STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **035297**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **09/25/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SURPRISE HEALTH AND REHABILITATION CENTER	**14660 W PARKWOOD DRIVE SURPRISE, AZ 85374**

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 0658

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure services provided by the nursing facility meet professional standards of quality.
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on observations, clinical record review, staff interviews and review of policy and procedures, the facility failed to ensure that medication was administered in accordance with the physician's orders [REDACTED].#103). The deficient practice could result in residents experiencing complications from not receiving medications as ordered.
Findings include:
Resident #103 was admitted to the facility on (MONTH) 20, 2019, with [DIAGNOSES REDACTED].
A physician's orders [REDACTED].
A care plan dated (MONTH) 21, 2019 revealed the resident had [MEDICAL CONDITION]/SOB related to age, and [MEDICAL CONDITION] changes/spine curvature. A goal was that the resident would display optimal breathing pattern daily. Interventions were to
give [MEDICATION NAME][MEDICATION NAME] as ordered and to monitor/document any side effects and effectiveness.
Review of the Medication Administration Record (MAR) for (MONTH) 2019 revealed that the [MEDICATION NAME]-[MEDICATION NAME]
Solution had not been administered on four occasions (September 21, 23, and 25 at midnight and (MONTH) 25 at 6:00 a.m.).
The MAR included a code of 6, which indicated the resident was sleeping.
Review of the nursing progress notes from (MONTH) 21 to (MONTH) 25 2019, revealed no documentation as to why the [MEDICATION NAME]-[MEDICATION NAME] Solution was not administered or of any communication with the provider regarding the omitted
doses, until (MONTH) 25, at 9:56 a.m.
The nursing note dated (MONTH) 25, 2019 at 9:56 a.m., now included that the nurse had spoken to the physician about the resident not receiving the midnight dose due to sleeping and that new orders were received to change the order to PRN (as needed).
Review of the provider progress notes from (MONTH) 21 to (MONTH) 25, 2019 revealed no documentation that the [MEDICATION NAME]-[MEDICATION NAME] Solution was not administered or of communication regarding the omitted doses.
An interview was conducted with a Licensed Practical Nurse (LPN/staff #27) on (MONTH) 25, 2019 at 9:10 a.m. She stated that the nurses need to follow the provider's orders as written. She stated if the MAR did not reflect a check mark, and instead contained a code of 6 (sleeping), the dose was not administered. She stated that if a resident was sleeping at the time a medication was scheduled to be given, the resident should have been woken up and the medication administered. She stated that if the medication was not given the nurse should notify the physician, and document an assessment of the resident and the communication with the physician. At this time, staff #27 reviewed the MAR and stated that the nurse did not follow the facility's expectations for following the provider's orders and for medication administration. She said the medication was a scheduled medication and it should have been given as ordered. She stated the omission of the medication would increase the resident's risk for shortness of breath. She stated that she followed the nurse who held the medication on (MONTH) 25, 2019 at midnight and 6:00 a.m., and the nurse did not communicate in report that the scheduled medication had not been given.
An interview was conducted with the Director of Nursing (DON/staff #47) on (MONTH) 25, 2019 at 9:25 a.m. She stated the expectation is for nurses to follow the physician's orders [REDACTED]. She stated that a nurse may hold a medication based on nursing judgement, but the nurse would then be expected to notify the provider and document the reason why the medication was held, and document the provider communication in the medical record. She stated that if a medication is ordered to be given during the night or in the early morning hours, and there is no order for the medication to be given while awake, then the resident should be woken up and the medication administered. She stated that if the nurse is unable to administer the medication, there should be documentation that the provider was notified that the medication was held, and the nurse should obtain a clarification order if needed (obtain an order to give the medication while awake). On review of the MAR regarding the [MEDICATION NAME]-[MEDICATION NAME] Solution, she stated the nurse did not meet expectations for medication administration.
Review of the policy on physician orders [REDACTED].
Review of the policy on medication administration revealed that medications shall be administered as prescribed by the attending physician and that medications must be administered in accordance with the written orders of the attending physician. The policy included that if the medication is withheld, refused, or given other than at the scheduled time, the documentation will be reflected in the clinical record. The policy stated that the seven rights of medication administration included that medications are administered according to the dose prescribed.

F 0732

Level of harm - Potential for minimal harm

Residents Affected - Some

Post nurse staffing information every day.

Based on review of facility documentation, staff interviews, and policy review, the facility failed to ensure the daily staff postings were accurate on multiple occasions.
Findings include:
Review of the facility's staff posting forms and the staff sign in sheets revealed the following inconsistencies:
-On (MONTH) 8, 2019, the staff posting form indicated that one Licensed Practical Nurse (LPN) would be working from 6:00 a.m. to 6:00 p.m. However, the staff sign in sheet reflected that one Registered Nurse (RN) worked from 6:00 a.m. to 6:00 p.m.
-On (MONTH) 15, 2019, the staff posting form indicated that one LPN would be working from 6:00 a.m. to 6:00 p.m. and one LPN would be working from 6:00 p.m. to 6:00 a.m. However, the staff sign in sheet reflected that one RN worked from 6:00 a.m. to 6:00 p.m., a second RN worked from 2:00 p.m. to 10:00 p.m., and a LPN worked from 6:00 p.m. to 6:00 a.m.
-On (MONTH) 21, 2019, the staff posting form indicated that one LPN would be working from 6:00 p.m. to 6:00 a.m. for 12 hours. However, the only staff who signed for this shift was an LPN from 6:00 p.m. to midnight.
-On (MONTH) 23, 2019, the staff posting form indicated that one RN and one LPN would be working from 6:00 p.m. to 6:00 a.m. However, the staff sign in sheet reflected that two LPNs' worked from 6:00 p.m. to 6:00 a.m.
-On (MONTH) 24, 2019, the staff posting form indicated that one LPN and one RN would be working from 6:00 p.m. to 6:00 a.m. However, the staff sign in sheet reflected that one LPN worked from 6:00 p.m. to 6:00 a.m.
An interview was conducted with the Administrator (staff #8) on (MONTH) 25, 2019 at 10:16 a.m. He stated that the staff posting is required to include the number of nurses and CNA's that are on each shift. He stated that the staff posting should match/reflect the disciplines and hours actually worked that day. He acknowledged that the staff postings reviewed did not match the hours/disciplines that worked and therefore, did not meet his expectations for the staff postings.
Review of the policy for posting staffing numbers revealed to post the number of staff working who are directly responsible for resident care and to post the number in Full Time Equivalence. The policy stated to include hours worked by Registered Nurses, Licensed Practical/Vocational Nurses, and Nursing Assistants for each shift.

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

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

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NAME OF PROVIDER OF SUPPLIER **SURPRISE HEALTH AND REHABILITATION CENTER**		STREET ADDRESS, CITY, STATE, ZIP **14660 W PARKWOOD DRIVE SURPRISE, AZ 85374**	

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 0732 **Level of harm -** Potential for minimal harm **Residents Affected -** Some	(continued... from page 1)
F 0760 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, staff interviews and review of policy and procedures, the facility failed to ensure one resident (#102) was free from a significant medication error. The deficient practice could result in residents receiving the incorrect medication dose and possibly experiencing medical complications. Findings include: Resident #102 was admitted to the facility on (MONTH) 17, 2019, with [DIAGNOSES REDACTED]. A provider's initial progress note dated (MONTH) 18, 2019 at 8:30 a.m. included the resident was receiving [MEDICATION NAME] (corticosteriod) 45 milligrams (mg) for the treatment of [REDACTED]. The assessment and plan included a recent [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. During a medication administration observation conducted on (MONTH) 24, 2019 at 7:40 a.m., a Licensed Practical Nurse (LPN/staff #7) was observed preparing multiple medications for the resident. While preparing the medications, the LPN removed a 1/2 tablet (which equaled 5 mg) of [MEDICATION NAME] from the bubble pack. The LPN was then observed to administer the medications to resident #102, which included only 5 mg of [MEDICATION NAME]. However, review of the (MONTH) 2019 Medication Administration Record (MAR) revealed documentation that staff #7 had signed off that the resident had received [MEDICATION NAME] 4.5 tablets (10 mg tablets plus 1/2 tablet to equal 45 mg) at 8:00 a.m. on (MONTH) 24. Further review of the (MONTH) 2019 MAR revealed documentation by the nurses that the resident had received 4.5 tablets of [MEDICATION NAME] 10 mg tablets (to equal 45 mg) from (MONTH) 19, through (MONTH) 23. During an interview with staff #7 conducted at 8:55 a.m. on (MONTH) 24, 2019, staff #7 confirmed that she had only given 5 mg of [MEDICATION NAME] (one half tablet of a 10 mg tablet). She stated that the order was for 4.5 mg of [MEDICATION NAME] and that half of 10 is 4.5. The LPN then re-read the order and looked in the medication cart where she found a bubble pack card with whole tablets of [MEDICATION NAME] 10 mg. She stated that she had made an error in dosage, because of how the order was written. She stated the order needs to be written more clearly. The LPN then administered 4 tablets of [MEDICATION NAME] 10 mg tablets to the resident. On (MONTH) 24, 2019 at 1:17 p.m., the [MEDICATION NAME] bubble pack cards for the resident were reviewed. The bubble pack cards were provided to the facility by the pharmacy on (MONTH) 17, 2019, for a total of 56 whole tablets of [MEDICATION NAME] 10 mg and fourteen 5 mg tablets, which were divided onto three cards. The label directions were to administer 4.5 tablets (45 mg) by mouth every day. Card #1 contained 28 whole tablets of [MEDICATION NAME] 10 mg and none had been removed. Card #2 originally contained 28 whole tablets of [MEDICATION NAME] however; 17 tablets had been removed and 11 tablets remained. Card #3 originally contained 14 half tablets (5 mg) but 6 half tablets had been removed and 8 half tablets remained. If the 45 mg dose, (4 tablets of [MEDICATION NAME] 10 mg and 1/2 tablet of [MEDICATION NAME] 10 mg) had been given each day to the resident from (MONTH) 19, through (MONTH) 24, 2019 as documented on the MAR, there would have been 4 whole tablets remaining on card #2, instead of 11 tablets. During an interview conducted on (MONTH) 24, 2019 at 1:50 p.m., the Director of Nursing (DON/staff #47) stated that she had called the pharmacy when the LPN reported the error to her. She stated the pharmacy reported that they didn't have a 45 mg option for [MEDICATION NAME] so they sent what they had, which was 10 mg tablets of [MEDICATION NAME] and 1/2 tablets of [MEDICATION NAME] 10 mg. The DON said that she would expect the nurse to give four 10 mg tablets of [MEDICATION NAME] and one 1/2 tablet (5 mg) to make the 45 mg dose. She also stated that she was working with the pharmacy to write the order in such a way to prevent the error from being repeated in the future. Review of the policy on physician orders [REDACTED]. Review of the policy on medication administration revealed that medications shall be administered as prescribed by the attending physician and that medications must be administered, in accordance with the written orders of the attending physician. The policy included that if the medication is withheld, refused or given other than at the scheduled time, the documentation will be reflected in the clinical record. The policy stated the seven rights of medication administration included that medications are administered according to the dose prescribed.