STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035207	A. BUILDING _____ B. WING _____	06/28/2019

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SPRINGDALE VILLAGE HEALTHCARE	7255 EAST BROADWAY ROAD MESA, AZ 85208

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F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interviews, the Resident Assessment Instrument (RAI) manual, and policy review, the facility failed to ensure that the Minimum Data Set (MDS) assessment for one of twenty sampled residents (#10) accurately reflected the resident's status regarding oxygen. The deficient practice could affect continuity of care. Findings include: Resident #10 was readmitted to the facility on (MONTH) 24, (YEAR), with [DIAGNOSES REDACTED]. Review of the physician's admission orders [REDACTED]. However, review of nursing admission notes dated (MONTH) 24, (YEAR) and (MONTH) 26, (YEAR), revealed the resident was receiving oxygen via nasal cannula. Review of the admission MDS assessment dated (MONTH) 28, (YEAR), revealed documentation that the resident was not receiving oxygen. Review of the nurse practitioner's history and physical dated (MONTH) 10, (YEAR), revealed the resident was oxygen dependent and was receiving continuous oxygen at a rate of two liters per minute. However, review of the physician's orders [REDACTED]. Review of the resident's vital signs dated (MONTH) 23, (YEAR), (MONTH) 2, (YEAR), (MONTH) 18, (YEAR), and (MONTH) 22, 2019, revealed the resident was receiving oxygen via nasal cannula. The quarterly MDS assessment dated (MONTH) 28, (YEAR), stated the resident was not receiving oxygen. The significant change MDS assessment dated (MONTH) 5, 2019, stated the resident was not receiving oxygen. An interview was conducted on (MONTH) 26, 2019 at 12:32 p.m., with the MDS assistant coordinator (staff #20). She stated she follows the RAI manual to code the MDS assessments. She stated that she would review the current physician's orders [REDACTED]. She said based on the physician recapitulation of orders for (MONTH) (YEAR), the resident was not receiving oxygen. She said that because there was not a current physician's orders [REDACTED]. An interview was conducted on (MONTH) 26, 2019 at 3:29 p.m. with the Director of Nursing (DON/staff #16). She said there should be a physician's orders [REDACTED]. She stated there was not an order for [REDACTED]. The RAI manual instructs to review the resident's clinical record to determine whether or not the resident received oxygen within the last 14 days and code oxygen delivered to the resident to relieve [MEDICAL CONDITION]. Review of the facility's RAI policy revealed the purpose of the MDS assessment is to describe the resident's capability and to identify significant impairments in functional capacity. All persons who have completed any portion of the MDS assessment must sign the document to attest to the accuracy of the information.
F 0645 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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 the Pre-Admission Screening and Resident Review (PASARR) process was completed as required for one of two sampled residents (#11) by not making sure the resident was screened prior to admission for possible mental disorders, intellectual disabilities, and/or related conditions. The deficient practice could potentially result in residents not receiving the level of service they require. Findings include: Resident #11 was admitted on (MONTH) 1, 2019 with [DIAGNOSES REDACTED]. Review of the admission Minimum Data Set assessment dated (MONTH) 8, 2019 revealed the admitted was (MONTH) 1, 2019 and that the resident was admitted from the community. Review of the clinical record revealed a PASARR level I screening dated (MONTH) 25, 2019 that was completed for another skilled nursing facility. Further review of the clinical record revealed no evidence that a PASARR level I screening was completed for this resident prior to admission to this facility. In an interview with the social services director (staff #17) conducted on (MONTH) 27, 2019 at 10:22 a.m., she stated that the social services assistant completes a PASARR screening within 30 days of a resident's admission to the facility. She stated that when the resident's skilled stay ends and the resident stays at the facility, another PASARR level I screening will be completed. During an interview conducted with the assistant director of nursing (ADON/staff #9) on (MONTH) 28, 2019 at 2:16 p.m., the ADON stated that she is responsible for ensuring a PASARR level I screening is completed upon admission. The facility's policy regarding Behavior Assessment, Intervention and Monitoring included that all residents will receive a Level I PASARR screen prior to admission. If the level I screen indicates that the individual may meet the criteria for a mental disorder, intellectual disability or related condition, he or she will be referred to the state PASARR representative for the Level II (evaluation and determination) screening process.
F 0655 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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 reviews, staff interviews, and policy review, the facility failed to provide one resident (#11) and the resident's representative with a summary of the baseline care plan and failed to ensure the baseline care plan reflected the respiratory needs for one resident (#275). The sample size was 5. The deficient practice could result in residents' needs not being met. Findings include: -Resident # 11 was admitted on (MONTH) 1, 2019 with [DIAGNOSES REDACTED]. Review of the undated baseline care plan revealed the resident was on a regular diet, had a history of [REDACTED]. The boxes for the following sections were blank: -Completion date -Date it was reviewed with the resident or representative -Staff signature -Resident signature -Representative signature.

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

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F 0655 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) Further review of the clinical record revealed no evidence the resident and the resident's representative was provided with a summary of the baseline care plan. Review of the requested copy of the baseline care plan revealed the boxes for completion and reviewed with resident dates were filled in with a handwritten date of (MONTH) 1, 2019. The copy also revealed a staff signature and a wavy line for the resident signature and a handwritten note talked with daughter on phone for the representative signature. During an interview conducted with the assistant director of nursing (ADON/staff #9) on (MONTH) 27, 2019 at 11:35 a.m., the ADON identified the staff signature on the baseline care plan as belonging to a Register Nurse (RN/staff #113). In an interview with RN (staff #113) conducted on (MONTH) 27, 2019 at 11:50 a.m., she stated she discussed the baseline care plan with the resident's Power of Attorney on (MONTH) 1, 2019 and that she forgot to sign the care plan. She stated that she signed the baseline care plan yesterday (June 26, 2019) and that the wavy line was not the signature of the resident. Another interview was conducted with the ADON (staff #9) on (MONTH) 28, 2019 at 2:16 p.m. She stated the baseline care plan is developed and signed by the resident or their representative within 7 days of admission. She stated it was not an acceptable practice for staff #113 and the nurses, in general to sign the baseline care plan months after it was developed.The facility's policy on Baseline Care Plan revealed the facility's IDT (Interdisciplinary Team) is responsible for implementing and completing a baseline care plan within 48 hours of admission to the facility. It also stated The facility must provide the resident and the representative, if applicable, with a written summary of the baseline care plan .the medical record must contain evidence that the summary was given to the resident and resident representative, if applicable .-Resident #275 was admitted (MONTH) 16, 2019, with [DIAGNOSES REDACTED]. During an initial observation conducted of the resident on (MONTH) 24, 2019 at 09:44 a.m., the resident was observed to have oxygen on at 2 liters per nasal cannula. Review of the clinical record did not reveal a physician's orders [REDACTED]. Further review of the clinical record did not reveal a baseline care plan had been developed for oxygen therapy. An interview was conducted with a RN (staff #97) on (MONTH) 25, 2019 at 1:18 p.m. The RN stated that there should be a physician's orders [REDACTED]. During an interview conducted with the Director of Nursing (DON/staff #16) on (MONTH) 28, 2019 at 3:59 p.m., the DON stated that if a resident is on oxygen therapy there should be a physician's orders [REDACTED]. Review of the facility's policy regarding baseline care plan revealed the baseline care plan will be developed for every resident within 48 hours of admission. It states that the baseline care plan must include the minimum health care information necessary to properly care for each resident immediately upon their admission which would address resident specific health and safety concerns to prevent decline or injury.
F 0679 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide activities to meet all resident's needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observations, resident and staff interviews, and policy review, the facility failed to provide one sampled resident (#275) with an ongoing program to support the resident in his choice of activities. The deficient practice could result in residents not having activities that are meaningful to them. Findings include: Resident #275 was readmitted on (MONTH) 16, 2019, with [DIAGNOSES REDACTED]. Review of the clinical record did not reveal an Activity, interest and participation admission form had been completed for the readmission. The admission Minimum Data Set (MDS) assessment dated (MONTH) 20, 2019, revealed the resident was able to make himself understood and understood others. The section for activities and preferences revealed it was very important for the resident to have books, magazines and newspaper to read and that he liked listening to music and getting fresh air when the weather is good. Review of the care plan dated (MONTH) 25, 2019, revealed the resident currently engages in following leisure/recreation pursuits: attending organized activities, music, reading/writing and that he enjoys painting, drawing, pet therapy visits, and religious activities. Interventions included offering the resident materials appropriate towards his interests and that the resident enjoys reading, music programs, playing games, painting and drawing and religious activity and pet therapy. However, review of the activities daily documentation in the electronic record from (MONTH) 16 - 28, 2019, revealed the only activity the resident was involved in was independent television watching. No books, music or reading material was observed in the resident's room during multiple observations conducted from (MONTH) 25 - 28, 2019. During an interview conducted with the resident on (MONTH) 25, 2019 at 9:03 a.m., the resident stated that he would like to go out to the courtyard but that no one offers or assists him in getting up and getting ready to go to the courtyard. An interview was conducted with the Activities Director (staff #14) on (MONTH) 28, 2019, at 11:50 a.m. She stated that to develop an activity plan for a resident she does an activity assessment for each resident upon admission to find out what kind of activities the resident likes and the type of activities the resident liked to do when they were home. She acknowledged resident #14 was not assessed for activities on this admission and that the care plan does not reflect his likes and preferences. She stated that the resident does not like to attend the group activities. After reviewing the activity care plan, she stated that the care plan was not appropriate for the resident because the resident has never participated in any group activities. She stated that the expectation is that the activity assessments and care plans be complete and accurate. Staff #14 stated that the only place to document whether the resident participated in an activity or refused an activity is in the electronic record. She also stated that she had no additional documentation of this resident's activity participation or refusals. Staff #14 stated they offer 1:1 visits to residents who do not like to attend activity groups. She stated that 1:1 visits were not offered to resident #275. She stated that any 1:1 visits would be documented in the electronic records. An interview was conducted with a Certified Nursing Assistant (CNA/staff #28) on (MONTH) 28, 2019 at 2:31 p.m. The CNA stated that resident #275 usually rests in his room and that staff encourages him to eat and watch television. He stated that the resident does not enjoy watching television. Staff #28 stated that the resident likes to sleep and have visitors from the church. During an interview conducted with a Registered Nurse (RN/staff # 98) on (MONTH) 28, 2019 at 2:33 p.m., the RN stated that they assist the resident to the reclining chair for dinner. He stated that the resident refuses to get out of bed on many occasions due to pain in his back. Staff #98 stated the resident does not like to watch television much so they encourage him to do simple exercises. An interview was conducted with the Director of Nursing (DON/staff #16) on (MONTH) 28, 2019 at 3:59 p.m. She stated her expectation is that the activity staff conducts an assessment on admission to determine residents' likes, dislikes, and preferences. She stated that she expects the activity staff to go over the activity calendar and the activities that are offered at the facility with the residents. She also stated that residents that do not like to leave their room for activities should be provided 1:1 visits. The DON stated that the care plan for activities should reflect the residents' likes and preferences. After reviewing the activity documentation, the DON stated that more activities and 1:1 visits should have been offered to this resident and that if the resident refused, it should have been documented. Review of the facility's policy regarding Activities revealed residents shall have the right to choose the type of activities and special events in which they wish to participate. Residents are assessed upon admission for activity preferences. Residents are encouraged to choose the type of cultural and religious activities and social events in which they prefer to participate in. When the care planning team develops the residents activity and social care plans, the resident will be given an opportunity to choose when, where, and how he or she will participate in the activity and social events, Activities, social events, and schedules will be developed in conjunction with the residents interests, physical and mental assessment and plan of care. Residents may also have 1:1 visits with the activity staff as needed. The policy also included activities will be scheduled throughout the day, as well as during weekends and holidays.
F 0684 **Level of harm** - Actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.**

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F 0684 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, resident and staff interviews, facility documentation and policies and procedures, the facility failed to ensure that physician orders [REDACTED].#9) resulting in ongoing vaginal pain, failed to ensure the physician was notified regarding elevated blood sugars for one resident (#13), failed to ensure there was a physician's orders [REDACTED]. The deficient practice resulted in one resident experiencing ongoing vaginal pain without treatment. The deficient practice could also result in complications related to elevated blood sugars without physician interventions and the physician not being aware of a resident's therapy plan of care. Also, a resident could experience a decrease in mobilty/range of motion if RNA services were not provided. Findings include: -Resident #9 was admitted to the facility on (MONTH) 27, (YEAR), with [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. A care plan dated (MONTH) 9, (YEAR) included the resident was at risk for alteration in comfort and pain, related to a [MEDICAL CONDITION]. Interventions included to administer medication for pain relief and assess effectiveness, and to assess the resident's pain status on an ongoing basis. A quarterly Minimum Data Set (MDS) assessment dated (MONTH) 3, 2019 revealed the resident's Brief Interview for Mental Status (BIMS) score was 15, which indicated the resident was cognitively intact. A health status note dated (MONTH) 7, 2019 included the resident had been on an antibiotic for a urinary tract infection and continued to complain of vaginal itching and discomfort. The nurse practitioner (NP) was called and new orders were given. A physician's orders [REDACTED]. Review of the (MONTH) 2019 Medication Administration Record [REDACTED]. However, instead of initials indicating the medication was given, a 9 was documented which according to the chart code it meant other/see nurse notes. There was no documentation that the [MEDICATION NAME] was given. Review of the eMAR (electronic Medication Administration Review) note dated (MONTH) 8, 2019 for the above order revealed the following documentation: waiting on medication, start date changed. There was no documentation on the MAR indicated [REDACTED]. A NP's note dated (MONTH) 9, 2019 included the resident was having vaginal itching and discomfort similar to a yeast infection. The plan was to give fluconazole (antifungal) one time for a yeast infection and that it was okay to use over the counter [MEDICATION NAME] topical cream for vaginal itch. A physician's orders [REDACTED]. Review of the (MONTH) 2019 MAR indicated [REDACTED] A physician's orders [REDACTED]. Review of the (MONTH) 2019 MAR indicated [REDACTED]. The corresponding eMAR note dated (MONTH) 9, 2019 revealed the family was to supply the above medication. A physician's orders [REDACTED]. Review of the (MONTH) 2019 MAR indicated [REDACTED]. The medication was administered on (MONTH) 11, and was effective. The MAR indicated [REDACTED]. A health status note dated (MONTH) 11, 2019 revealed the resident had vaginal itching and [MEDICATION NAME] cream was applied as ordered. A health status note dated (MONTH) 12, 2019 included the resident complained of burning in her vagina and it is being treated with [MEDICATION NAME]. A physician's orders [REDACTED]. Further review of the (MONTH) 2019 Medication Administration Record [REDACTED]. A quarterly MDS assessment dated (MONTH) 5, 2019 revealed the resident's Brief Interview for Mental Status (BIMS) score was 15, which indicated the resident was cognitively intact. A health status note dated (MONTH) 13, 2019 included the resident was complaining of burning with urination and vaginal discomfort, the physician was aware and gave an order to obtain a urine sample, which was collected. A physician's orders [REDACTED]. Review of the (MONTH) 2019 MAR indicated [REDACTED]. On (MONTH) 14, there was a 9 which indicated to see the nurses notes. An eMAR note dated (MONTH) 14, 2019 for the above order included the medication was not in stock and the dosage was to be determined. Review of the clinical record revealed no documentation that the [MEDICATION NAME] Cream was administered for 5 days as ordered. A physician's orders [REDACTED]. Review of the MAR for (MONTH) 2019 included the above order. However, a 9 was documented, which indicated to see the nurses notes for (MONTH) 3 and 4. There was no other documentation that this order was administered. A corresponding eMAR note dated (MONTH) 3, 2019 revealed the medication was on order. An eMAR note dated (MONTH) 4, 2019 included the medication was not available pharmacy sending. A health status note dated (MONTH) 4, 2019 included the NP was notified to clarify the above order and a duration for the medication was obtained. A physician's orders [REDACTED]. Review of the (MONTH) 2019 MAR indicated [REDACTED]. A 9 was documented, indicating to see the nursing notes. Review of the eMAR notes for the above medication included can't find rx. A NP note dated (MONTH) 5, 2019 included this was the monthly visit and follow up for vaginal itching. The resident was complaining of vaginal irritation and itchiness. The plan was for [MEDICATION NAME] to be given for three days. A physician's orders [REDACTED]. Review of the MAR for (MONTH) 2019 included the above medication order, however a 9 was documented, indicating to see the nurse's notes. A corresponding eMAR note dated (MONTH) 5, 2019 included the above medication was on order. A physician's orders [REDACTED]. Review of the (MONTH) 2019 MAR indicated [REDACTED]. On (MONTH) 8, the medication is documented as administered. Review of the eMAR notes dated (MONTH) 6 and 7 included the medication was on order. The eMAR note dated (MONTH) 9, revealed waiting for medication from pharmacy. The eMAR note dated (MONTH) 10, revealed the medication was on order. A physician's orders [REDACTED]. Review of the (MONTH) 2019 MAR indicated [REDACTED]. A corresponding eMAR note dated (MONTH) 15, 2019 for the above medication revealed not available will ask pharm to send. Review of the clinical record revealed no documentation the [MEDICATION NAME] 3 Combo Pack was given on (MONTH) 15, 16 or 17. Further review of the clinical record revealed no evidence that the physician was notified that the medications were not available for the resident. Review of the (MONTH) 2019 MAR indicated [REDACTED]. An eMAR note dated (MONTH) 24, at 1:16 p.m., included that [MEDICATION NAME] 5-325 mg was given by mouth for a pain scale of 6-10 for pain in vagina. A physician's orders [REDACTED]. An interview with resident #9 was conducted on (MONTH) 25, 2019 at 8:49 a.m. The resident stated that she was concerned regarding not having an appointment for her vaginal pain and discomfort. She stated some time ago she had an order for [REDACTED]. She stated there was no follow up after she did not receive the full treatment of [REDACTED]. A physician's orders [REDACTED]. Another physician's orders [REDACTED]. In a follow up interview with resident #9 on (MONTH) 27, 2019 at 9:47 a.m., she stated that when she is sitting in her wheelchair which she does most of the day, she feels like there is a knife sticking up her, and that it has been this way for a couple of weeks. She stated that she has made staff aware and they tell her they will contact the doctor, but she is

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F 0684 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 3) unsure if they have. She also stated that when she urinates, she feels burning and itching. An interview with a Licensed Practical Nurse (LPN/staff #93) was conducted on (MONTH) 27, 2019 at 12:07 p.m. Staff #93 is familiar with the resident's care. Staff #93 stated that she is aware the resident has complained of vaginal discomfort and was aware that [MEDICATION NAME] and creams were ordered for her vaginal discomfort, but was unsure if the treatments were carried out as ordered. She stated the resident has a history of wearing several layers of briefs and has been educated on the risks of doing so, but she continues to do it. In an interview with a Registered Nurse (RN/staff #112) on (MONTH) 27, 2019 at 5:22 a.m., she stated that if a medication is not available, she will pass on the information to the day shift to call the pharmacy, because the pharmacy does not have an after hours line that the night shift can call. She stated she would also inform the physician to let them know. She stated contacting the physician and/or pharmacy would be documented in the eMAR notes. An interview with the Director of Nursing (DON/staff #16) was conducted on (MONTH) 28, 2019 at 11:51 a.m. She said the nurses should contact the pharmacy and physician or nurse practitioner if a medication is unavailable. She also stated if a medication was administered, it should have been documented. Further, she stated that she was not sure why the nurses would not have documented if a medication was administered. Review of a facility policy titled Quality of Life-Dignity with no date included, Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. Review of a facility policy titled Medication and Treatment Orders with no date included, Orders for medications and treatments will be consistent with principles of safe and effective order writing. Review of a facility policy titled, Change in Condiditon/MD-Designee notification dated 12/01/2018 included, It is the policy of Allegiant Healthcare that resident change of condition is identified for proper treatment and implementation. The physician is informed of resident events and/or change in resident's condition. -Resident #13 was admitted to the facility on (MONTH) 6, (YEAR), with [DIAGNOSES REDACTED]. Review of the (MONTH) (YEAR) recapitulation of physician orders [REDACTED]. BS (blood sugar) between 0-70, call physician and initiate [DIAGNOSES REDACTED] protocol BS of 71-150 give 0 units BS of 151-200 give 3 units BS of 201-250 give 5 units BS of 251-300 give 7 units BS of 301-350 to give 10 units BS 351+ give 12 units and call the physician Review of the MAR's (medication administration record) from (MONTH) 1, (YEAR) through (MONTH) 31, (YEAR), revealed the above Humalog insulin sliding scale orders. Further review revealed the resident exhibited blood sugars greater than 351 approximately 6 occasions in (MONTH) and October, approximately 14 occasions in (MONTH) (YEAR) and 9 occasions in December.However, review of the clinical record revealed no documentation that the physician was notified of the elevated BS at the time that the elevated BS were identified. A care plan which was revised on (MONTH) 10, (YEAR) included the resident had type II diabetes. The goals were for the resident to not have complications related to diabetes and to be free from signs and symptoms of hypo/[MEDICAL CONDITION] through the review date. An intervention included medications as ordered by the physician. Review of the MAR's from (MONTH) 1, 2019 through (MONTH) 31, 2019 continued to include the order for Humalog insulin per sliding scale subcutaneously before meals and at bedtime as follows: BS 0-70, call physician and initiate [DIAGNOSES REDACTED] protocol BS 71-150 give 0 units BS 151-200 give 3 units BS 201-250 give 5 units BS 251-300 give 7 units BS 301-350 give 10 units BS 351+ give 12 units and call physician. Review of the MAR from (MONTH) 1, 2019 through (MONTH) 31, 2019 revealed resident had BS levels greater than 351 as follows: approximately 20 occasions in January, approximately 20 occasions in (MONTH) and 5 occasions in March. However, review of the clinical record revealed no documentation the physician was notified of the elevated BS at the time they were identified. A physician's note dated (MONTH) 21, 2019 included the resident had type II DM with [MEDICAL CONDITION]. Per the documentation, the resident had a very poor dietary compliance and BS was difficult to control. Review of the (MONTH) 2019 MAR indicated [REDACTED]. During the month, there were three occasions when the resident's BS was greater than 351. There was no evidence found in the clinical record that the physician was notified of the elevated BS in (MONTH) 2019. According to a NP (nurse practitioner) note dated (MONTH) 6, 2019, the BS logs were reviewed and BS ranges in the mid-high 300's within the last month. Assessment included Type II DM with chronic complications. The plan included to continue to monitor BS before meals and at bedtime and report BS over 400. Despite documentation in the NP note to report BS over 400, the physician's orders [REDACTED]. The (MONTH) 2019 physician orders [REDACTED]. BS 0-70, call physician and initiate [DIAGNOSES REDACTED] protocol BS 71-150 give 0 units BS 151-200 give 3 units BS 201-250 give 5 units BS 251-300 give 7 units BS 301-350 give 10 units BS 351+ give 12 units and to call physician. Review of the nursing progress notes from (MONTH) (YEAR) through (MONTH) 31, 2019 revealed only one progress note dated (MONTH) 30, 2019 which documented a voicemail message was left for the NP regarding BS readings of 595 and 513. In an interview with a licensed practical nurse (LPN/staff #93) conducted on (MONTH) 27, 2019 at 8:01 a.m., she stated that she will administer the sliding scale order according to the resident's blood sugar. She stated she will contact the physician for a certain BS result, when there is an order. She said that she will document in the clinical record that she informed the physician of the BS reading and what the physician had recommended or ordered. An interview with a registered nurse (RN/staff #5) was conducted on (MONTH) 27, 2019 at 10:55 a.m. Staff #5 stated when a resident is on insulin sliding scale, she will administer the insulin dose appropriate for the BS reading of the resident. She said if the BS is outside of the prescribed parameter, she will give a certain amount of insulin as ordered and then call the physician. She stated she will call the physician if the resident's BS level is high, even if there's no order to do so. She said she will then document in the progress note that she called the physician and the orders she received. During an interview with another LPN (staff #77) conducted on (MONTH) 28, 2019 at 12:55 p.m., he stated there usually is a physician's orders [REDACTED]. He stated if the BS is above or below the ordered parameter, there are usually specific interventions and instructions to call the physician. He stated if the BS is above 351, there is usually an order to give 10 units or 12 units of insulin and to call the physician. He also said he would always call the physician if the resident's BS reading was above or below the prescribed parameters. He said that he will document in the progress note that he called the physician and the orders he received. An interview with the Assistant Director of Nursing (ADON/staff #9) was conducted on (MONTH) 28, 2019 at 2:16 p.m. Staff #9 stated the nurses are expected to follow the physician ordered parameters; call the physician if the resident's values are above or below or abnormal; and should document it in the clinical record. She stated she could not think of any reason why the nurse would not document that they called the physician for any value above or below the prescribed parameter. Review of a policy titled, Administering Medications revealed that medications are administered in a safe and timely manner, and as prescribed. Review of a policy titled, Change in Condition/Physician-Designee Notification revealed The physician is notified of resident events . and notify the physician/designee of a clinical problem. The physician/designee develops a working

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F 0684 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 4) [DIAGNOSES REDACTED]. Further, the policy included to document in the medical record all attempts to notify the physician/designee. -Resident #275 was admitted on (MONTH) 7, 2019. [DIAGNOSES REDACTED]. A nurse's progress note dated (MONTH) 12, 2019, revealed the resident had a fall on (MONTH) 12, 2019 and was sent to the hospital. A health status progress note dated (MONTH) 13, 2019 by the unit clerk included the resident was inpatient at the hospital, with a [DIAGNOSES REDACTED]. Per the note, no current discharge plan as of yet as they need to fit resident with a brace. Review of the clinical record revealed the resident was readmitted to the facility on (MONTH) 16, 2019, with [DIAGNOSES REDACTED]. Review of the treatment administration records (TAR) for (MONTH) 2019 revealed the following: Use TLSO (Thoracolumbosacral orthosis) brace when out of bed every shift which was initiated on (MONTH) 16, 2019, and discontinued on (MONTH) 16, 2019. A Physical Therapy plan of care dated (MONTH) 17, 2019, by a physical therapist (PT/staff #125) included under precautions that the resident is a fall risk and wears a TLSO brace for all out of bed activities. Further review of the PT treatment notes dated (MONTH) 17, 19, 20, 24 and 25, 2019 revealed the resident was wearing a TLSO brace during therapy. However, review of the admission physician's orders [REDACTED]. Review of the resident's care plans revealed no documentation that the resident was utilizing a TLSO brace. There was also no CNA documentation that the resident utilized a TLSO brace. During an observation conducted on (MONTH) 26, 2019 at 9:40 a.m., a CNA was observed wheeling the resident in a wheelchair down the hallway. The resident was observed wearing a TLSO brace. At this time, the resident was taken to the therapy gym and the resident was observed participating in therapy excerices with the brace on. An interview was conducted on (MONTH) 26, 2019 at 10:47 a.m. with a CNA (Certified Nursing Assistant/staff #40). Staff #40 stated that resident #275 can not be up greater than 30 degrees, without a TLSO brace on. An interview was conducted on (MONTH) 26, 2019 at 11:06 a.m. with a RN (Registered Nurse/staff #97), who stated the resident should have his brace on at all times when he gets out of bed. She stated there should be a physician's orders [REDACTED].#97 reviewed the current physician orders [REDACTED].#97 said the nurses and the CNAs should document that the resident uses a TLSO brace when getting out of bed. An interview was conducted on (MONTH) 26, 2019, at 11:10 a.m. with the Director of Nursing (DON/staff #16). The DON stated that resident #275 is supposed to use a TLSO brace when out of bed. She stated that a physicians order should have been written for the TLSO brace. She further stated that the brace should have been care planned so that it could be initiated as a task for the CNA's. The resident's care plans were reviewed with the DON and there was no mention of a TLSO brace. An interview was conducted with the Director of Rehab (staff #128) on (MONTH) 26, 2019 at 11:22 a.m. He stated that resident #275 is to be wearing a TLSO brace when out of bed and it is documented in the therapy evaluation. He stated that after the evaluation, therapy will verbally communicate it to nursing and to the CNA's, and that the nurse should have written an order for [REDACTED].>An interview was conducted with the physical therapist (PT/staff #125) on (MONTH) 26, 2019 at 12:06 p.m. Staff #125 stated that when a resident is admitted , therapy will conduct an initial evaluation and will communicate with nursing staff if any precautions like a TLSO brace need to be followed. She stated it is in the hospital documentation that resident #125 needs to wear the TLSO brace when out of bed. The facility's policy and procedure titled Splint/Brace revealed that Splints and braces are worn on the recommendation of the occupational or physical therapist and on the order of the physician and to document the activity of the placement of the brace in the electronic medical records. -Resident #10 was readmitted to the facility on (MONTH) 24, (YEAR), with [DIAGNOSES REDACTED]. Review of the care plan initiated on (MONTH) 29, (YEAR) for self-care performance deficit revealed the resident required extensive assistance from 2 staff members for bed mobility, dressing, and personal hygiene and for transfers in and out of bed or chair. The goal was for the resident to reach her rehabilitation goals and return home safely. A physical therapy screening/re-evaluation dated (MONTH) 23, 2019, included the resident had been assessed for rehabilitation potential. The documentation stated the resident had no change in function with no new recommendations, and that the resident would be placed on the restorative nursing program. Review of the Restorative Nursing Training Program dated (MONTH) 23, 2019, revealed the resident was to receive upper extremity and lower extremity strengthening exercises to maintain and maximize range of motion, mobility, and function. The frequency was not included. The quarterly Minimum Data Set assessment dated (MONTH) 7, 2019, revealed a Brief Interview for Mental Status score of 15, which indicated the resident was cognitively intact. The MDS assessment also included the resident had received one day of restorative treatment for [REDACTED]. Review of the RNA documentation for (MONTH) 2019, revealed the resident received 15 minutes of active range of motion exercises and 15 minutes of passive range of motion exercises on (MONTH) 2, 14, and 25. The documentation included the resident refused restorative treatment on (MONTH) 1. Further review revealed no documentation the resident had been offered or received restorative treatments for any other day in (MONTH) 2019. During an interview conducted with the resident on (MONTH) 24, 2019 at 10:09 a.m., the resident stated that she was not receiving any therapy or services. She said she felt like she was just stuck in bed. An interview was conducted on (MONTH) 26, 2019 at 11:05 a.m. with a Restorative Nursing Assistant (RNA/staff #114). She stated the therapy department provides the RNA with information about which residents are to receive RNA services, as well as directions for the type and frequency of services. The RNA stated that if the directions did not include a frequency, she would provide RNA services three times a week, because that is considered a standard frequency. She said she documents RNA treatments provided or refused in the resident's electronic record and in the progress notes. The RNA stated that resident #10 should be receiving RNA treatments three times a week for upper and lower extremity strengthening, including weights, kicks, and knee bends. She said the reason the resident had not received regular treatments in (MONTH) is because of doctor appointments, going out of town, and being pulled to work as a nurse aide. During an interview conducted on (MONTH) 26, 2019 at 1:12 p.m. with the Director of Nursing (DON/staff #16), the DON stated the frequency for RNA treatments is as tolerated not three times a week. She said they try to conduct weekly meeting or least monthly meeting to discuss the residents' progress. The DON stated the meetings do not focus on a specific frequency of treatments or auditing RNA treatment records for completion. She said as long as treatments are being provided as tolerated, and the residents' abilities are maintained, the RNA program would be considered effective. An interview was conducted on (MONTH) 26, 2019 at 3:47 p.m. with the Director of Therapy (staff #128). He said there was no standard frequency for the number of RNA treatments to be provided each week. Staff #128 stated that treatments should be provided as needed to maintain the resident's abilities. He said the treatments would be considered effective as long as the resident did not have a decline in abilities. Staff #128 stated that if a decline is observed, a therapy screening would be initiated and he would initiate therapy services for the resident. Review of the facility's policy regarding Restorative Nursing Program revealed the restorative nursing program was designed to maintain or improve a resident's abilities to the highest practicable level. Residents will be assessed in accordance with the facility's assessment protocols. Residents will receive services from restorative aides when they are assessed to have a need for such services, including passive or active range of motion. A resident's restorative nursing plan would include the type of activities to be performed and the frequency of activities. Restorative aides will perform the activities and document it in the electronic record. The policy included the Restorative Coordinator will provide oversight of the restorative aide activities, and they will meet monthly to evaluate the effectiveness of the plan.
F 0689 **Level of harm** - Actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, interviews and policy review, the facility failed to ensure that one resident's (#10) environment was free from accident hazards, which resulted in a fall with injury and subsequent

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	035207	A. BUILDING _____ B. WING _____	06/28/2019

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F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 5) hospitalization . The deficient practice could result in further falls with injuries. Findings include: Resident #10 was readmitted to the facility on (MONTH) 24, (YEAR), with [DIAGNOSES REDACTED]. Review of the self care deficit care plan initiated on (MONTH) 28, (YEAR), revealed the resident required contact guard assistance from staff for transfers in and out of the bed, chair or wheelchair. Review of a care plan for fall risk revised on (MONTH) 9, (YEAR), revealed the resident was at risk for falls related to unsteady gait and/or balance. The goal included for the resident's level of independence to be maintained while reducing the likely hood of falls or injury. Interventions included to keep the floor free from clutter and observe the resident in her personal environment for safety. Review of the quarterly Minimum Data Set (MDS) assessment dated (MONTH) 28, (YEAR), revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. The assessment also documented that the resident required limited assistance from staff for transfers, and that the resident had not had any falls since admission.A nursing progress note dated (MONTH) 6, (YEAR) stated, writer was told by aide that patient was using curling iron in her room, placing it on bed. Aide spoke to patient concerning this. This writer went to speak with patient, asked if anyone spoke with her about the curling iron, patient replied no one had spoke to her about it. Writer informed patient that she cannot use the curling iron (which was on her night table) in this facility due to fire code regulations. Patient acknowledged with ok. Review of a social services progress note dated (MONTH) 6, (YEAR), revealed the social worker and case manager spoke with the resident about the curling iron, and there was an agreement that the resident would only use the curling iron when supervised by staff in the shower room. The curling iron was removed from the resident's room and was given to nursing to store. The note further stated that the social worker talked with the resident about her belongings being disorganized and intruding on her roommates side of the room. The note also included that a power strip was observed hanging from the resident's bed and that maintenance was informed, and the plan was to mount the power strip for the resident's safety. A nursing progress note dated (MONTH) 20, (YEAR) at 3:48 p.m. stated, aide found patient yelling out, lifted dresser of pt's R leg, then called writer to room. Writer found patient lying flat on her back on floor, bare feet, call light not on. Patient had numerous wires and cords tangled around her feet and under her back .patient has a large hematoma on her R leg, no other injuries noted. A nursing progress note dated (MONTH) 20, (YEAR) at 4:00 p.m., stated emergency medical transport (EMT) reported that the resident's hematoma had ruptured when moving the resident for transport, and there was a significant amount of blood in the room that needed to be cleaned. Review of the facility's post fall huddle report dated (MONTH) 20, (YEAR), revealed the resident was transferring herself from the bed to the wheelchair, and the bed was not locked. The resident fell on to the floor, then got tangled in her numerous cords causing the nightstand to fall on her. The report stated the cause of the fall was the bed was not locked and there were too many cords near the resident. The resident was sent to the hospital. The report concluded that the intervention to prevent the fall from happening again would be to make sure the bed was locked. However, the report did not address the issue of the resident becoming tangled in numerous cords and pulling the nightstand down on top of her. Further review of report revealed an attached staff in-service sign-in sheet dated (MONTH) 20, (YEAR). The subject was ensure patients bed in the locked position every shift. The subject matter did not address the concern regarding the numerous cords. Review of the hospital records revealed a physician's progress note dated (MONTH) 26, (YEAR), stating the resident had [MEDICATION NAME] trauma to the right lower extremity resulting in hematoma. The resident was status [REDACTED]. The note stated blood loss was anticipated with dressing changes given the large open friable wound and venous hypertension. A hospital physician's progress note dated (MONTH) 27, (YEAR), indicated the resident received received a transfusion of 1 unit of blood due to low hemoglobin levels. Review of the clinical record revealed the resident was readmitted to the facility on (MONTH) 29, (YEAR). Review of the care plan for fall risk revealed an intervention was added on (MONTH) 7, 2019, to ensure the locks on the bed were in the locked position. However, the care plan did not address the concern regarding the numerous cords as a causative factor in the fall. An interview was conducted with the resident on (MONTH) 24, 2019 at 10:01 a.m. She stated that in (MONTH) (YEAR), she was transferring from her bed to the wheelchair. She said that she leaned on the bed which was unlocked, and the bed rolled away from her and she fell . She said on the way down, she grabbed something on the nightstand/dresser, and the dresser fell on her leg. She said she received a crush wound on her right leg. At this time an observation of the resident's room was conducted and the room appeared cluttered. The entire wall facing the foot of the resident's bed was lined with equipment, including an electric wheelchair in the corner of the room, a wooden chair and a manual wheelchair. The seat of the wooden chair contained linens and an oscillating fan which was approximately 18-24 inches tall. The seat of the manual wheelchair contained a large package of incontinence briefs, a hoyer sling and two wheelchair footrests. Further observations revealed there was a dresser next to the resident's bed, which was approximately 3 feet tall, 2 feet wide and 2 feet deep. The dresser had one top drawer and a bottom cabinet. On top of the dresser were stacks of papers, a nebulizer machine and a bi-pap machine, each with cords dangling down the side and back of the dresser. There was also an oxygen concentrator and a portable air conditioner near the head of the resident's bed. Both machines were plugged in and operating. In addition, there were cords observed on the floor under and behind the resident's bed, however, no cords were observed on the floor in foot traffic areas. The resident's bed was locked. An interview was conducted on (MONTH) 26, 2019 at 9:58 a.m., with a charge nurse (staff #5). She said the resident was transferring herself from the bed and the bed moved away from her and the resident fell . She said the dresser then fell on top of the resident's right leg. She said when she arrived in the resident's room, staff had already removed the dresser from on top of the resident's right leg. She said the resident had cords wrapped around her legs from a power strip that had been attached to the dresser. She said the resident was completely tangled in cords. She said the bed was away from the resident at an angle. She stated the resident had a solid hematoma on her right leg. She said she worked on making room for the EMT to arrive, and when they came in the room, she left to prepare paperwork for the resident's transfer to the hospital. She said the EMT then came and told her they broke the hematoma in the room and there was a lot of blood. An observation of the resident's room was conducted on (MONTH) 26, 2019 at 11:40 a.m. The resident's bed was in the locked position. The resident's dresser was still stacked with papers, the nebulizer and the bi-pap machine. There was a curling iron resting on the handle of the dresser drawer, with a cord that was not plugged in. During the observation, the resident said she did not use the curling iron independently, but she calls staff to assist her when she wants her hair curled. She said the curling iron was designed to shut off automatically after ten minutes of non-use. The electric wheelchair, the manual wheelchair and the wooden chair still remained against the wall which was opposite of the foot of the resident's bed, with the same linens, supplies and equipment stacked on top. The oxygen concentrator and the portable air conditioner were still near the head of the resident's bed. Both machines were plugged in and operating. There was no power strip observed on top of or attached to the resident's dresser. However, there were still several cords which were dangling from the dresser drawer and down the side and back of the dresser from the [MEDICAL CONDITION] machine, the nebulizer machine and the curling iron. An interview was conducted on (MONTH) 26, 2019 at 3:09 p.m., with a Licensed Practical Nurse (LPN/staff #87). She said that she heard a noise coming from the resident's room, and she went to see what was going on. She said when she arrived, the resident was on the floor and staff were clearing the room. She said staff used a hoyer lift to get the resident back into bed, and that the resident had a hematoma on her right leg. She said within thirty minutes, EMT's had arrived and were preparing the resident for a transfer to the hospital. She said the EMT's stated the hematoma had burst around the time the resident transferred to stretcher. She said the EMT's then left with the resident. An observation was conducted from the doorway of the resident's room on (MONTH) 27, 2019 at 5:46 a.m. The curling iron was still resting on the resident's dresser handle, with the cord dangling down the front of the dresser. The [MEDICAL CONDITION] machine was on top of the dresser, along with a gallon-sized water jug and stacks of papers. The top dresser drawer was partially open, with the nebulizer machine resting inside the drawer. There were cords trailing down the side and back of the dresser. The resident's electronic health record (EHR) was reviewed on (MONTH) 27, 2019. Across the top of the screen was a banner

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F 0689 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 6) which stated, curling iron will be kept in cabinets above charts at nurses station. An interview was conducted with the Director of Nursing (DON/staff #16) on (MONTH) 27, 2019 at 6:40 a.m. She said the banner on the EHR is not really part of the resident's care plan. She said she did not know who had access to view or modify the banner. She said that she did have access, but she did not know what other staff members could access it. Another interview was conducted with staff #16 on (MONTH) 27, 2019 at 10:42 a.m. She said her expectation for fall and accident prevention was for staff to keep the room free of clutter, keep the call light and common items within reach of the resident, and ensure beds were locked. She said some residents had a preference to accumulate personal items, but staff would be expected to keep the room orderly. She said the appropriateness of having a power strip would be evaluated by maintenance and that residents were not to have extension cords. Regarding this resident's fall, she stated that she was aware that the resident's bed ended up at an angle away from the resident. She said the resident's cords were on top of the dresser and that is what had caused it to fall on the resident's leg. She said at the time, the resident was very specific about the arrangement of her room, and she would spread her items to the other side of the room. She said staff would educate the resident that she could only use her side of the room and had attempted to clean up the resident's room multiple times. Review of a facility's policy for Safety and Supervision of Residents revealed that resident safety and accident prevention was a facility-wide priority. Employees should be trained on potential accident hazards and demonstrate competency on how to identify and prevent avoidable accidents. Facility oriented and resident oriented approaches would be used together to consider the hazards identified in the environment and individual resident risk factors, and then adjust interventions accordingly. Risk factors and environmental hazards would include: bed safety, falls and safe movement of residents.
F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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 observation, clinical record review, interviews and policy review, the facility failed to address a urologist's note regarding catheter removal for one (#41) resident. The deficient practice could result in possible complications related to extended catheter use. Findings include: Resident #41 was readmitted to the facility on (MONTH) 21, (YEAR), with [DIAGNOSES REDACTED]. Review of the (MONTH) (YEAR) physician orders [REDACTED]. The orders also included for catheter care to be performed every shift (three times a day) for [MEDICAL CONDITION]. A care plan dated (MONTH) 2, 2019 included the resident had a Foley catheter related to [MEDICAL CONDITION]. The goal was that the resident will remain free of catheter related trauma through the review date of (MONTH) 22, 2019. Interventions included that catheter care be provided during routine peri care, signs and symptoms of pain or discomfort due to the catheter will be monitored and documented and the resident will be monitored for signs and symptoms of a UTI. A urology note dated (MONTH) 11, 2019 included the resident had recurrent UTI's and overflow incontinence and the use of the catheter is recommended for now. Follow up with the resident in 2 weeks at an out of facility appointment. A follow up urology note dated (MONTH) 25, 2019 revealed the resident's family member was present at this outside appointment. The resident's catheter remained intact. Per the note, the resident did not like the catheter, despite remaining dry. The family and the resident are requesting the facility remove the catheter. The plan included that the resident does not want the Foley catheter in place at this time and the family is requesting to have the catheter removed at the facility. The physician note also included that it is ok to remove the Foley catheter at the family's request and the risks and benefits of removing catheter were discussed. Review of the (MONTH) 2019 Treatment Administration Record (TAR) revealed the catheter was changed on (MONTH) 28, and that catheter care was performed three times a day. A significant change Minimum Data Set (MDS) assessment dated (MONTH) 15, 2019 included the resident had severe cognitive impairment and had an indwelling catheter. Review of the (MONTH) 2019 TAR revealed the resident's catheter was changed on (MONTH) 28, and that catheter care was performed every shift. Review of the clinical record revealed there was no documentation that the urologist note stating that it was ok to remove the resident's catheter was followed up on or that the catheter had been removed, nor was there documentation of the rationale for the continued use of the catheter by a physician/nurse practitioner in (MONTH) or (MONTH) 2019. According to a Hospice visit note dated (MONTH) 30, 2019, the resident was found to have a UTI and was prescribed Keflex (antibiotic) 500 mg twice a day for 7 days. A physician's orders [REDACTED]. Review of the Medication Administration Record [REDACTED]. Further review revealed the resident was receiving catheter care as ordered until (MONTH) 23, 2019. An observation was conducted on (MONTH) 24, 2019 at 10:04 a.m., of the resident lying in bed with a catheter bag hanging from the bed. In an interview with a Registered Nurse (RN/staff #5) on (MONTH) 28, 2019 at 3:18 p.m., she stated when a resident goes for an outside appointment, they usually bring back paperwork, which may contain progress notes of the appointment and new orders. She stated if no paperwork is provided, the provider is called and they fax over any documents. She said the charge nurses look at the documentation from outside providers and transcribes any new orders or notes into the clinical record. She said if the charge nurse is not available, the documentation is to be reviewed by the floor nurse. She stated if there are new appointments in the documentation, it goes in the scheduling book. Also, she said when the documentation has been reviewed, it is placed into a pile to be scanned into the electronic record. A catheter care observation of resident #41 was conducted on (MONTH) 28, 2019 at 3:45 p.m. As catheter care was being performed, resident #41 stated she was to have this thing (pointing to the catheter) taken out one of these days. Staff #5 continued with care and did not respond to the resident's comment. The resident then stated it must be something the doctor has to do. In an interview with the Director of Nursing (DON/staff #16) on (MONTH) 28, 2019 at 4:27 p.m., she stated when a resident comes back from an outside appointment, the documents from the appointment are obtained and reviewed and any new orders are transcribed into the electronic record. After reviewing the documentation for this resident, she stated the order to remove the resident's catheter was missed. Review of a facility policy titled, Medication and Treatment Orders included Orders for medications and treatments will be consistent with principles of safe and effective order writing.
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, clinical record review, and policy review, the facility failed to ensure that two of two sampled residents (#10 and #275) received respiratory care and services in accordance with professional standards of practice. The deficient practice could result in respiratory complications. Findings include: -Resident #10 was readmitted to the facility on (MONTH) 24, (YEAR), with [DIAGNOSES REDACTED]. Review of the physician's admission orders [REDACTED]. However, review of nursing admission notes dated (MONTH) 24, (YEAR) and (MONTH) 26, (YEAR), revealed the resident was receiving oxygen via nasal cannula. Review of the admission Minimum Data Set (MDS) assessment dated (MONTH) 28, (YEAR), revealed documentation that the resident was not receiving oxygen. However, review of the physician's progress note dated (MONTH) 29, (YEAR), revealed the resident was receiving oxygen via nasal cannula. The note further revealed the resident needed close clinical follow-up to avoid hospital re-admission. The note included the resident had multiple complex co-morbidities and was at high risk for clinical decompensation.

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F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 7) Review of the physician's orders [REDACTED]. However, review of the resident's vital signs dated (MONTH) 23, (YEAR), (MONTH) 2, (YEAR), (MONTH) 18, (YEAR), and (MONTH) 22, 2019, revealed the resident was receiving oxygen via nasal cannula. An interview was conducted on (MONTH) 26, 2019 at 3:29 p.m., with the Director of Nursing (DON/staff #16). She said there should be a physician's orders [REDACTED]. She stated that there was no order for the resident to receive oxygen, but one should have been obtained from the physician. -Resident #275 was admitted (MONTH) 16, 2019, with [DIAGNOSES REDACTED]. During an initial observation conducted of the resident on (MONTH) 24, 2019 at 09:44 a.m., the resident was observed to have oxygen on at 2 liters per nasal cannula. Review of a nurse progress note dated (MONTH) 18 and 20, 2019, revealed the resident was on oxygen at 2 liters per nasal cannula and that no shortness of breath was noted. Review of the admission MDS assessment dated (MONTH) 20, 2019, revealed the resident was not receiving oxygen therapy. Another observation was conducted of the resident on (MONTH) 25, 2019 at 9:36 a.m. The resident was observed sleeping with oxygen on at 2 liters per nasal cannula. However, review of the clinical record did not reveal a physician's orders [REDACTED]. An interview was conducted with a Registered Nurse (RN/staff #97) on (MONTH) 25, 2019 at 1:18 p.m. The RN stated that there should be a physician's orders [REDACTED]. During an interview conducted with the DON (staff #16) on (MONTH) 28, 2019 at 3:59 p.m. The DON stated that if a resident is on oxygen therapy there should be a physician's orders [REDACTED]. Review of the facility's policy regarding Respiratory Clinical Services revealed that no oxygen can be initiated without a physician's orders [REDACTED]. If oxygen is ordered by either of the caregivers listed above, the order must be written in the chart following all the necessary criteria for any other valid order. The policy also included that if approved protocols are not utilized the responsible physician should be contacted as soon as possible to advise that oxygen was needed, and that the order must be re-enforced by the physician at their next available time on the unit.
F 0698 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Past noncompliance - remedy proposed** **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 sampled resident (#24) who required [MEDICAL TREATMENT] received such services, consistent with professional standards of practice and the comprehensive person-centered care plan. The deficient practice could result in [MEDICAL TREATMENT] related complications not being identified and treated timely. Findings include: Resident #24 was readmitted to the facility on (MONTH) 26, 2019, with [DIAGNOSES REDACTED]. A Nurse Practitioner note dated (MONTH) 28, 2019 revealed the resident was on [MEDICAL TREATMENT] and had an AV (arteriovenous) fistula located on the left forearm that had a positive bruit and strong thrill. Review of the care plan revised (MONTH) 13, 2019, revealed the resident was receiving [MEDICAL TREATMENT] on Monday, Wednesday, And Friday with a goal that the resident will remain free of signs and symptoms of infection. Interventions included monitoring the [MEDICAL TREATMENT] for signs and symptoms of infection such as redness, swelling, warmth or drainage, documenting, and reporting to the physician as needed and that if bleeding occurs from the [MEDICAL TREATMENT] graft/fistula, apply direct pressure over the site and call for help. Additional review of the care plan revised (MONTH) 13, 2019, revealed the resident was at risk for complications related to [MEDICAL CONDITION] and [MEDICAL CONDITION] with a goal of reducing the likelihood of the [MEDICAL TREATMENT] site sustaining injury, signs and symptoms of infection, and bleeding. Interventions included [MEDICAL TREATMENT] as ordered, monitoring the [MEDICAL TREATMENT] catheter for signs and symptoms of infection, and reporting abnormal findings to the physician for evaluation. Review of the quarterly Minimum Data Set assessment dated (MONTH) 5, 2019 revealed a score of 15 on the Brief Interview for Mental Status which indicated the resident was alert and oriented. The assessment also included the resident was receiving [MEDICAL TREATMENT] services. Review of the pre and post [MEDICAL TREATMENT] assessments from (MONTH) to (MONTH) 2019 revealed documentation the [MEDICAL TREATMENT] site was assessed and monitored on [MEDICAL TREATMENT] days. However, continued review of the clinical record revealed no physician order for [REDACTED]. Further review of the clinical record revealed no evidence the [MEDICAL TREATMENT] site was assessed and monitor on the days the resident did not have [MEDICAL TREATMENT]. An interview was conducted with a Licensed Practical Nurse (LPN/staff #77) on (MONTH) 28, 2019 at 12:55 p.m. Staff #77 stated the resident goes to [MEDICAL TREATMENT] and has an AV shunt site on the left forearm. The LPN stated a pre and post [MEDICAL TREATMENT] assessment form is completed on [MEDICAL TREATMENT] days which include the resident's weight, vital signs and an assessment of the AV shunt site. The LPN stated that the AV shunt site is assessed for signs and symptoms of infection and for the presence/absence of bruit and thrill every shift. He stated that this is done on [MEDICAL TREATMENT] days and on the days the resident does not go to [MEDICAL TREATMENT]. The LPN also stated that the assessment is documented on the Medication Administration Record/Treatment Administration Record. After reviewing the clinical record, the LPN stated he was unable to find an order to assess the AV shunt site for bruit and thrill and signs and symptoms of infection or documentation the [MEDICAL TREATMENT] site was assessed on the days the resident did not go to [MEDICAL TREATMENT]. During an interview conducted with the assistant Director of Nursing (ADON/staff #9) on (MONTH) 28, 2019 at 2:16 p.m., the ADON stated pre and post [MEDICAL TREATMENT] assessments which include vital signs and assessing the AV shunt site for presence or absence of bruit and thrill and signs and symptoms of infection are conducted by the nurses. She stated that on the days the resident does not go to [MEDICAL TREATMENT], the nurses continue to assess the [MEDICAL TREATMENT] site but that they only document the assessment if something is abnormal. The ADON further stated that there no way to know if the [MEDICAL TREATMENT] site was assessed on the days the resident did not go to [MEDICAL TREATMENT] unless it was documented that something was abnormal. She said she does not know why there was no order to monitor and assess the [MEDICAL TREATMENT] site. The facility's policy regarding [MEDICAL TREATMENT] implemented (MONTH) (YEAR) revealed nursing staff will monitor and provide necessary treatments for residents receiving any [MEDICAL TREATMENT] services, whether in house or out of facility. The nurse will verify orders for [MEDICAL TREATMENT] treatment for [REDACTED]. The policy also included the facility will provide safe and appropriate treatment for [REDACTED].
F 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** Based on resident and staff interviews, facility documentation, and policy review, the facility failed to ensure there was sufficient nursing staff to meet the needs of residents. The deficient practice resulted in residents' needs not being met. The census was 82 residents. Findings include: During the initial phase of the survey, 6 out of 22 residents reported concerns of not having enough staff. Residents reported that they waited up to 2 hours for call lights to be answered. They stated they waited from 45 minutes to 1 hour while staff left them sitting on the toilet or sitting in soiled briefs. They stated there was no one to answer call lights while staff assisted other residents with showers. They stated that long wait times occurred both on day and night shifts. Review of the facility assessment dated (MONTH) 16, 2019, revealed the facility's general approach to ensure sufficient staff to meet the needs of residents included 2.28 nurse aide hours per patient day. Review of the weekend nursing staff postings for (MONTH) 8, 9, 22, and 23, 2019, revealed the facility had a census of 83, 82, 83, and 83 residents, respectively. Review of the nurse aide payroll records for (MONTH) 8, 9, 22, and 23, 2019, revealed the total nurse aide hours worked for

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F 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 8) each day was 163.75, 158.75, 166.75, and 155.5 hours, respectively. Based on the review of weekend nursing staff postings and nurse aide payroll records, the number of nurse aide hours per patient day was below 2.28 hours, as follows: June 8 - 1.97 hours per patient day June 9 - 1.94 hours per patient day June 22 - 2.01 hours per patient day June 23 - 1.87 hours per patient day Review of the entire nurse staff postings and nurse aide payroll records for (MONTH) 28-June 27, 2019, revealed the nurse aide hours per patient day were below 2.28 hours for 21 out of 27 days. There were no nurse staff postings with census information for (MONTH) 1, 2, 15, or 16, 2019, so the information from these dates was not included in the total. An interview was conducted on (MONTH) 26, 2019 at 11:05 a.m., with a Restorative Nursing Assistant (RNA/staff #114). She stated the RNA is responsible for providing restorative nursing treatments, obtaining resident weights, and providing dining assistance to residents during breakfast and lunch. She stated that she does not have enough time to provide all restorative treatments on the days when she has to weigh residents. She said on days when there are not enough nurse aides working, she would be pulled from restorative duties to work as a nurse aide. She stated that on the days she worked as a nurse aide, restorative treatments would not be done. She said this happens once or twice each month. An interview was conducted on (MONTH) 26, 2019 at 2:06 p.m., with the staffing coordinator (staff #117). She stated that she was not aware of any concerns expressed by the resident council regarding staffing. She said she had started working as the staffing coordinator in mid (MONTH) 2019. She stated the basic staffing strategy for nurse aides is to have 4 aides on the long term care unit, 2 aides on the skilled unit, and 1 aide on the behavioral unit for each day and evening shift. Staff #117 stated the basic strategy for the night shift is to have 2 aides on the long term care unit, 1 aide on the skilled unit, and 1 aide on the behavioral unit. She said that staffing was based primarily on census. She said the general staffing strategy would include increasing the number of aides on the units if there were more than 5 residents on the behavioral unit or if the facility census was greater than 90 residents. During an interview conducted with a resident on (MONTH) 28, 2019 at 8:50 a.m., the resident stated that 2 staff members are required to operate the equipment to transfer her from the chair to the toilet. She said when she used her call light to go to the bathroom; a staff member would answer the light and then tell her they needed to find another staff member to assist with the transfer. She said the staff member would leave and that it would take a long time for the 2 staff members to return to assist her. She said there had been about 5 times recently that she had experienced incontinence because she waited so long for 2 staff members to return to assist her with toileting. An interview was conducted with another resident on (MONTH) 28, 2019 at 10:53 a.m. She stated that when she has a bowel movement, she uses her call light to alert staff, and that waiting a long time for staff to come and clean her results in her buttocks stinging. She stated in the past few months, there had been about 10 times that she has had a bowel movement and staff did not respond to her light right away, up to a 45 minute wait. She said that during the wait, she would have to sit in the bowel movement while it was stinging her skin. An interview was conducted with the Administrator (staff #3) on (MONTH) 28, 2019 at 12:46 p.m. He stated that staffing was based primarily on the facility census. He stated that the number of staff hours per patient day in the facility assessment was based on industry standards and feedback from previous years of operation in the facility. He said the 2.28 nurse aide hours per patient day would be a goal to approach, but actual staffing hours would not match that number exactly every day. The Administrator stated that in general, the facility strives to meet or exceed the number of nurse aide hours per patient day listed in the facility assessment. He said that management is aware of the staffing concerns expressed by the resident council. He said the concerns were discussed in the quality assurance committee meeting, and that the department heads were taking the necessary actions needed to address the concerns. He stated that staffing hours are reviewed monthly and that the nurse aide staffing hours did not appear to be low; they appeared to be on target. Review of the facility's staffing policy revealed the facility would provide sufficient numbers of staff to provide care for all residents in accordance with the resident care plans and the facility assessment. The policy further stated that certified nursing assistants would be available 24 hours a day to provide direct resident care services, staffing numbers would be determined by the needs of the residents based on their care plans, and inquiries or concerns relative to the facility's staffing should be directed to the Administrator or his designee. -Review of the resident council meeting notes dated (MONTH) 9, 2019 revealed residents reported the call light wait times are an issue again and that the weekend staff are a bit slower with the call lights. No response or follow up was documented in the notes. Review of the resident council meeting notes dated (MONTH) 10, 2019 revealed the residents reported call light response times are starting to slow down. No response or follow up was documented in the notes. Review of the resident council meeting notes dated (MONTH) 8, 2019 revealed the residents reported the call light response issue had returned. The residents felt like the nursing staff were doing a good job but that the call light time could use some work. No response or follow up was documented in the notes. Review of resident council meeting notes dated (MONTH) 5, 2019 revealed the residents stated that nursing is doing a good job, but the call light response time is a little too long. No response or follow up was documented in the notes. The above council meeting notes were all signed by the Administrator (Staff #3). A Resident Council interview was conducted on (MONTH) 25, 2019 at 1:33 p.m. The residents stated that sometimes they have to wait an hour to get up in the morning. They stated the staff work hard, there just are not enough of them. The residents stated that sometimes the staff will state they will be right back, but no one ever comes back. The residents stated that showers have been missed due to staff not having enough time and incontinence have occurred due to having to wait too long for assistance. The residents stated they have expressed their concerns to the Administrator (staff #3) on several occasions and that he stated that he will speak with the charge nurse, however, nothing has changed. The residents also stated that the Administrator told them they can speak to the charge nurse as well. The residents stated there has been no follow up regarding their concern about staffing. During an interview conducted with the Director of Activities (staff #14) on (MONTH) 27, 2019 at 9:42 a.m., she stated that long call light response times are an issue that the residents bring up frequently in the Resident Council meeting. She stated concerns are reported to the department it concerns. Staff #14 also stated everyone has been educated that they can answer call lights. She stated that the Director of Nursing (DON/staff #16) has spoken to the Certified Nursing Assistants (CNAs) regarding the residents' concerns. In an interview conducted with the DON (staff #16) on (MONTH) 28, 2019 at 9:39 a.m., she stated the expectation is that staff answer call lights as promptly as they can. A facility policy titled, Resident Council dated (MONTH) (YEAR) included, 1. The purpose of the Resident Council is to provide a forum for: a. residents, families and resident representatives to have input in the operation of the facility; b. Discussion of concerns and suggestions for improvement; c. Consensus building and communication between residents and facility staff; and d. Disseminating information and gathering feedback from interested residents . 5. A Resident Council Response Form will be utilized to track issues and their resolution. The facility department related to any issues will be responsible for addressing the item(s) of concern.
F 0726 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.** Based on interview, personnel file review, the Facility Assessment, and policy review, the facility failed to ensure that 3 of 6 sampled nursing staff (#67, #52, and #65) were able to demonstrate competencies and skills necessary to provide resident care. The deficient practice could result in delayed care and inadequate care for residents. The facility census was 82 residents. Findings include: Review of the Facility assessment dated (MONTH) 16, 2019, revealed that the facility could provide care for up to forty long

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F 0726 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 9) term care residents, forty-nine short stay residents, and eight long term care behavioral residents. Services and care would be based on residents' needs, and would include restorative nursing, contracture prevention/care, catheter care, ostomy care, respiratory care, diabetes management, nutrition support, pressure injury care and prevention, medication administration, infection identification and prevention, palliative care, IV therapy, care and support for individuals with psychiatric diagnoses, cognitive impairment, and assistance with activities of daily living. The assessment included that staff competency training would be performed upon hire and as needed throughout employment. -Review of the personnel record for a Licensed Practical Nurse (LPN/staff #67), revealed a hire date of (MONTH) 27, (YEAR), for full time employment. The personnel record contained no evidence of a comprehensive evaluation for nursing skills and competencies upon hire or annually thereafter. -Review of the personnel record for a Certified Nursing Assistant (CNA/staff #52), revealed a hire date of (MONTH) 8, (YEAR), for full time employment. The personnel record contained no evidence of a comprehensive evaluation for nursing skills and competencies upon hire or annually thereafter. -Review of the personnel record for a CNA (staff #65), revealed a hire date of (MONTH) 21, (YEAR), for full time employment. The personnel record contained no evidence of a comprehensive evaluation for nursing skills and competencies upon hire or annually thereafter. An interview was conducted on (MONTH) 28, 2019 at 2:17 p.m. with the DON (staff #16). She stated she was not able to find any documentation of skills checklists, or orientation skills training, for staff #52, #65, or #67. She said she could not prove that these staff members had the necessary skills to provide care for residents. In follow-up interviews later that day, the DON stated that all nurses and CNAs should have demonstrated their skills by completing competency checklists upon hire, and completed skills checklists should be maintained in their employee files. The DON stated that they have been unable to locate the records of staff training and skills maintained by the previous staffing coordinator. Review of the facility's policy regarding Competency of Nursing Staff revealed the staff development and training program was created by nursing leadership, with input from the medical director, and was designed to train nursing staff to deliver individualized, safe, quality care and services for the residents. Factors considered in the creation of the competency-based staff development program included an evaluation of the current program to ensure basic nursing competencies, any gaps in education or training that may contribute to poor outcomes, specialized skills or training needed based on the resident population, and a method to track, assess, plan, implement and evaluate the effectiveness of training. Facility and resident-specific competency evaluations would be conducted upon hire, annually, and as deemed necessary based on the facility assessment. Competency evaluations would include: -lecture with return demonstration for physical activities -A pre and posttest for documentation issues -Demonstrated ability to use tools, devices, or equipment used to care for residents -Demonstrated ability to perform activities that are within the scope of practice an individual is licensed or certified to perform.
F 0730 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Observe each nurse aide's job performance and give regular training.** Based on personnel file review, interviews, and policy review, the facility failed to complete a yearly performance review and provide regular in-service education based on the outcome of the review for 2 of 2 sampled Certified Nursing Assistants (CNA/#52 and #65). The deficient practice could result in insufficient and inadequate care for residents. The facility census was 82 residents. Findings include: -Review of the personnel file for a CNA (staff #52), revealed a hire date of (MONTH) 8, (YEAR), for full time employment. The personnel file contained documentation that the staff member had received orientation upon hire for dementia care, behavioral health care, resident's rights, and abuse prevention. Continued review of the file revealed the CNA had received two in-service trainings regarding general topics and survey readiness in 2019. Review of the file did not reveal a yearly performance review had been completed or any evidence of in-service education based on a yearly review. -Review of the personnel record for a CNA (staff #65), revealed a hire date of (MONTH) 21, (YEAR), for full time employment. There was no evidence in the file that the staff member had received orientation upon hire. The CNA had received two in-service trainings during 2019, for general topics and survey readiness. Review of the file did not reveal a yearly performance review had been completed or any evidence of in-service education based on a yearly review. During interviews conducted on (MONTH) 28, 2019 with the Director of Nursing (DON/staff #16), the DON stated that they had not been conducting regular performance reviews for nurse aides, but they planned to begin soon. The DON stated the plan was to conduct performance reviews annually and upon request. An interview was conducted on (MONTH) 28, 2019 at 4:45 p.m., with the ADON (staff #9). She stated the facility did not have a policy for nurse aide training and in-service. Review of the facility's policy titled Competency of Nursing Staff revealed facility and resident-specific competency evaluations would be conducted upon hire, annually, and as deemed necessary based on the facility assessment. Competency evaluations would include: -lecture with return demonstration for physical activities -A pre and posttest for documentation issues -Demonstrated ability to use tools, devices, or equipment used to care for residents -Demonstrated ability to perform activities that are within the scope of practice an individual is licensed or certified to perform.
F 0732 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**Post nurse staffing information every day.** Based on observation, interviews and policy review, the facility failed to ensure that the nursing staff information was accurate and posted daily. The deficient practice could result in inadequate staffing for resident needs. The facility census was 82 residents. Findings include: Review of the facility's nursing staff posting records for (MONTH) 2019, revealed there was no staff posting information for Saturday and Sunday, (MONTH) 1-2, as well as Saturday and Sunday, (MONTH) 15-16. An observation was conducted on (MONTH) 24, 2019 at 7:13 a.m., of the nursing staff posting information which was at the front desk of the facility. The nursing staff posting data was dated (MONTH) 21, 2019, with a resident census of 84. An interview was conducted on (MONTH) 27, 2019 at 10:36 a.m., with the staffing coordinator (staff #117). She stated she receives an email in the morning with the daily census, and she uses that number combined with the staffing numbers to create the daily nursing staff posting. She stated that she posts the information every day she works, which is Monday through Friday. She said she was not sure who posted the nursing staff information on the weekends. An interview was conducted on (MONTH) 27, 2019 at 10:41 a.m., with the Assistant Director of Nursing (ADON/staff #9). She stated no one has been doing the nursing staff postings on the weekends. Regarding the nursing staff hours on the daily staff posting: Review of the CNA punch in and punch out logs for (MONTH) 2019 revealed that CNAs worked approximately 7.5 hours per shift. Review of the nursing staff posting for (MONTH) 24, 2019, revealed the total number of CNA hours worked during the day shift was 60 hours, during the evening shift was 52.5 hours, and during the night shift was 30 hours. However, review of the staff sign-in sheets for (MONTH) 24, 2019, revealed that 9 CNAs worked the day shift, which would be a total of 67.5 hours, 8 CNAs worked the evening shift and 1 CNA worked a partial 4 hour evening shift, which would be a total of 64 hours, and that 5 CNAs worked the night shift, which would be a total of 37.5 hours. Review of the nursing staff posting for (MONTH) 25, 2019, revealed the total number of CNA hours worked during the day shift was 60 hours, during the evening shift was 60 hours, and during the night shift was 30 hours. However, review of the staff sign-in sheets for (MONTH) 25, 2019, revealed that 9 CNAs worked the day shift, which would be a total of 67.5 hours, 9 CNAs worked the evening shift, which would be a total of 67.5 hours, and 5 CNAs worked the night shift, which would be a total of 37.5 hours.

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F 0732 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	(continued... from page 10) Review of the nursing staff posting for (MONTH) 27, 2019, revealed the total number of CNA hours worked during the day shift was 60 hours, during the evening shift was 60 hours, and during the night shift was 30 hours. However, review of the staff sign-in sheets for (MONTH) 27, 2019, revealed that 9 CNAs worked the day shift, which would be a total of 67.5 hours, 9 CNAs worked the evening shift, which would be a total of 67.5 hours, and 5 CNAs worked the night shift, which would be a total of 37.5 hours. An interview was conducted on (MONTH) 28, 2019 at 2:12 p.m., with the DON (staff #16) and the Administrator (staff #3). Staff #3 stated the hours on the daily nursing staff postings were incorrect. He stated the hours worked by nursing staff in the secured behavioral unit had not been included in the hours on the facility's nursing staff posting. He stated the nursing staff posting had been corrected beginning (MONTH) 28, 2019. Review of the facility's policy for posting of nursing hours revealed the staffing coordinator would post nursing hours at the front desk daily and as needed for changes. The staffing coordinator would fill out the nursing staff hours for the following day, and place the staff posting in the staffing binder at the nurses station.
F 0741 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility documentation, staff interviews, personnel record reviews and policy review, the facility failed to ensure that three nursing staff (#4, #65 and #67) were competently trained regarding the provision of care for residents which are cognitively impaired, and those with behavioral health and psychosocial needs. The deficient practice could result in a lack of person centered care and needs not being met for residents. The facility census was 82 residents, which includes 18 residents with dementia, 18 residents with psychiatric [DIAGNOSES REDACTED]. Findings include: Review of the facility assessment dated (MONTH) 16, 2019, revealed that common [DIAGNOSES REDACTED]., [MEDICAL CONDITION], impaired cognition, depression, [MEDICAL CONDITION] disorder, [MEDICAL CONDITION], post-traumatic stress disorder, anxiety disorder, mental disorder and behaviors that require interventions. Types of care the facility provided included the following: mental health and behavioral care, management of medical conditions and medication-related issues causing psychiatric symptoms and behavior, psycho/social/spiritual support and assistance with activities of daily living. The assessment included that staff would receive a general orientation upon hire, and a more detailed orientation per their specific discipline. Competency trainings would occur upon hire and as needed throughout employment. The assessment stated the facility was licensed to provide care for up to 8 long term care behavioral residents. Review of the personnel record for a Licensed Practical Nurse (LPN/staff #67) revealed a hire date of (MONTH) 27, (YEAR), for full time employment. The personnel record contained no evidence of any training for dementia care or behavioral health management, upon hire or annually thereafter. Review of the personnel record for a Certified Nursing Assistant (CNA/staff #65), revealed a hire date of (MONTH) 21, (YEAR) for full time employment. The personnel record contained no evidence of training for dementia care or behavioral health management upon hire or annually thereafter. Review of the personnel record for a Registered Nurse (RN/staff #4), revealed a hire date of (MONTH) 22, (YEAR) for full time employment. The personnel record contained no evidence of training for dementia care or behavioral health management upon hire or annually thereafter. Review of the staff schedule and sign-in sheets for (MONTH) 2019, revealed that staff #67 regularly worked on the secured behavioral unit, staff #65 regularly worked on the long term care unit (which includes residents with dementia) and staff #4 regularly worked as the charge nurse. An interview was conducted on (MONTH) 28, 2019 at 2:17 p.m., with the Director of Nursing (DON/staff #16) and the Administrator (staff #3). Staff #16 stated she was not able to find any documentation of dementia and behavioral health training for the three staff members (#4, #65 and #67). Staff #3 stated that staff members should receive special training prior to working on the secured behavioral unit. He stated that staff #67 regularly worked on the secured behavioral unit and should have received special behavioral training. However, he was unable to provide documentation of this type of training which was done. A follow-up interview was conducted with staff #16 on (MONTH) 28, 2019 at 3:32 p.m. She stated that the previous staffing coordinator was responsible for auditing and maintaining records of staff training. She said the previous staffing coordinator left employment with the facility about a month ago, and the expectation of maintaining staff training records had not yet been communicated to the new staffing coordinator. She said she did not know where the previous staffing coordinator had kept the records of staff training. Review of the facility's Staffing policy revealed the facility will provide sufficient numbers of staff with the skills and competencies necessary to provide care and services for all residents, in accordance with resident care plans and the facility assessment. Review of a policy for Competency of Nursing Staff revealed the staff development and training program was created by nursing leadership with input from the medical director, and was designed to train nursing staff to deliver individualized, safe, quality care and services for the residents. Factors considered in the creation of the competency-based staff development program included an evaluation of the current program to ensure basic nursing competencies, any gaps in education or training that may contribute to poor outcomes, specialized skills or training needed based on the resident population, and a method to track, assess, plan, implement and evaluate the effectiveness of training. Facility and resident-specific competency evaluations would be conducted upon hire, annually, and as deemed necessary based on the facility assessment. Competency evaluations would include: the following: -lecture with return demonstration for physical activities -A pre and post test for documentation issues -Demonstrate ability to use tools, devices or equipment used to care for residents -Demonstrate ability to perform activities that are within the scope of practice an individual is licensed or certified to perform.
F 0744 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observations, staff interviews and policy review, the facility failed to ensure one sample resident (#13) diagnosed with [REDACTED]. The deficient practice could result in residents with dementia not attaining or maintaining their highest practicable physical, mental, and psychosocial well-being. Findings include: Resident #13 was admitted on (MONTH) 6, (YEAR) with [DIAGNOSES REDACTED]. Review of the recapitulation of physician's orders [REDACTED]. Review of the care plan initiated (MONTH) 13, (YEAR) and revised (MONTH) 5, 2019 revealed the resident was demonstrating difficulty with behaviors by others that can be characterized as provoking, antagonizing, disrespectful, angry, insensitive, and annoying as evidenced by accusatory comments about others and included the resident was taking [MEDICATION NAME] for behaviors. Review of the care plan initiated on (MONTH) 13, (YEAR) and revised (MONTH) 5, 2019, revealed the resident used the [MEDICAL CONDITION] medication [MEDICATION NAME] related to dementia with accusatory/paranoid behaviors. Interventions included administering the [MEDICAL CONDITION] medication as ordered, consulting with pharmacy and for the physician to consider a dose reduction when clinically appropriate. Review of the clinical record including the Medication Administration Record [REDACTED]. The MARs for this time period included the resident was administered [MEDICATION NAME].

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F 0744 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 11) Continued review of the clinical record revealed the resident was not being monitored for paranoid behaviors and no evidence was found in the clinical record the resident exhibited paranoid behaviors (MONTH) 1, (YEAR) through (MONTH) 31, (YEAR). The CNA (Certified Nursing Assistant) behavioral documentation from (MONTH) 1, (YEAR) through (MONTH) 31, (YEAR) revealed no behavioral symptoms coded for the resident. The pharmacist Medication Regimen Review dated (MONTH) 7, (YEAR) included a note to the physician with a recommendation to decrease [MEDICATION NAME] ER to 3 mg by mouth every day. The physician response was a handwritten note follow up with psych. The psychiatric consultation/follow up note dated (MONTH) 27, (YEAR) revealed it was a psychiatric follow up for medication review. The note included the resident was alert and oriented to self, place, time, day, month, season, current events and situation. However, the note did not include anything regarding [MEDICATION NAME]. Review of the MARs for (MONTH) (YEAR), (MONTH) (YEAR), and (MONTH) 2019 revealed the resident was being monitored for accusatory behaviors and that the resident did not exhibit any accusatory behaviors for this time period. The MARs also included the resident was administered [MEDICATION NAME]. Continued review of the clinical record revealed the resident was not being monitored for paranoid behaviors. The CNA behavioral documentation from (MONTH) 1, (YEAR) through (MONTH) 31, 2019 revealed no behavioral symptoms coded for the resident. Review of the psychiatric consultation/follow up note dated (MONTH) 7, 2019 revealed the resident was alert and oriented and most recently had been more active and out of her room nearly every day. The note included the resident remains on multiple medications including [MEDICATION NAME] 6 mg but that her moods and behaviors are relatively stable and to continue the medications for now. The note also included the resident had [MEDICAL CONDITION] and [MEDICAL CONDITION] without behavior disturbances. The pharmacist Medication Regimen Review dated (MONTH) 17, 2019 included a note to the physician that if the resident is at the lowest effective dose due to the potential the resident's condition will decompensate if the dose is decreased, please check agree below and further GDR attempts will be clinically contraindicated. It also included an instruction to place [MEDICATION NAME] 6 mg by mouth every morning at LED (lowest effective dose). The physician response was a handwritten note follow up with psych. The physician order [REDACTED]. This order was transcribed onto the MAR for (MONTH) 2019 and monitoring of paranoid behaviors was started on the 2:00 p.m. to 10:00 p.m. shift on (MONTH) 5, 2019. Review of the monitoring for paranoid behaviors revealed the resident had no paranoid behaviors from (MONTH) 5 through (MONTH) 30, 2019. The pharmacist Medication Regimen Review dated (MONTH) 11, 2019 included a note to the physician that included a recommendation to either decrease [MEDICATION NAME] to 3mg by mouth every morning or that [MEDICATION NAME] is at the LED due to _____. The note included a handwritten note that it needs review by the psych Nurse Practitioner (NP). The NP response was the resident has significant history of [MEDICAL CONDITION] and acting out behaviors and that decreasing the dose would exacerbate the signs and symptoms. Review of the monitoring for paranoid behaviors revealed the resident had no paranoid behaviors from (MONTH) 1 through (MONTH) 25, 2019. Review of the behavior monitoring from (MONTH) 1, 2019 through (MONTH) 25, 2019 revealed the resident did not have accusatory behaviors. Review of the nursing progress notes from (MONTH) 1, (YEAR) through (MONTH) 25, 2019 revealed no evidence the resident exhibited accusatory and/or paranoid behaviors. During multiple observations conducted on (MONTH) 27, 2019 and (MONTH) 28, 2019, the resident was observed in her room sleeping in her bed. The resident was not observed to have interaction with her roommate. In an interview conducted with a Certified Nursing Assistant (CNA/staff #23) on (MONTH) 27, 2019 at 9:40 a.m., she stated the resident is alert and oriented but can be confused at times. She stated the resident attends activities or eats in the dining room depending on her mood. She stated yelling is the only behavior the resident has. The CNA stated the resident can be verbally aggressive and that she tells her roommate to shut up but that it usually happens when the resident is confused. The CNA stated that she has not seen the resident having behaviors, hallucinations or delusions. An interview was conducted with a Licensed Practical Nurse (LPN/staff #77) on (MONTH) 28, 2019 at 12:55 p.m. The LPN stated the resident is alert and oriented, can be forgetful but is able to make her needs known. He stated in the past (could not remember the time), the resident had accusatory behaviors, but that he has not seen the resident manifest this behavior for at least two months. The LPN stated the resident is not combative and does not have any psychotic behaviors, paranoia, delusions or hallucinations. He further stated that the resident does not manifest any behavior other than lack of motivation to do things. The LPN stated the resident needs lots of encouragement to participate in activities and to sit in the chair. During an interview conducted with the assistant Director of Nursing (ADON/staff #9) on (MONTH) 28, 2019 at 2:16 p.m., she stated that it is hard when the pharmacist recommends GDR on residents without behaviors and the provider declines the recommendation. She said for these cases, the resident will be referred to psychiatry for evaluation. Review of the clinical record was conducted with staff #9 during the interview and she stated that the resident was first prescribed [MEDICATION NAME] on (MONTH) 13, (YEAR) and that the resident is still taking the medication. An interview was conducted with the Director of Nursing (DON/staff #16) on (MONTH) 28, 2019 at 5:12 p.m. The DON stated that behaviors are monitored and documented in the clinical record and that she expects staff to report resident behaviors to the provider and social services, and obtain a psychiatry consult. She also stated the CNAs should report resident behaviors to the nurse along with interventions provided to the resident whether the interventions were effective or not. The facility's policy on Behavior Assessment, Intervention and Monitoring described Behavioral or Psychological Symptoms of Dementia (BPSD) as behavioral symptoms in individuals with dementia that cannot be attributed to a specific medical and psychiatric cause. It also included that appropriate assessment and treatment of [REDACTED]. Further, the policy stated, Current guidelines recommend the use of non-pharmacological interventions for BPSD. Continued review of the policy revealed that non-pharmacologic approaches will be utilized to the extent possible to avoid or reduce the use of antipsychotic medications to manage behavioral symptoms; and, documentation will include other approaches and interventions tried prior to the use of antipsychotic medications.
F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** Based on observations, facility documentation, staff interviews and policy review, the facility failed to ensure that quality control testing was performed on three glucometers, per their policy. The deficient practice could result in incorrect glucometer readings which could affect insulin administration, possibly causing adverse consequences. Finding include: During a medication storage observation conducted on (MONTH) 27, 2019 at 1:20 p.m. with a Registered nurse (RN/staff #5), the Glucometer Control Check Record for the month of (MONTH) 2019 was reviewed. According to this form, there were sections to document the following: the date, the high solution control ranges and the results, and the low solution control ranges and results for each day of the month. Further review revealed that on Station 1, there were missing glucometer control solution checks for (MONTH) 7 and 18; on station 2, there were missing glucometer control solution checks for (MONTH) 4, 14 and 16; and on station 3, there were missing glucometer control solution checks on (MONTH) 16, 17, 18, 19, 22, 23 and 24. At this time, an interview was conducted with staff #5, who stated that the glucometer quality control testing is done daily by the night shift and is supposed to be documented on the Glucometer Control Check Records. An interview was conducted with a Registered Nurse (RN/staff #97) on (MONTH) 28, 2019 at 9:34 a.m. The nurse stated that glucometers are calibrated every night during the night shift to make sure the blood sugar readings are correct. She stated that if the calibration is not done every day, there is a possibility that the resident can be under treated or over

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	035207	A. BUILDING _____ B. WING _____	06/28/2019

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SPRINGDALE VILLAGE HEALTHCARE	7255 EAST BROADWAY ROAD MESA, AZ 85208

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F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 12) treated with insulin, due to incorrect blood sugar readings. An interview was conducted on (MONTH) 28, 2019 at 10:08 a.m., with a Licensed Practical Nurse (LPN/staff #81). Staff #81 stated that glucometers are calibrated every day to check if the machine is working properly. Staff #81 said the night shift nurses are responsible for checking and documenting the checks. She stated that if the calibration is not done, they would not know if they are getting correct blood sugar readings on the glucometers. An interview was conducted with the Director of Nursing (DON/staff #16) on (MONTH) 28, 2019 at 3:59 p.m. The DON stated that glucometer calibrations should be done every day on the night shift. She stated that when calibrating the glucometers, they are testing to make sure the glucometers are reading blood sugars correctly. Review of the facility policy for Glucometer Calibration revealed that a control test should be performed every night on each meter. The policy stated that the date, the control lot number, the control range and the test results should be recorded in the glucometer log.
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 observations, clinical record review, staff interviews, facility documentation and policy review, the pharmacist failed to consistently identify in medication reviews of the need for gradual dose reductions (GDRs) for one resident (#13) receiving [MEDICAL CONDITION] medications and the facility also failed to ensure that when [MEDICAL CONDITION] medications continued to be administered, there was documentation by the physician of the clinical rationale as to why the GDR's were contraindicated. The deficient practice could result in resident's receiving [MEDICAL CONDITION] medications that are not necessary and could possibly result in residents experiencing adverse reactions. Findings include: Resident #13 was admitted on (MONTH) 6, (YEAR), with [DIAGNOSES REDACTED]. Regarding the [MEDICATION NAME] ([MEDICAL CONDITION]/antidepressant) medication: Review of a Pharmacy Consultation Report dated (MONTH) 21, (YEAR) revealed the resident has received [MEDICATION NAME] 50 mg at bedtime for [MEDICAL CONDITION] since (MONTH) (YEAR). The report included that CMS (Centers for Medicare & Medicaid Services) regulations require periodic evaluation of all [MEDICAL CONDITION] medications for clinical appropriateness of a gradual dose reduction. Per the report, the pharmacist recommended that the physician review for a possible gradual dose reduction, while concurrently monitoring for re-emergence of depressive and/or withdrawal symptoms; and if therapy is to continue at the current dose, the physician is to provide a rationale describing a dose reduction as clinically contraindicated. The report further included the physician declined the recommendation and marked an X on the section which was pre-printed which read, Continued use is in accordance with the current standard of practice and a GDR attempt at this time is likely to impair this individual's function or cause psychiatric instability by exacerbating an underlying medical condition or psychiatric disorder as documented below. The section for the documentation of the CMS REQUIRED patient-specific rationale describing why a GDR attempt is likely to impair function or cause psychiatric instability was blank. A pharmacy consultation report dated (MONTH) 12, (YEAR) revealed no recommendation by the pharmacist for a GDR regarding the [MEDICATION NAME] medication. Review of the physician orders [REDACTED]. The quarterly MDS (Minimum Data Set) assessment dated (MONTH) 11, (YEAR) included the resident received an antidepressant medication during the last 7 days. A pharmacy consultation report dated (MONTH) 13, (YEAR) revealed no recommendation by the pharmacist for a GDR regarding the [MEDICATION NAME] medication. According to the MARs for April, May, (MONTH) and (MONTH) (YEAR), the resident received [MEDICATION NAME] 50 mg daily. In addition, there was no documentation that a GDR for the [MEDICATION NAME] had been attempted from (MONTH) 8, (YEAR) through (MONTH) (YEAR), nor was there documentation by the physician as to why a GDR was clinically contraindicated. Review of a form titled, Note to Attending Physician/Prescriber completed by the pharmacist dated (MONTH) 14, (YEAR), revealed no recommendation by the pharmacist for a GDR regarding the [MEDICATION NAME]. A physician progress notes [REDACTED]. Per the note, there were no medication changes as she (referring to the resident) has polypharmacy issues. Assessments included depression with a history of [MEDICAL CONDITION] and polypharmacy. Review of the MARs for (MONTH) and (MONTH) (YEAR) revealed the resident received [MEDICATION NAME] 50 mg daily. Review of the Note to Attending Physician/Prescriber completed by the pharmacist dated (MONTH) 10, (YEAR) revealed no recommendation by the pharmacist for a GDR regarding the [MEDICATION NAME]. Review of the Note to Attending Physician/Prescriber completed by the pharmacist dated (MONTH) 7, (YEAR) revealed that Federal guidelines states that psychopharmacological drugs should have an attempt at a gradual dose reduction (GDR) twice per year for the first year in 2 quarters with 1 month between attempts, then annually thereafter, when used to manage behavior, stabilize mood or treat psych disorder. The report stated that current orders include [MEDICATION NAME] 50 mg by mouth at bedtime. The review was signed by the physician/prescriber but was undated, and there was a handwritten note that read follow up with psych. Review of the Note to Attending Physician/Prescriber completed by the pharmacist dated (MONTH) 11, (YEAR) revealed no written recommendation by the pharmacist for a GDR regarding the [MEDICATION NAME] medication. Review of the clinical record from (MONTH) (YEAR) through (MONTH) (YEAR) revealed there was no documentation that a GDR was attempted or that the physician had documented the rationale as to why a GDR was contraindicated. Review of the (MONTH) 2019 physician orders [REDACTED]. Review of the Note to Attending Physician/Prescriber completed by the pharmacist dated (MONTH) 17, 2019 revealed that Federal guidelines states that psychopharmacological drugs should have an attempt at a gradual dose reduction (GDR) twice per year for the first year in 2 quarters with 1 month between attempts, then annually thereafter, when used to manage behavior, stabilize mood or treat psych disorder. The report included that current orders include [MEDICATION NAME] 50 mg by mouth at bedtime. Recommendations included if the physician agrees that the resident is at the 'lowest effective dose' due to the potential that resident condition will decompensate if dose is decreased, please check 'agree' below and further GDR attempts will be clinically contraindicated. The report included to place [MEDICATION NAME] 50 mg at bedtime at LED (lowest effective dose). The review was signed on (MONTH) 4, 2019 by the physician/prescriber and a handwritten note which read follow up with psych. Review of the Note to Attending Physician/Prescriber completed by the pharmacist dated (MONTH) 12, 2019 included the resident was taking 25 scheduled medications and for the physician to please evaluate the continued use of these medications. Recommendations included to decrease [MEDICATION NAME] from 50 mg by mouth at bedtime to [MEDICATION NAME] 50 mg by mouth at bedtime as needed for [MEDICAL CONDITION] for 14 days. The 'agree' box in the section on the physician/prescriber response was marked and the note was signed by the physician on (MONTH) 18, 2019. Review of the MAR from (MONTH) 2019 through (MONTH) 17, 2019 revealed the resident continued to receive [MEDICATION NAME] 50 mg daily. There was no clinical record documentation that a GDR was attempted or that the physician documented the clinical rational as to why a GDR was contraindicated regarding the [MEDICATION NAME] from (MONTH) 2019 through (MONTH) 17, 2019. A physician's orders [REDACTED]. Regarding the [MEDICATION NAME] (antipsychotic) medication: Review of a pharmacy consultation report dated (MONTH) 21, (YEAR) revealed the resident has received [MEDICATION NAME] 6 mg for [MEDICAL CONDITION] since (MONTH) (YEAR). The documentation to the physician included that CMS regulations require periodic evaluation of all [MEDICAL CONDITION] medications for clinical appropriateness of a gradual dose reduction. The review included the pharmacist recommended for the physician to review for a possible gradual dose reduction, while concurrently monitoring for re-emergence of depressive and/or withdrawal symptoms; and if therapy is to continue at the current dose for the physician to provide a rationale describing a dose reduction as clinically contraindicated. Per the report, the physician declined the recommendation and marked an X on the section that stated Continued use is in accordance

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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F 0756

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

(continued... from page 13)
with the current standard of practice and a GDR (gradual dose reduction) attempt at this time is likely to impair this individual's function or cause psychiatric instability by exacerbating an underlying medical condition or psychiatric disorder as documented below. However, the section for the documentation of the CMS REQUIRED patient-specific rationale was blank.
Review of the (MONTH) (YEAR) physician orders [REDACTED]. (The order had an original order date of (MONTH) 13, (YEAR)).
The pharmacy consultation report dated (MONTH) 12, (YEAR) revealed no written recommendation by the pharmacist for a GDR regarding the use of [MEDICATION NAME].
A care plan for the use of [MEDICAL CONDITION] medication identified the resident uses [MEDICATION NAME] due to dementia
with accusatory/paranoid behaviors. Interventions included to administer medications as ordered and to consult with pharmacy and the physician to consider dose reduction when clinically appropriate.
A significant change in status MDS assessment dated (MONTH) 4, (YEAR) included the resident received an antipsychotic medication during the last 7 days. Per the MDS, the resident received an antipsychotic on a routine basis, that no GDR had been attempted and there was no physician documentation that a GDR was clinically contraindicated.
Review of the behavior monitoring records from (MONTH) (YEAR) through (MONTH) (YEAR) revealed the resident exhibited accusatory behaviors on the morning shift as follows: two episodes on (MONTH) 11, three episodes on (MONTH) 7, three episodes on (MONTH) 8, and two episodes on (MONTH) 27.
The pharmacy consultation report dated (MONTH) 13, (YEAR) revealed no written recommendation by the pharmacist for a GDR regarding the [MEDICATION NAME] medication.
According to the MARs, [MEDICATION NAME] 6 mg daily continued to be administered from (MONTH) 8, (YEAR) through (MONTH)
(YEAR).
Review of the clinical record revealed there was no documentation that a GDR was attempted or of physician documentation as to why the GDR was contraindicated from (MONTH) 8, (YEAR) through (MONTH) (YEAR).
A psychiatric consultation note dated (MONTH) 21, (YEAR) revealed the resident had delusions but did not have hallucinations. The assessment included [MEDICAL CONDITION] and [MEDICAL CONDITION] without behavior disturbances. [MEDICATION NAME] was not listed as a current medication.
Review of the physician orders [REDACTED].
Review of the Note to Attending Physician/Prescriber completed by the pharmacist dated (MONTH) 14, (YEAR) revealed no written recommendation by the pharmacist for a GDR regarding the [MEDICATION NAME] medication.
The physician progress notes [REDACTED]. Per the note, there were no medication changes as she (referring to the resident) has polypharmacy issues. Assessments included depression with a history of [MEDICAL CONDITION] and polypharmacy. Medications included [MEDICATION NAME] as atypical [MEDICAL CONDITION] for depression with psychotic features. However, the documentation did not specify what psychotic behaviors the resident had.
Review of the Note to Attending Physician/Prescriber completed by the pharmacist dated (MONTH) 10, (YEAR) revealed no written recommendation by the pharmacist for a GDR regarding the [MEDICATION NAME] medication.
The quarterly MDS assessment dated (MONTH) 11, (YEAR) included the resident received an antipsychotic medication on a routine basis during the last 7 days, that no GDR had been attempted and there was no physician documentation that a GDR was clinically contraindicated.
Review of the Note to Attending Physician/Prescriber completed by the pharmacist dated (MONTH) 7, (YEAR) revealed printed documentation which stated that Federal guidelines include that psychopharmacological drugs should have an attempt at a gradual dose reduction (GDR) twice per year for the first year in 2 quarters with 1 month between attempts, then annually thereafter, when used to manage behavior, stabilize mood or treat psych disorder. The report further stated that current orders include [MEDICATION NAME] 6 mg by mouth every morning. The review was signed by the physician/prescriber but was undated, and there was a handwritten note which read follow up with psych.
An NP note dated (MONTH) 16, (YEAR) included the resident was alert and doing well. The assessment included current, moderate major [MEDICAL CONDITION] and paranoid disorders.
Review of a psychiatric consultation note dated (MONTH) 27, (YEAR) revealed the resident was alert and oriented to self, place, time, day and month. Per the note, the resident had delusions but did not have hallucinations and had [MEDICAL CONDITION] and [MEDICAL CONDITION] without behavior disturbances. [MEDICATION NAME] was not listed as a current medication.Review of the Note to Attending Physician/Prescriber completed by the pharmacist dated (MONTH) 11, (YEAR) revealed no
written recommendation by the pharmacist for a GDR regarding the [MEDICATION NAME] medication.
Review of the behavior monitoring records from (MONTH) (YEAR) through (MONTH) (YEAR) revealed the resident did not exhibit any delusional, paranoid or accusatory behaviors.
According to the MARs, the resident continued to receive [MEDICATION NAME] 6 mg daily from (MONTH) (YEAR) through (MONTH)
(YEAR).
Continued review of the clinical record revealed there was no evidence that a GDR was attempted or that there was physician documentation as to why a GDR was clinically contraindicated from (MONTH) (YEAR) through (MONTH) (YEAR).
Review of the (MONTH) 2019 physician orders [REDACTED].
Review of the psychiatric consultation note dated (MONTH) 7, 2019 revealed the resident had delusions but did not have hallucinations. The assessment included [MEDICAL CONDITION] and [MEDICAL CONDITION] without behavior disturbances. Current
medication included for [MEDICATION NAME] 6 mg daily.
Review of the Note to Attending Physician/Prescriber completed by the pharmacist dated (MONTH) 17, 2019 revealed that Federal guidelines states that psychopharmacological drugs should have an attempt at a gradual dose reduction (GDR) twice per year for the first year in 2 quarters with 1 month between attempts, then annually thereafter, when used to manage behavior, stabilize mood or treat psych disorder. The report also included that there were current orders for [MEDICATION NAME] 6 mg by mouth every morning. Recommendations included that if the physician agrees that the resident is at the 'lowest effective dose' due to the potential that resident condition will decompensate if dose is decreased, please check 'agree' below and further GDR attempts will be clinically contraindicated. The section for the physician/prescriber to indicate if they agreed or disagreed was left blank. The review was signed by the physician/prescriber on (MONTH) 4, 2019, with a handwritten note that read follow up with psych. There was also no rationale documented for continuing its use.
According to the behavior monitoring records from (MONTH) 2019 through (MONTH) 31, 2019, the resident did not exhibit any accusatory or paranoid behaviors.
Review of the CNA behavior notes from (MONTH) 2019 through (MONTH) 2019 revealed the resident did not exhibit any behaviors.
Review of the MARs revealed the resident continued to receive [MEDICATION NAME] 6 mg daily from (MONTH) 2019 through (MONTH) 2019.
Review of the Note to Attending Physician/Prescriber completed by the pharmacist dated (MONTH) 12, 2019 included the resident was taking 25 scheduled medications. A note to the physician/prescriber included to please evaluate the continued use for the medications. In the section to indicate if the physician/prescriber agreed or disagreed revealed agree was checked. However, there were no recommendations regarding the [MEDICATION NAME] medication.
The annual MDS assessment dated (MONTH) 13, 2019 included the resident received an antipsychotic medication during the last 7 days on a routine basis, that no GDR had been attempted and there was no physician documentation that a GDR was clinically contraindicated.
Review of the Note to Attending Physician/Prescriber completed by the pharmacist dated (MONTH) 11, 2019 included that Federal guidelines states that psychopharmacological drugs should have an attempt at a gradual dose reduction (GDR) twice per year for the first year in 2 quarters with 1 month between attempts, then annually thereafter, when used to manage behavior, stabilize mood or treat psych disorder. The report also stated that current orders included for [MEDICATION NAME] 6 mg by mouth every morning. Recommendations included choices to decrease [MEDICATION NAME] to 3 mg by mouth every morning or [MEDICATION NAME] is at LED. The report had a handwritten note on the side which read needs review by the psychiatry NP. Under the section for physician/prescriber response, the box for 'disagree' was marked and a handwritten note dated (MONTH) 4, 2019 by the psychiatry NP read client has significant history of [MEDICAL CONDITION], acting out behaviors, falls prior to [MEDICATION NAME] at this dose. Decreasing dose would exacerbate s/s (signs and symptoms).
However, further review of the clinical record from (MONTH) 2019 through (MONTH) 2019 revealed no documentation that the resident exhibited ongoing psychotic behaviors related to the use of the antipsychotic. There was also no evidence found in the clinical record that a GDR for [MEDICATION NAME] was attempted, nor was there documentation by the physician of the

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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F 0756 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 14) clinical rationale for it's continued use. According to the MARs, the resident continued to receive [MEDICATION NAME] 6 mg daily from (MONTH) 8, 2019 through (MONTH) 25, 2019. Multiple observations of resident #13 were conducted on (MONTH) 27 and 28, 2019, at various times of the day. During the observations, the resident was observed laying in bed sleeping each time. An interview with a pharmacist (staff #161) was conducted on (MONTH) 28, 2019 at 8:23 a.m. Staff #161 stated she started as the pharmacist at the facility in (MONTH) (YEAR). She stated that she conducts monthly chart reviews and make recommendations if needed. She stated every morning between 4:00 a.m. and 5:00 a.m., she checks the electronic record of all the admissions from the previous day. She stated she reviews the hospital records/orders and reviews all medications for any discrepancies. Staff #161 said the goal was to ensure that at 7:00 a.m., the physician can review her recommendations if any. She said that every month all residents who are due for GDR's are reviewed and recommendations are made by her to decrease or discontinue the medications. She said if a resident still has behaviors based on her review, she may not necessarily recommend a GDR. However, she said if a resident does not manifest or exhibit any behaviors, she will recommend the GDR and will continue to do, so even if the provider declines it. She stated when the provider declines her recommendation, she will try again the following month; and if she is having problems with the provider regarding a GDR, she will discuss it in the monthly QAPI meeting and talk about the issue with the medical director. Regarding resident #13, staff #161 stated that resident had 25 medications which she was successful in the discontinuation of these medications. She stated the resident was on [MEDICATION NAME] which was recently discontinued per her recommendation. She also stated the resident was on [MEDICATION NAME] for dementia with behaviors. She said on (MONTH) (YEAR), (MONTH) 17, 2019 and (MONTH) 2019, she made recommendations to decrease the dose of [MEDICATION NAME] from 6 mg to 3 mg, but the psychiatry provider declined and she did not know why. An interview with a LPN (staff #77) was conducted on (MONTH) 28, 2019 at 12:55 p.m. He stated if a resident is prescribed or admitted with [MEDICAL CONDITION] medications, the resident will be reassessed after 7 days and then every 30 days for effectiveness of the medication. He stated the physician is updated on changes in the resident's behaviors. He said the pharmacist also reviews the resident's records and makes recommendations. Staff #77 said if the resident does not manifest the target behavior for a month or so, he will inform the physician and ask if the physician would like to decrease or discontinue the medication. In an interview with the assistant director of nursing (ADON/staff #9) conducted on (MONTH) 28, 2019 at 2:16 p.m., she stated the number of behaviors are monitored and documented in the clinical record every shift. She stated the pharmacist keeps a log of residents due for a GDR and makes recommendations as appropriate. Staff #9 said this issue is also discussed in the monthly QAPI meeting. She said when pharmacy recommendations are forwarded to the provider, they will agree or disagree with the recommendation. She stated the provider is supposed to write a reason why he/she disagrees. She said it's hard when the pharmacist's recommends a GDR especially on residents without behaviors and the provider declines the recommendation. She said in these cases, the resident will be referred to a psychiatry consult for evaluation. During this interview, the resident's clinical record was reviewed with staff #9. She stated the resident was first prescribed [MEDICATION NAME] on (MONTH) 13, (YEAR), and that the resident is still taking the medication. She stated that [MEDICATION NAME] was first prescribed on (MONTH) 27, (YEAR) and it was just recently discontinued. Review of a policy on [MEDICAL CONDITION] Medication revealed that physicians and mid-level providers will use [MEDICAL CONDITION] medications appropriately, working with the interdisciplinary team to ensure appropriate use, evaluation and monitoring. The policy included that the primary care physician, PA (physician assistant) or NP is responsible for the attempt of a GDR and decrease or discontinuation of [MEDICAL CONDITION] medications after no more than 3 months unless clinically contraindicated. Gradual dose reductions must be attempted in 2 separate quarters (with at least one month between attempts). Gradual dose reductions must be attempted annually thereafter or as the resident's clinical condition warrants. The policy further stated that nursing staff reviews the use of the medication with the physician and the interdisciplinary team on a quarterly basis to determine the continued presence of target behaviors. The pharmacist monitors [MEDICAL CONDITION] drug use to ensure that medications are not used in excessive doses or for excessive duration; and notifies the physician and the nursing unit, whenever a [MEDICAL CONDITION] medication is past due for review.
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 and policy review, the facility failed to ensure there was adequate indications for the use of [MEDICAL CONDITION] medications for one of five sampled residents (#13), and that GDR (gradual dose reductions) were attempted within the required timeframe or that there was documentation by the physician of the clinical rationale as to why GDRs were contraindicated. The deficient practice could result in residents receiving [MEDICAL CONDITION] medications that are not necessary. Findings include: Resident #13 was admitted on (MONTH) 6, (YEAR), with [DIAGNOSES REDACTED]. -Regarding [MEDICATION NAME] (antidepressant): Review of the physician order [REDACTED]. The [MEDICATION NAME] order was discontinued (MONTH) 18, 2019. The pharmacy consultation reports dated (MONTH) 12, (YEAR), (MONTH) 13, (YEAR), and (MONTH) 14, (YEAR) revealed no recommendation by the pharmacist for a GDR regarding [MEDICATION NAME] medication. The NP (nurse practitioner) note dated (MONTH) 21, (YEAR) revealed the resident was alert and oriented x 3 and included the resident was sleeping well. The pharmacist note to the attending physician dated (MONTH) 10, (YEAR) revealed no recommendation by the pharmacist for a GDR regarding [MEDICATION NAME] medication. Review of the pharmacist note to the physician dated (MONTH) 7, (YEAR) revealed the resident's current orders included [MEDICATION NAME] 50 mg by mouth at bedtime but did not include a recommendation for a GDR. The NP note dated (MONTH) 16, (YEAR) revealed the resident had no sleep disturbances. The pharmacist review note dated (MONTH) 11, (YEAR) revealed no recommendation by the pharmacist for a GDR regarding [MEDICATION NAME] medication. The NP note dated (MONTH) 29, 2019 included the resident had no sleep disturbances. Review of the pharmacist note to the physician dated (MONTH) 17, 2019 revealed a recommendation that if the physician agree that resident is at 'lowest effective dose' due to the potential that resident condition will decompensate if dose is decreased, please check 'agree' below and further GDR attempts will be clinically contraindicated It also included to place [MEDICATION NAME] 50 mg at bedtime at LED (lowest effective dose). The response was a handwritten note to follow up with psych. The pharmacist note to the physician dated (MONTH) 12, 2019 included a recommendation to decrease [MEDICATION NAME] from 50 mg by mouth at bedtime to [MEDICATION NAME] 50 mg by mouth at bedtime as needed for [MEDICAL CONDITION] for 14 days. The physician's response dated (MONTH) 18, 2019 was an X in the agree box. Review of the MAR (Medication Administration Record) from (MONTH) (YEAR) through (MONTH) 17, 2019 revealed the resident was administered [MEDICATION NAME] as ordered. Review of the behavior monitoring from (MONTH) 1, (YEAR) through (MONTH) 18, 2019 revealed the resident did not exhibit any episodes of sleeplessness or complaints of [MEDICAL CONDITION]. A physician order [REDACTED]. Continued review of the clinical record revealed no evidence that a GDR was attempted before (MONTH) 18, 2019, nor documentation by the physician of the clinical rationale as to why a GDR was contraindicated.

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	035207	A. BUILDING _____ B. WING _____	**06/28/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SPRINGDALE VILLAGE HEALTHCARE	**7255 EAST BROADWAY ROAD MESA, AZ 85208**

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 0758

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

(continued... from page 15)
-Regarding [MEDICATION NAME] (antipsychotic)
Review of the recapitulation of physician's orders [REDACTED].
Review of the care plan initiated on (MONTH) 13, (YEAR) and revised (MONTH) 5, 2019, revealed the resident used the [MEDICAL CONDITION] medication [MEDICATION NAME] related to dementia with accusatory/paranoid behaviors. Interventions included
administering the [MEDICAL CONDITION] medication as ordered, consulting with pharmacy and for the physician to consider a dose reduction when clinically appropriate.
The SCIS (significant change in status) MDS assessment dated (MONTH) 4, (YEAR) revealed resident had no hallucinations, delusions or behaviors exhibited during the last 7 days. The assessment included the resident was administered an antipsychotic medication for the 7 days of the look-back period and that a GDR had not been attempted and that the physician had not documented GDR as clinically contraindicated.
The behavior monitoring from (MONTH) 1, (YEAR) through (MONTH) 30, (YEAR) revealed the resident had accusatory behavior on
the following dates on the morning shift:
-3 episodes on (MONTH) 7, (YEAR)
-3 episodes on (MONTH) 8, (YEAR)
-2 episodes on (MONTH) 27, (YEAR)
Review of the clinical record including the Medication Administration Record (MAR) from (MONTH) 1, (YEAR) through (MONTH) 31, (YEAR) revealed the resident was monitored for accusatory behaviors and that the resident did not exhibit accusatory behavior.
The CNA (Certified Nursing Assistant) behavioral documentation from (MONTH) 1, (YEAR) through (MONTH) 31, (YEAR) revealed no behavioral symptoms coded for the resident.
Continued review of the clinical record revealed the resident was not being monitored for paranoid behaviors and no evidence was found in the clinical record the resident exhibited paranoid behaviors (MONTH) 1, (YEAR) through (MONTH) 31, (YEAR).
The pharmacist notes to the attending physician dated (MONTH) 13, (YEAR), (MONTH) 14, (YEAR), and (MONTH) 10, (YEAR), revealed no recommendation by the pharmacist for a GDR regarding [MEDICATION NAME] medication.
The pharmacist Medication Regimen Review dated (MONTH) 7, (YEAR) included a note to the physician with a recommendation to decrease [MEDICATION NAME] ER to 3 mg by mouth every day. The physician/prescriber response was a handwritten note follow up with psych.
Review of the physician note dated (MONTH) 16, (YEAR), revealed the resident had depression with a history of [MEDICAL CONDITION] and that the resident was receiving [MEDICATION NAME] 6 mg every am for depression with psychotic features. The
documentation did not include what psychotic features the resident had or anything regarding a GDR for [MEDICATION NAME].
The psychiatric consultation/follow up note dated (MONTH) 27, (YEAR) revealed it was a psychiatric follow up for medication review. The note included the resident was alert and oriented to self, place, time, day, month, season, current events and situation. However, the note did not include anything regarding [MEDICATION NAME].
The pharmacist note to the attending physician dated (MONTH) 11, (YEAR) revealed no recommendation by the pharmacist for a GDR regarding [MEDICATION NAME] medication.
Review of the MARs for (MONTH) (YEAR), (MONTH) (YEAR), and (MONTH) 2019 revealed the resident was being monitored for
accusatory behaviors and that the resident did not exhibit any accusatory behaviors for this time period.
Continued review of the clinical record revealed the resident was not being monitored for paranoid behaviors.
The CNA behavioral documentation from (MONTH) 1, (YEAR) through (MONTH) 31, 2019 revealed no behavioral symptoms coded for
the resident.
The psychiatric consultation/follow up note dated (MONTH) 9, 2019 revealed the resident was alert and oriented to self, place, time, day, month, season, situation and current events. The note included the resident did not have hallucinations but had delusions. The note also included the resident was receiving [MEDICATION NAME] 6 mg by mouth daily and to continue the same medications for now.
The quarterly MDS assessment dated (MONTH) 11, 2019 revealed the resident had no hallucinations, delusions or behaviors exhibited during the last 7 days.
Review of the psychiatric consultation/follow up note dated (MONTH) 7, 2019 revealed the resident was alert and oriented and most recently has been more active and out of her room nearly every day. The note included the resident remains on multiple medications including [MEDICATION NAME] 6 mg but that her moods and behaviors are relatively stable and to continue the medications for now. The note also included the resident had [MEDICAL CONDITION] and [MEDICAL CONDITION] without behavior
disturbances.
The pharmacist Medication Regimen Review dated (MONTH) 17, 2019 included a note to the physician that if the resident is at the lowest effective dose due to the potential the resident's condition will decompensate if the dose is decreased, please check agree below and further GDR attempts will be clinically contraindicated. It also included an instruction to place [MEDICATION NAME] 6 mg by mouth every morning at LED (lowest effective dose). The physician/prescriber response was a handwritten note follow up with psych.
Review of the behavior monitoring from (MONTH) 1, 2019 through (MONTH) 31, 2019 revealed 0 indicating the resident did not have accusatory behavior.
The CNA (certified nursing assistant) documentation of behaviors from (MONTH) 1, 2019 through (MONTH) 31, 2019 revealed the resident did not have any behaviors.
A physician order [REDACTED].
This order was transcribed onto the MAR for (MONTH) 2019 and monitoring of paranoid behaviors was started on the 2:00 p.m. to 10:00 p.m. shift on (MONTH) 5, 2019.
Review of the behavior monitoring from (MONTH) 5 - 31, 2019 revealed the resident did not have any behaviors of paranoia.
The pharmacy review note dated (MONTH) 12, 2019 included the resident was taking 25 scheduled medications and a note to the physician to please evaluate the continued use for the medications. However, there were no recommendations regarding [MEDICATION NAME] medication.
The pharmacist Medication Regimen Review dated (MONTH) 11, 2019 included a note to the physician that included a recommendation to either decrease [MEDICATION NAME] to 3mg by mouth every morning or that [MEDICATION NAME] is at the LED
due to _____. The note included a handwritten note that it needs review by the psych Nurse Practitioner (NP). The NP response was that the resident has significant history of [MEDICAL CONDITION] and acting out behaviors and that decreasing the dose would exacerbate the signs and symptoms.
Review of the behavior monitoring from (MONTH) 1, 2019 through (MONTH) 25, 2019 revealed the resident did not have accusatory behaviors.
Review of the monitoring for paranoid behaviors revealed the resident had no paranoid behaviors from (MONTH) 1 through (MONTH) 25, 2019.
Review of the nursing progress notes from (MONTH) 1, (YEAR) through (MONTH) 25, 2019 revealed no evidence the resident exhibited accusatory and/or paranoid behaviors.
During multiple observations conducted on (MONTH) 27, 2019 and (MONTH) 28, 2019, the resident was observed in her room sleeping in her bed. The resident was not observed to have interaction with her roommate.
An interview was conducted with a pharmacist (staff #161) on (MONTH) 28, 2019 at 8:23 a.m. Staff #161 stated that she started as the pharmacist at the facility in (MONTH) (YEAR). She stated every month all residents that are due for GDR are reviewed and recommendations to decrease or discontinue the medications are sent to the physician. She said if a resident still has behaviors based on her review, she may not necessarily recommend a GDR. The pharmacist stated that if or when the resident does not manifest or exhibit any behaviors, she will recommend a GDR. She stated that she will continue to recommend the GDR until the physician declines it. Staff #161 stated that when the physician declines her recommendation, she will try again the following month. The pharmacist stated that if she is having problems with a provider regarding a GDR, she will discuss it in the monthly QAPI meeting with the medical director.
Regarding resident #13, staff #161 stated the resident was on [MEDICATION NAME] which was recently discontinued per her recommendation. She also stated the resident was receiving [MEDICATION NAME] for dementia with behaviors. The pharmacist further stated she made recommendations to decrease the dose of [MEDICATION NAME] from 6 mg to 3 mg in (MONTH) (YEAR),
(MONTH) 17, 2019, and (MONTH) 2019 but that the psych provider declined the recommendations and she does not know why.
In an interview conducted with a Certified Nursing Assistant (CNA/staff #23) on (MONTH) 27, 2019 at 9:40 a.m., she stated

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 16) the resident is alert and oriented but can be confused at times. She stated the resident attends activities or eats in the dining room depending on her mood. She stated yelling is the only behavior the resident has. The CNA stated the resident can be verbally aggressive and that she tells her roommate to shut up but that it usually happens when the resident is confused. The CNA stated that she has not seen the resident having behaviors, hallucinations or delusions. An interview was conducted with a Licensed Practical Nurse (LPN/staff #77) on (MONTH) 28, 2019 at 12:55 p.m. The LPN stated that if a [MEDICAL CONDITION] medication is prescribed for a resident, the resident will be reassessed to see if the medication is effective or not on the 7th day and every 30 days. He stated the physician is notified of any changes in the resident's behaviors. He stated that behaviors are monitored every shift and are documented on the MAR which includes the number of times the behavior occurred or was observed during the shift, what interventions were implemented, and whether the interventions were effective or not. The LPN said the pharmacist will review the resident's clinical record and make recommendations. He further stated that if the resident does not manifest the target behavior for a month or so, he will inform the physician and ask the physician if he/she would like to decrease or discontinue the medication. Regarding resident #13, the LPN stated the resident is alert and oriented, can be forgetful but is able to make her needs known. He stated in the past (could not remember the time), the resident had accusatory behaviors, but that he has not seen the resident manifest this behavior for at least two months. The LPN stated the resident is not combative and does not have any psychotic behaviors, paranoia, delusions or hallucinations. He further stated that the resident does not manifest any behavior other than lack of motivation to do things. The LPN stated the resident needs lots of encouragement to participate in activities and to sit in the chair. During an interview conducted with the assistant Director of Nursing (ADON/staff #9) on (MONTH) 28, 2019 at 2:16 p.m., the ADON stated behaviors are monitored and the number of behaviors exhibited is documented in the clinical record every shift. She stated the pharmacist keeps a log of residents due for GDR and make recommendations as appropriate to the physician. The ADON stated the pharmacist recommendations are then forwarded to the physician who will agree or disagree with the recommendation. She stated that if the physician disagrees, the physician is supposed to write a reason why he/she disagrees. The ADON stated that it is hard when the pharmacist recommends GDR on residents without behaviors and the provider declines the recommendation. She said for these cases, the resident will be referred to psychiatry for evaluation. Review of the clinical record was conducted with staff #9 during the interview; she stated that the resident was first prescribed [MEDICATION NAME] (MONTH) 13, (YEAR) and that the resident is still taking the medication and that [MEDICATION NAME] was first prescribed (MONTH) 27, (YEAR) and was just recently discontinued. The ADON also stated that GDR are discussed in the monthly QAPI (Quality Assurance and Performance Improvement) meeting. The facility's policy titled [MEDICAL CONDITION] Medication dated (MONTH) (YEAR) revealed physicians and mid-level providers will use [MEDICAL CONDITION] medications appropriately working with the Interdisciplinary team (IDT) to ensure appropriate use, evaluation and monitoring. Gradual dose reduction must be attempted annually after the first year or as the resident's condition warrants. The policy included nursing will monitor for the presence of target behaviors on a daily basis charting when the behaviors are present. Nursing reviews the use of the medication with the physician and the IDT on a quarterly basis to determine the continued presence of target behaviors. The policy also included the pharmacist monitors [MEDICAL CONDITION] drug use to ensure that medications are not used in excessive doses or for excessive duration and participates in the IDT quarterly review of residents on psychoactive medications. The policy included the Medical Director identifies any resident care or potential regulatory issues with the use of [MEDICAL CONDITION] medications and discusses it with the medical staff as appropriate.
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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews and policy review, the facility failed to ensure that expired medications were discarded and not available for use. The deficient practice could result in residents receiving expired medications. The facility census was 82 residents. Findings include: During an observation conducted on (MONTH) 26, 2019 at 1:20 p.m. with the Charge Nurse (staff #5), one prefilled [MEDICATION NAME] syringe 0.3 mg was found in the Station 1 medication room. The [MEDICATION NAME] syringe had an expiration date of (MONTH) 2019. At this time, staff #5 stated that the medication should not have been in the medication room, as it was expired. An interview was conducted with the Director of Nursing (DON/staff #16) on (MONTH) 28, 2019 at 3:59 p.m. The DON stated that there shouldn't be any expired medications in the medication room. Review of the facility policy regarding the Storage of Medications revealed Discontinued, outdated or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, Center for Disease Control guidelines and policy review, the facility failed to ensure that one housekeeping staff implemented infection control measures, while cleaning a resident's room who was on contact isolation for [MEDICAL CONDITIONS]. The deficient practice could result in the spread of infection. Findings include: During an observation conducted on (MONTH) 27, 2019 at 6:56 a.m., there was a housekeeper's (staff #157) cleaning cart outside a resident's room who was on isolation precautions for [MEDICAL CONDITION]. Before entering the room, staff #157 donned a gown and gloves and grabbed two wash cloths and a sporicidal disinfectant cleanser. Staff #157 then entered the room with these items. She then squirted the disinfectant from the bottle onto the rags and wiped down the bed, side table, bed rails, phone, bathroom doors and sink. She then went to the cart which was by the door and disposed of the rags in a white trash bag and placed the disinfectant bottle back in the cart. Staff #157 did not wipe down the bottle of disinfectant, prior to putting it back in the cleaning cart. Staff #157 then changed gloves and mopped the room and disposed of the mop head in the white trash bag and wiped the mop stick with bleach, before putting it back on the cart. When staff #157 was done cleaning the room, she disposed of the gloves and proceeded to the nurse's station where she washed her hands in the sink. Following the observation an interview was conducted with staff #157, who stated that she should have cleaned the bottle of disinfectant, before placing it back in the cart. An interview was conducted with the Director of Nursing (DON/staff #16) on (MONTH) 28, 2019 at 3:59 p.m. The DON stated if staff take something with them into an isolation room for [MEDICAL CONDITION], the item needs to be cleaned with the bleach wipes and their hands should be washed, prior to leaving the isolation room. Review of the facility policy titled Contact isolation revealed that when exiting an isolation room staff should disinfect all tools utilized to clean the [MEDICAL CONDITION] room using the EPA approved solution. Review of the CDC guidelines revealed that [MEDICAL CONDITION] spores are transferred to patients mainly via the hands of people who have touched a contaminated surface or item. [MEDICAL CONDITION] spores can live for months or sometimes years on surfaces. For prevention of transmission of [MEDICAL CONDITION] in healthcare settings, use contact precautions for patients with known or suspected [MEDICAL CONDITION]. The guidelines included to use gloves and gowns when entering patient rooms and during care, and for all interactions that may involve contact with patient or potentially contaminated areas in the patients environment. The guidelines included that before exiting the patient room, discard gowns and gloves, and wash hands to contain the [MEDICAL CONDITION] pathogens. The guidelines further stated to clean and disinfect surfaces that are likely to be contaminated with pathogens.
F 0947 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure nurse aides have the skills they need to care for residents, and give nurse aides**

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F 0947 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 17) **education in dementia care and abuse prevention.** Based on personnel file review, interviews, and policy review, the facility failed to ensure two of two sampled Certified Nursing Assistants (CNA/#52 and #65) had no less than 12 hours per year of required in-service training to ensure the continuing competence of the nurse aides. The deficient practice failed to ensure the continuing competence of the CNAs. The facility census was 82 residents. Findings include: -Review of the personnel file for a CNA (staff #52), revealed a hire date of (MONTH) 8, (YEAR), for full time employment. The personnel file contained documentation that the CNA had received orientation upon hire for dementia care, behavioral health care, resident's rights, and abuse prevention. Further review of the file revealed the CNA had received two in-service trainings during 2019, for general topics and survey readiness. Each in-service was 30 minutes long. The file did not contain any evidence of additional in-service training. -Review of the personnel record for a CNA (staff #65), revealed a hire date of (MONTH) 21, (YEAR), for full time employment. There was no evidence in the file that the CNA had received orientation upon hire. The CNA received two in-service trainings during 2019, for general topics and survey readiness. Each in-service was 30 minutes long. The file did not contain any evidence of additional in-service training. An interview was conducted on (MONTH) 28, 2019 at 2:17 p.m., with the Director of Nursing (DON/staff #16). She stated that she was not able to find records of 12 hours of annual training for staff #52 and #65. In follow-up interviews later that day, the DON stated that sixty minute meetings were held each month for all staff members to address identified areas of concern, however, she was only able to find two in-service sign-in sheets with signatures for staff #52 and #65, one for general topics and one for survey readiness. An interview was conducted on (MONTH) 28, 2019 at 4:45 p.m., with the Assistant DON (staff #9). She stated the facility did not have a policy for nurse aide training and in-service. Review of the facility's policy regarding Competency of Nursing Staff revealed the staff development and training program was created by nursing leadership, with input from the medical director, and is designed to train nursing staff to deliver individualized, safe, quality care and services for the residents. The policy also revealed the facility assessment includes an evaluation of the staff competencies that are necessary to provide level and types of care specific to the resident population.