verify that the resident's vital signs are within the ordered parameters, before giving the medication.
-Resident #32 was admitted to the facility on (MONTH) 21, (YEAR), with [DIAGNOSES REDACTED].
Review of a quarterly MDS assessment dated (MONTH) 19, 2019, revealed that resident #32 had a BIMS score of 15, which indicated intact cognition. The MDS included that the resident received as needed pain medication, had occasional pain at a 4 on a scale of 1-10 and received an opioid on 5 days of the look back period.
Review of the physician's orders [REDACTED].
A care plan revealed the resident posed a risk for alteration in comfort level as evidenced by acute/chronic pain, with an intervention to administer [MEDICATION NAME] medication per orders.
Review of the Medication Administration Record [REDACTED].
The (MONTH) 2019 MAR indicated [REDACTED].
Review of the (MONTH) 2019 MAR indicated [REDACTED].
An observation of the resident was conducted on (MONTH) 19, 2019 at 1:35 p.m. The resident did not exhibit any signs or symptoms of pain or over sedation.
An interview was conducted with a LPN (staff #145) on (MONTH) 21, 2019 at 11:09 a.m. She stated the physician's orders [REDACTED]. She stated the nurse must get orders from the doctor to make any changes to the medication orders. After reviewing the MARs regarding administering pain medications outside of the ordered parameters, staff #145 stated when [MEDICATION NAME] was given for pain levels other than 1-5 and [MEDICATION NAME] was given for pain levels other than 6-10, the medications were not given per the ordered parameters.
An interview was conducted with a LPN (staff #99) on (MONTH) 21, 2019 at 12:55 p.m. She stated that she is expected to follow the physician's orders [REDACTED]. She stated the resident usually reports that he has a pain level of 6 or above, and when she documented that she gave the pain medication for a pain level of 0, she documented the wrong number. She stated that her documentation did not meet the facility's expectation for accurate documentation.
An interview was conducted with the DON on (MONTH) 23, 2019 at 8:59 a.m. She stated that her expectation for the nurses is to follow the parameters as ordered, when administering medication. She stated that she reviewed the MARs for resident #32 and the nurses were not following the physician ordered parameters for pain medications. She stated that she would expect the nurse to communicate the resident's preferences to the provider to see if the nurse can go outside the parameter to give the medication at that time, and that there should be documentation of the communication with the provider. She stated that she expects accuracy regarding nurse's documentation.
A policy titled, Physician order [REDACTED]. The policy stated that it was the policy of the facility to accurately implement orders, in addition to medication orders in accordance with the resident's plan of care.
A policy regarding Documentation and Charting of Pain Medication included to provide a complete account of the resident's care, treatment, response to care, as well as the progress of the resident's care and a record of the physical and mental status of the residents and the elements of quality medical nursing care. The policy included that documentation pertaining to medication administration should include accurate administration of pain medication as ordered.