STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035273	A. BUILDING _____ B. WING _____	02/21/2019

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SPLENDIDO AT RANCHO VISTOSO	13500 NORTH RANCHO VISTOSO BLVD TUCSON, AZ 85755

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

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F 0552 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that residents are fully informed and understand their health status, care and treatments.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policy review, the facility failed to ensure one resident (#5) was informed of the risks and benefits before being administered a [MEDICAL CONDITION] medication. Findings include: Resident #5 was admitted to the facility on (MONTH) 18, 2012 with [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. An annual Minimum Data Set (MDS) assessment dated (MONTH) 1, (YEAR) included the resident had a brief interview for mental status (BIMS) score of 3, which indicates the resident was severely cognitively impaired. A care plan dated (MONTH) 9, (YEAR) revealed the resident was taking [MEDICATION NAME] related to anxiety. Interventions included that the resident and family be educated on risks and benefits of the medication. Review of the electronic MAR (Medication Administration Record) revealed the resident was administered [MEDICATION NAME] from (MONTH) (YEAR) through present (February 2019). However, review of the clinical record revealed no evidence that the resident/representative was informed of the risks and benefits of taking [MEDICATION NAME], prior to administering the medication. In an interview with a Licensed Practical Nurse (LPN/staff #62) on (MONTH) 21, 2019 at 10:17 a.m., she stated when a resident gets a physician's orders [REDACTED]. She stated, before the medication is started, a consent form must be signed. She said, the consent form includes what the drug is, what the side effects may be, and what the benefits are of taking the medication. In an interview with the Director of Nursing (DON/staff #41) on (MONTH) 21, 2019 at 10:52 a.m., she stated the consent for [MEDICATION NAME] for this resident was unable to be located. Additionally, she stated, the expectation is that a consent for a [MEDICAL CONDITION] medication is obtained prior to the first administration of the medication. Review of a facility policy titled, [MEDICAL CONDITION] Medication Management for Residents with Dementia and other Conditions included, [MEDICAL CONDITION] medication is not to be prescribed or administered without the informed consent of the resident's responsible agent.
F 0756 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews and policy and procedures, the facility failed to act upon pharmacy recommendations for one resident (#16). Findings include: Resident #16 was admitted to the facility on (MONTH) 28, 2014, with [DIAGNOSES REDACTED]. Review of the quarterly MDS (Minimum Data Set) assessment dated (MONTH) 9, (YEAR), revealed a BIMS (Brief Interview for Mental Status) score of 5, which indicated the resident had severe cognitive impairment. Regarding the [MEDICATION NAME]: Review of the physician's orders [REDACTED]. Review of the pharmacist's Medication Regimen Review dated (MONTH) 29, (YEAR), revealed the resident had been prescribed [MEDICATION NAME] 25 mg one tablet by mouth in the evening for [MEDICAL CONDITION] since (MONTH) (YEAR). The pharmacist recommended a gradual reduction of the antipsychotic medication from 25 mg to 12.5 mg. Further review revealed there was no physician response documented regarding the pharmacy recommendation. Review of the Medication Administration Record [REDACTED]. A physician's orders [REDACTED]. Review of the MAR from (MONTH) 1, 2019 through (MONTH) 30, 2019 revealed the resident was administered [MEDICATION NAME] 25 mg at bedtime for [MEDICAL CONDITION] was daily. A physician's orders [REDACTED]. 5 mg by mouth at bedtime for [MEDICAL CONDITION] with behavioral disturbance. There was no clinical record documentation that the pharmacy recommendation from (MONTH) (YEAR) was responded too or acted upon until (MONTH) 31, 2019. Regarding other [MEDICAL CONDITION] medications: [REDACTED] Review of the physician's orders [REDACTED]. Review of the pharmacist's Medication Regimen Review dated (MONTH) 29, (YEAR), revealed the resident had been prescribed [MEDICATION NAME] 0.5 mg as needed for anxiety. The pharmacist recommended a stop date and a rationale for the use of the drug. However, there was no documentation that the physician acted upon or addressed the recommendations by the pharmacists. Review of the pharmacist's Medication Regimen Review dated (MONTH) 28, (YEAR), revealed the resident had fallen the month prior, and the symptoms associated with the following medications could be contributing factors with falls: [MEDICATION NAME] 25 mg, [MEDICATION NAME] 0.5 mg, [MEDICATION NAME] Sprinkles (mood stabilizer/anti epileptic) 125 mg per day and [MEDICATION NAME] (treatment for [REDACTED]. Further review of the Medication Regimen Review revealed the pharmacist asked for a confirmed need for the medications and recommended that the medications be reduced to the lowest dosages to reduce the risk of falls. However, there was no documentation that the physician acted upon or addressed the recommendations by the pharmacists. Review of the MAR for (MONTH) (YEAR) revealed that [MEDICATION NAME] 0.5 mg daily as needed for anxiety and agitation was available for use. Review of the MAR for (MONTH) and (MONTH) (YEAR), and for (MONTH) through (MONTH) 21, 2019 revealed that [MEDICATION NAME] sprinkles 125 mg was administered daily. Review of the MAR for (MONTH) and (MONTH) (YEAR) and (MONTH) through (MONTH) 20, 2019 revealed that 7.5 mg was administered daily. There was no further documentation that the pharmacy recommendations from (MONTH) 28, (YEAR) were addressed or acted upon from (MONTH) (YEAR) through (MONTH) 20, 2019. An interview was conducted on (MONTH) 20, 2019 at 1:38 p.m. with a licensed practical nurse (LPN/staff #62), who said that

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 0756 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) pharmacy recommendations are put on the physician's clip board which is kept at the main nurse's station and the physician completes the pharmacist's Medication Regimen Review form indicating whether the physician agrees for disagrees with the pharmacist's recommendations. She said once the physician completes the form, she documents any changes in Point Click Care and the paper copy is filed in the resident's paper chart. She reviewed the resident's chart, but was unable to provide documentation by the physician that the pharmacy recommendations were addressed or acted upon. An interview was conducted on (MONTH) 21, 2019 at 10:38 a.m. with the Administrator (staff #19), who acknowledged that the pharmacist's recommendations had not been reviewed or completed by the resident's physician. An interview was conducted on (MONTH) 21, 2019 at 11:06 a.m. with the Director of Nursing (DON/staff #41), who stated that the facility does not have a process in place to ensure that the physicians are reviewing and completing the Medication Regimen Review forms, which is the form the pharmacist uses for medication recommendations. She stated the nurses may request that a physician complete the form, but there is no one responsible for ensuring that it is done. Review of the Medication/Treatment Management policy revised (MONTH) 2019, revealed the facility procures services from a pharmacy consultant to review resident medications and make recommendations to physicians, to assist in reviewing resident medications in conjunction with occurrences like falls, and to provide guidance to the facility regarding pharmacy standards related to medication administration. The pharmacist must report any irregularities to the attending physician, the facilities medical director and the DON, and these reports must be acted upon. The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any action has been taken to address it. If there is no change in the medication, the attending physician should document the rationale in the resident's medical record. If the pharmacy consultant provides recommendations, those recommendations should be acted upon within 60 days.
F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, facility documentation and policy and procedures, the facility failed to ensure there were adequate indications for the use of an antipsychotic medication for one resident (#16). Findings include: Resident #16 was admitted to the facility on (MONTH) 28, 2014, with [DIAGNOSES REDACTED]. Review of the (MONTH) (YEAR) physician orders [REDACTED]. Review of a quarterly MDS (Minimum Data Set) assessment dated (MONTH) 8, (YEAR) revealed a BIMS score of 4, which indicated the resident had severe cognitive impairment. The MDS also included that the resident did not have any psychotic behaviors or behaviors of any kind. According to the Medication Administration Record [REDACTED]. A physician's orders [REDACTED]. Review of the Treatment Administration Record (TAR) for (MONTH) and (MONTH) (YEAR) revealed the resident was being monitored for [MEDICAL CONDITION]. Review of the (MONTH) 2019 MAR indicated [REDACTED]. Further review of the clinical record revealed there was no documentation that the resident had any [MEDICAL CONDITION] and there was no documentation of the clinical rational for administering an antipsychotic medication. A physician's orders [REDACTED]. According to the (MONTH) and (MONTH) 2019 MAR, the resident received [MEDICATION NAME] 12. 5 mg at bedtime for [MEDICAL CONDITION] with behavioral disturbance from (MONTH) 31 through (MONTH) 20. A care plan dated (MONTH) 5, 2019 included a problem area for [MEDICAL CONDITION]. An intervention included for the administration of [MEDICATION NAME]. An interview was conducted on (MONTH) 20, 2019 at 1:38 p.m. with a licensed practical nurse (LPN/staff #62), who stated that antipsychotic medications are prescribed by the physician and there usually is a formal diagnosis. Review of the [MEDICAL CONDITION] Medication Management policy revealed that an antipsychotic drug means a neuroleptic drug that is helpful in the treatment of [REDACTED]. [MEDICAL CONDITION] medications are not given for the purposes of convenience or discipline and that are not required to treat the resident's medical conditions/symptoms. Residents are not given antipsychotic drugs unless antipsychotic drug therapy is necessary, as documented in the resident's comprehensive assessment. They are used to treat a specific or suspected psychotic condition as diagnosed and documented in the medical record. The policy further included that residents who use antipsychotic drugs may receive attempts at gradual dose reductions, unless clinically contraindicated. Dose reduction attempts will be documented in the medical record by the physician and/or clinical staff and may include but are not limited to: effects of dose reduction on the target behavior and additional actions, such as continue further dose reduction, hold at current dose, medication changes, etc and why.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observations, staff interviews, facility documentation and policies and procedures, the facility failed to ensure the dish machine in the main kitchen was maintained at the proper rinse temperature, and that the dish machine temperature logs were accurate. Findings include: During an initial tour of the kitchen on (MONTH) 19, 2019 at 10:40 a.m., the final rinse temperature of the dish machine was observed to reach 129.7 degrees Fahrenheit. A red indicator on the front of the dish machine displayed Low Rinse Temperature. Immediately following, an interview was conducted with the dining room manager (staff #36). Staff #36 stated that the final rinse temperature should have reached 180 degrees Fahrenheit. Staff #36 stated that the indicator on the front of the dish machine was usually blue in color and that the red indicator was abnormal. Staff #36 further stated that he would immediately call to have the dish machine repaired. An interview was conducted with a dishwasher (staff #125) on (MONTH) 19, 2019 at 10:45 a.m. Staff #125 stated that the rinse temperature of the dish machine was usually checked every day and documented on the log, which is placed on a clipboard on the wall near the dish machine. Staff #125 pointed to the clipboard on the wall, however, no log was attached. He stated that he did not know where the log was, as he had just returned from a 5 day vacation. The dish machine logs for the past two months were immediately requested from staff #36. Approximately two hours later, staff #36 provided the dish machine logs for (MONTH) and (MONTH) 2019. Review of these logs revealed the (MONTH) log appeared to have been completed entirely by the same person, as the writing appeared to be the same. The (MONTH) 2019 log appeared to be completed entirely by another person, based on the handwriting. An interview was conducted with staff #125 on (MONTH) 19, 2019 at 1:00 p.m. Staff #125 stated that some of the dishwashers didn't always remember to complete the dish machine logs. When asked why many of the entries on the dish machine log were exactly the same temperatures, staff #125 stated that it was just logistics, as the previous dietary manager told him to just document numbers on the logs which were within the required temperature ranges. When asked if he completed either the (MONTH) or (MONTH) 2019 log, staff #125 stated that he completed the entire (MONTH) log, because staff forgot to do so. Staff #125 said that when he came back from vacation, he noticed the logs had not been completed, so he completed the log.

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F 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) When asked if he could attest to the entries being accurate on the (MONTH) log, he stated that the numbers that he entered on the log just needed to be within the required ranges. An interview was conducted with a cook (staff #126) on (MONTH) 19, 2019 at 1:10 p.m. Staff #126 stated that he filled out the entire log for (MONTH) 2019, because sometimes the dishwashers forget. When asked if he could attest that the entries he documented on the dish machine log were accurate, staff #126 stated no. An interview was conducted with a registered dietician (staff #127) on (MONTH) 20, 2019 at 9:00 a.m. Staff #127 stated that she did not know where the previous (MONTH) 2019 log went, as she saw it posted on the wall earlier and it was all crinkled and wet from being in the kitchen. Review of the facility's policy titled, Recording of Dish Machine Temperatures revealed .Record temperatures every shift on Dish Machine Temperature Log .Rinse temperature .greater than or equal to 180 degrees Fahrenheit .Any inaccurate temperatures must be brought to the attention of the Director of Food and Nutrition Services or other clinically qualified nutrition professional immediately .
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** Based on observations and staff interview, the facility failed to ensure that infection control measures were maintained, by storing beverage thickener and powdered supplements in an unsanitary manner. Findings include: An observation of medication cart B was conducted on (MONTH) 21, 2019 at 9:15 AM, with a Licensed Practical Nurse (LPN/staff #60). In one of the drawers was a container of beverage thickener. Inside of the container was a scoop and the handle was touching the powdered thickener. Also, a can of fiber therapy had a medication cup inside and the cup was touching the contents. Another observation was conducted on (MONTH) 21, 2019 at 9:30 AM with a Registered Nurse (RN/staff #108) of medication cart [NAME] In one of the drawers was a container of beverage thickener, which had a medication cup inside and the cup was touching the powdered thickener. An observation was made on (MONTH) 21, 2019 at 9:42 AM with a LPN (staff #62) of medication cart C. In one of the drawers there were two cans of fiber therapy and each had a medication cup inside. The medication cups were touching the contents of the cans. An interview was conducted with the Director of Nursing (DON/staff #41) on (MONTH) 21, 2019 at 9:59 AM. The DON stated that scoops and medication cups should not be left inside of the multi-use canisters.