STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **035116**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **01/18/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE REHABILITATION CENTER AT THE PALAZZO	**6246 NORTH 19TH AVENUE PHOENIX, AZ 85015**

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 0552 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that residents are fully informed and understand their health status, care and treatments.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policy review, the facility failed to ensure one resident (#7) was informed of the risks and benefits of [MEDICAL CONDITION] medications, prior to administration. Findings include: Resident #7 was readmitted on (MONTH) 3, (YEAR) with [DIAGNOSES REDACTED]. Review of the physician's recapitulation of orders dated (MONTH) 3, (YEAR)-January 31, 2019 revealed orders for the following medications: [REDACTED]. The admission MDS (Minimum Data Set) assessment dated (MONTH) 10, (YEAR) revealed a score of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact. Review of the Medication Administration Records for October, November, (MONTH) (YEAR) and (MONTH) 2019, revealed the resident was administered [MEDICATION NAME], aripiprazole and [MEDICATION NAME] per the physician's orders [REDACTED]. However, continued review of the clinical record revealed no evidence that the resident had been informed of the risks and benefits of these medications. An interview was conducted with the Director of Nursing (DON/staff #1) on (MONTH) 15, 2019 at 3:20 PM. The DON stated that informed consents should be obtained from the resident before they receive [MEDICAL CONDITION] medications. She stated that if the resident is unable to sign, the informed consent can be obtained from the resident's representative. The DON stated that the nurses may have been waiting for a family member to sign the informed consents for resident #7 and then forgot about it. The facility's policy regarding informed consents stated the facility shall promote the resident's right to self-determination and the right to participate in his/her plan of care, including the right to accept or refuse treatment. The policy included that informed consent is an educational process that must take place between the facility and the resident that includes the following elements: the nature of the decision or treatment; any reasonable alternatives; relative risks and benefits; and acceptance of the treatment by the resident.
F 0607 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, staff interviews, facility documentation and policy review, the facility failed to implement their policy regarding allegations of abuse for two residents (#19 and #4). Findings include: -Resident #19 was readmitted on (MONTH) 22, 2103 with [DIAGNOSES REDACTED]. Review of the facility's investigation dated (MONTH) 4, 2019 revealed that on (MONTH) 28, (YEAR) at 4:40 p.m., resident #19 reported to a Certified Nursing Assistant (CNA/staff #13) an allegation of verbal abuse by a CNA (staff #66). The investigation included interviews with the resident (#19) and an interview with the CNA (staff #66). However, there was no documentation of any interviews with other staff members or residents regarding the allegation. An interview was conducted with the Administrator (staff #64) on (MONTH) 15, 2019 at 2:05 p.m. He stated that the allegation was investigated as a potential abuse so the facility policy should have been followed in the investigation. An interview was conducted with the Director of Nursing (DON/staff #1) on (MONTH) 15, 2019 at 2:30 p.m. She stated that she did not interview any residents other than resident #19 and that she interviewed other CNA's but did not document the interviews. Another interview was conducted with the DON (staff #1) on (MONTH) 17, 2019 at 2:56 p.m. She stated that for a staff to resident allegation of abuse she would interview other CNAs and nurses as well as other residents that the alleged perpetrator had provided care for. The DON also stated that for this allegation they should have conducted interviews with other staff and other residents and documented the interviews. She stated that their policy regarding investigating was not followed. During an interview conducted with the Administrator (staff #64) on (MONTH) 17, 2019 at 3:30 p.m., he acknowledged that the investigation should have included further interviews with staff and residents. He stated that their policy was not followed for this investigation. -Resident #4 was admitted to the facility on (MONTH) 29, (YEAR) with [DIAGNOSES REDACTED]. Review of a significant change in status MDS (Minimum Data Set) assessment dated (MONTH) 3, 2019 revealed a BIMS (Brief Interview Mental Status) score of 7, which indicated the resident had severe impaired cognition. Review of the facility's investigation report dated (MONTH) 16, 2019 revealed the resident made an allegation of rape on (MONTH) 10, 2019 at approximately 12:00 p.m. The resident stated that she had been raped twice on the night shift and identified a certified nursing assistant (staff #74) as the person who had raped her. Further review of the report did not reveal any documentation that the alleged perpetrator had been interviewed or had been removed from providing care to residents, pending the investigation. The investigation further revealed that the allegation was unable to be substantiated. In addition, review of the State Agency data base revealed the allegation was not reported to the State Agency until (MONTH) 11, 2019 at 11:25 a.m., which was over the two hour timeframe for reporting. An interview was conducted with the Administrator (staff #64) on (MONTH) 17, 2019 at 12:23 p.m. The Administrator stated that staff #74 was not suspended because resident #4 was not able to give a description of the staff person. He stated that the resident stated she was raped at night and staff #74 does not work the night shift. The Administrator stated the information did not match and he would need for the information to match if he was going to suspend a staff member accused of rape. He also said that his expectation is that all allegations of abuse be reported to him immediately. The facility's policy titled Abuse Investigation and Reporting revealed the role of the investigator included conducting interviews with the person(s) reporting the incident, any witnesses to the incident, the resident (if medically appropriate), staff members on all shifts who have had contact with the resident during the period of the alleged incident, the resident's roommate, family members, and visitors, and other residents to whom the accused staff provided care or services. The policy included all alleged violations involving abuse will be reported by the Administrator, or his/her designee, to the State Agency within two hours. The policy also included that the administrator or designee will suspend immediately any staff who has been accused of resident abuse, pending the outcome of the investigation.

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

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

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F 0607 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1)
F 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation, staff interviews and policy review, the facility failed to report an allegation of sexual abuse for one resident (#4) to the State Agency within the required time frame. Findings include: Resident #4 was admitted to the facility on (MONTH) 29, (YEAR), with [DIAGNOSES REDACTED]. Review of a significant change in status MDS (Minimum Data Set) assessment dated (MONTH) 3, 2019 revealed a BIMS (Brief Interview Mental Status) score of 7, which indicated the resident had severe impaired cognition. Review of the facility's investigation report dated (MONTH) 16, 2019 revealed the resident made an allegation of sexual abuse on (MONTH) 10, 2019 at approximately 12:00 p.m. The resident stated that she had been raped twice on the night shift and identified a certified nursing assistant (staff #74) as the person who had raped her. The investigation further included that the allegation was unable to be substantiated. Review of the State Agency data base revealed the allegation was not reported to the State Agency until (MONTH) 11, 2019 at 11:25 a.m., which was over the two hour timeframe for reporting. An interview was conducted on (MONTH) 17, 2019 at 11:01 p.m. with the Director of Nursing (DON/staff #1). The DON stated that the resident made the allegation when she was being taken to the dining room for lunch and that staff #74 reported the allegation to her immediately. During an interview conducted with the Administrator (staff #64) on (MONTH) 17, 2019 at 12:23 p.m., the Administrator stated that his expectation is that all allegations of abuse be reported to him immediately. The facility's policy titled Abuse Investigation and Reporting revealed that all alleged violations involving abuse will be reported by the Administrator, or his/her designee, to the State Agency within two hours.
F 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility documentation, clinical record reviews, staff interviews, and policy review, the facility failed to thoroughly investigate two allegations of abuse for two residents (#19 and #4) and failed to protect residents from the potential for further abuse during an investigation for one resident (#4). Findings include: -Resident #19 was readmitted on (MONTH) 22, 2103 with [DIAGNOSES REDACTED]. Review of the facility investigation dated (MONTH) 4, 2019 revealed that on (MONTH) 28, (YEAR) at 4:40 p.m. resident #19 reported to a Certified Nursing Assistant (CNA/staff #13) an allegation of verbal abuse by a CNA (staff #66). The investigation included interviews with the resident (#19) and an interview with a CNA (staff #66), however, there was no documentation of interviews with any other staff members, residents, or family members regarding the allegation. An interview was conducted with the Administrator (staff #64) on (MONTH) 15, 2019 at 2:05 p.m. He stated that the allegation was investigated as a potential abuse so the facility policy should have been followed in the investigation. An interview was conducted with the Director of Nursing (DON/staff #1) on (MONTH) 15, 2019 at 2:30 p.m. She stated that she did not interview any residents other than resident #19 and that she interviewed other CNAs but did not document the interviews. Another interview was conducted with the DON (staff #1) on (MONTH) 17, 2019 at 2:56 p.m. She stated that for a staff to resident allegation of abuse she would interview other CNAs and nurses as well as other residents that the alleged perpetrator had provided care for. The DON also stated that for this allegation they should have conducted interviews with other staff and other residents and documented the interviews. She stated that their policy regarding investigating was not followed. During an interview conducted with the Administrator (staff #64) on (MONTH) 17, 2019 at 3:30 p.m., he acknowledged that the investigation should have included further interviews with staff and residents. He stated that their policy was not followed for this investigation. -Resident #4 was admitted to the facility on (MONTH) 29, (YEAR), with [DIAGNOSES REDACTED]. Review of a significant change in status MDS (Minimum Data Set) assessment dated (MONTH) 3, 2019 revealed a BIMS (Brief Interview Mental Status) score of 7, which indicated the resident had severe impaired cognition. Review of the facility's investigation report dated (MONTH) 16, 2019 revealed the resident made an allegation of rape on (MONTH) 10, 2019 at approximately 12:00 p.m. The report included the resident stated that she had been raped twice on the night shift and identified a certified nursing assistant (staff #74) as the person who had raped her. Further review of the report revealed the alleged perpetrator had not been interviewed or removed from providing care to residents, pending the investigation. Per the report, the allegation was unable to be substantiated. An interview was conducted on (MONTH) 17, 2019 at 11:01 p.m. with the DON. The DON stated that staff #74 was not suspended because the resident's statement changed when she interviewed the resident and staff #74 did not work the night shift. During an interview conducted with the Administrator (staff #64) on (MONTH) 17, 2019 at 12:26 p.m., the Administrator stated that if an employee has been accused of sexual abuse, he would suspend the employee if the resident is able to give some type of description and the staff was working at the time the alleged incident occurred. He stated that staff #74 does not work the night shift and that since the resident stated that she had been raped at night, he did not think that staff #74 should have been suspended. The facility's policy titled Abuse Investigation and Reporting revealed the role of the investigator included conducting interviews with the person(s) reporting the incident, any witnesses to the incident, the resident (if medically appropriate), staff members on all shifts who have had contact with the resident during the period of the alleged incident, the resident's roommate, family members, and visitors, and other residents to whom the accused staff provided care or services. The policy included that the administrator or designee will suspend immediately any staff who has been accused of resident abuse, pending the outcome of the investigation.
F 0655 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**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 and staff and resident interviews, the facility failed to provide two residents (#7 and #9), with a written summary of their baseline care plans. Findings include: -Resident #7 was admitted to the facility on (MONTH) 3, (YEAR), with [DIAGNOSES REDACTED]. According to the admission Minimum Data Set (MDS) assessment dated (MONTH) 10, (YEAR), revealed the resident had a Brief Interview for Mental Status score of 15, which indicated the resident had intact cognition. Review of the clinical record revealed the resident was receiving narcotic pain medication, an anticoagulant, antianxiety medication, antipsychotic medication, antidepressant medication and medication for ADHD (attention deficit [MEDICAL CONDITION] disorder). Review of the resident's baseline care plans revealed that care plans had been developed which addressed anticoagulant therapy, [MEDICAL CONDITION] medications, pain and psychosocial needs. However, there was no documentation in the clinical record or on the baseline care plans that the resident was provided a summary of the baseline care plans. An interview was conducted on (MONTH) 14, 2019 at 1:53 p.m., with resident #7. She stated that she had no knowledge of her plan of care. She reported that she was not given a copy of her care plans and that no one had spoken with her about the topic. An interview was conducted on (MONTH) 15, 2019 at 3:20 p.m., with the DON (Director of Nursing) (staff #1). She stated that

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F 0655 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) the process is to complete the baseline care plan on paper and after 24 hours, the resident signs the care plan and is given a copy. She said if a resident refused to sign or was unable to sign, there should be some kind of notation. She stated that it is a new process, we're still getting used to it. When asked about the lack of signature on resident #7's baseline care plan she stated that if there was no signature, it could have been misplaced or forgotten. -Resident #9 was admitted to the facility on (MONTH) 8, (YEAR), with [DIAGNOSES REDACTED]. Review of the clinical record revealed that baseline care plans dated (MONTH) 8, (YEAR) had been developed to address various care areas. An admission MDS assessment dated (MONTH) 15, (YEAR) included the resident had a BIMS score of 14, indicating she was cognitively intact. Further review of the clinical record including the baseline care plans revealed no documentation that the resident was provided a summary of the baseline care plans. An interview was conducted with the resident on (MONTH) 14, 2019 at 10:45 a.m. She stated that she didn't know anything about a care plan, but thought it would be nice to know about it. She said that she would like to feel involved in her plan of care. An interview was conducted on (MONTH) 16, 2019 at 12:41 p.m., with a licensed practical nurse (staff #11). She stated that after the resident signs the baseline care plan, the nurses make a copy of it and puts the copy in the resident's chart, That way we both have a copy.
F 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews and staff interviews, the facility failed to ensure that physician's orders were followed for two residents (#19 and #47). Findings include: -Resident #47 was admitted to the facility on (MONTH) 17, 2013, with readmissions on (MONTH) 14, (YEAR) and (MONTH) 16, 2019. [DIAGNOSES REDACTED]. An admission MDS assessment dated (MONTH) 26, (YEAR) included the resident scored a 15 on the BIMS (Brief Interview for Mental Status), indicating intact cognition. Physician orders dated (MONTH) 30, (YEAR) included for Nephrostomy site care every shift; monitor for redness and swelling; keep the catheter bags below the bladder; and monitor for signs and symptoms of a UTI. The orders also included to monitor nephrostomy tube drainage every shift. A care plan dated (MONTH) 30, (YEAR) included the resident had nephrostomy tubes in place related to [MEDICAL CONDITION]. The goal was for the resident to remain free from catheter related trauma through the review date. Interventions included the following: catheter care every shift; monitor/record/report to M.D. signs or symptoms of UTI (blood tinged urine, burning, cloudiness, no output, deepening of urine color, urinary frequency, foul smelling urine, fever). Review of a nursing progress note dated (MONTH) 4, (YEAR) revealed the total output from both nephrostomy bags was 1950 ml for the previous 12 hours. A nursing progress note dated (MONTH) 18, (YEAR) revealed the nephrostomy tube output on the resident's right side was 900 ml, but the left side was unknown as the resident was lying on it and being unwilling to have it looked at. There was no additional documentation in the nursing progress notes regarding the nephrostomy tube output amounts for (MONTH) (YEAR). Review of the Medication Administration Record [REDACTED]. As a result, there was no documentation on the MAR indicated [REDACTED]. A physician's order dated (MONTH) 4, (YEAR) (YEAR) included to monitor nephrostomy tube drainage every shift. Review of the MAR for (MONTH) (YEAR) revealed the above order. For (MONTH) 4 and 14 on the 7p-7a shift, there was no documentation of any output from the right and left nephrostomy tube, and on (MONTH) 28 on the 7a-7p shift, there was no output amount documented for the right tube. On (MONTH) 16, 2019 at 2:52 p.m., an interview was conducted with a licensed practical nurse (LPN/staff #11). She stated that she has cared for resident #47. She stated that her process was to empty the nephrostomy bag, measure the urine output, then input the information into the computer. -Resident #19 was readmitted on (MONTH) 22, 2013, with [DIAGNOSES REDACTED]. Review of the quarterly Minimum Data Set (MDS) assessment dated (MONTH) 3, (YEAR), revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. Review of the physician's orders revealed an order dated (MONTH) 19, (YEAR) to be started on (MONTH) 20, (YEAR) for [MEDICATION NAME] cream 5%, apply per direction topically one time only for scabies until (MONTH) 21, (YEAR). The order included to apply cream to body, neck, behind ears, and down to soles of feet getting in between fingers/toes. Leave on 10 hours and shower off in a.m. Change all bed linens after shower. Review of the Medication Administration Record [REDACTED]. However, there was no documentation that the cream for scabies was applied as ordered. The MAR further included a response of 9 (other/see nurse notes) regarding the [MEDICATION NAME] cream. However, review of the nurse's progress notes for (MONTH) 19, (YEAR) revealed no documentation regarding the administration of the [MEDICATION NAME] cream. Further review of the MAR for (MONTH) 21, (YEAR) revealed the [MEDICATION NAME] cream was to start on (MONTH) 20, (YEAR). However, a response of 9 was again documented. Review of the corresponding nurse's progress notes for (MONTH) 21, (YEAR) revealed the following documentation: no cream available. An interview was conducted with a Licensed Practical Nurse (LPN/staff #11) on (MONTH) 18, 2019 at 9:09 a.m. She stated that when there is a physician's order and the medication or treatment is not available, staff should call the pharmacy and call the physician to see if a stock item could be used. She stated that if the nurse documented the code (9) it refers you to the nurses notes, and there should have been an entry done at that time. She also stated if the nurse documented that there was no cream available, then the resident did not receive the treatment at that time. An interview was conducted with the Director of Nursing (DON/staff #1) on (MONTH) 18, 2019 at 10:09 a.m. She stated that her expectation is that the physician's order be followed as written. She stated that if the order is on the TAR and the medication is not available, the nurse should notify the physician, follow any orders given and document in the nurses notes. An interview was conducted with a Registered Nurse (staff #36) on (MONTH) 18, 2019 at 12:19 p.m. She reviewed the entry on the MAR from (MONTH) 21 for the [MEDICATION NAME] cream. She stated that she was the nurse that shift and she did not administer the treatment, because the cream was not available. She stated she would have reported to the oncoming nurse that she was unable to administer the treatment and the oncoming nurse would need to call the pharmacy and the physician. She stated the documentation does not indicate that the treatment was completed or that the physician's order was followed.
F 0691 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services.** **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 that care and services were provided as ordered for one resident (#19), with a suprapubic catheter. Findings include: Resident #19 was readmitted on (MONTH) 22, 2013, with [DIAGNOSES REDACTED]. Review of a physician's history and physical dated (MONTH) 10, (YEAR) revealed the resident's suprapubic catheter occasionally becomes clogged and that staff are able to flush and resolve. Review of the physician's orders [REDACTED]. -clean the suprapubic catheter site with normal saline/wound cleanser, pat dry, apply [MEDICATION NAME] cream and cover with

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F 0691 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 3) drain sponge and secure with a dry dressing every day for skin integrity. -monitor the peri suprapubic catheter site for signs and symptoms of infection and to call doctor if positive every shift for skin integrity. -flush catheter with 30 cc of normal saline every shift to prevent clogging. Review of a care plan revealed the resident had a suprapubic catheter. The goal included that the resident would be free of complications related to catheter use. Approaches included to observe for signs and symptoms of infection and to do suprapubic catheter care daily. Review of the Treatment Administration Record (TAR) for (MONTH) (YEAR) revealed the above orders for the suprapubic catheter. However, there was no documentation that the suprapubic catheter site was cleansed on (MONTH) 14 or 23; or documentation that the peri suprapubic catheter site was monitored for signs and symptoms of infection on (MONTH) 14 and 23 on the 7 a.m. to 7 p.m. shift or on (MONTH) 5, 7, 14, 18, 19 or 26 on the 7 p.m. to 7 a.m. shift. Review of the TAR for (MONTH) (YEAR) revealed the following: -no documentation that the suprapubic catheter was cleansed on (MONTH) 6, 14 or 18. -no documentation that the peri suprapubic catheter site was monitored for signs and symptoms of infection on (MONTH) 6 and 14 for the 7 a.m. to 7 p.m. shift or on (MONTH) 5 and 6 for the 7 p.m. to 7 a.m. shift. Review of the TAR for (MONTH) (YEAR) revealed the following: -no documentation that the suprapubic catheter was cleansed on (MONTH) 7, 8 or 16. -no documentation that the peri suprapubic catheter site was monitored on (MONTH) 7 and 8 on the 7 a.m. to 7 p.m. shift or on (MONTH) 11, 14 and 26 on the 7 p.m. to 7 a.m. shift. A physician's orders [REDACTED]. Review of the TAR for (MONTH) (YEAR) revealed the following: -no documentation the suprapubic catheter was cleansed on (MONTH) 18 and 25. -no documentation that the peri suprapubic catheter site was monitored for signs and symptoms of infection on (MONTH) 18 and 25 on the 7 a.m. to 7 p.m. shift or on (MONTH) 18 and 21 on the 7 p.m. to 7 a.m. shift. Review of the TAR for (MONTH) (YEAR) revealed the following: -no documentation that the suprapubic catheter was cleansed on (MONTH) 3, 5, 7 and 31. -no documentation that the peri suprapubic catheter site was monitored for signs and symptoms of infection on (MONTH) 3, 5 and 7 on the 7 a.m. to 7 p.m. shift or from (MONTH) 14-16, 19, 21-23 and from 28-30 on the 7 p.m. to 7 a.m. shift. Review of the Medication Administration Record [REDACTED]. Review of the TAR for (MONTH) (YEAR) revealed the following: -no documentation that the suprapubic catheter was cleansed on (MONTH) 4, 9-14, 18 and 28. -no documentation that the peri suprapubic catheter site was monitored for signs and symptoms of infection on (MONTH) 4, 9-14, 18 and 28 on the 7 a.m. to 7 p.m. shift. Review of an annual Minimum Data Set (MDS) assessment dated (MONTH) 2, (YEAR), revealed the resident had a Brief Interview for Mental Status score of 15, which indicated intact cognition. The MDS documented the resident had an indwelling catheter, a [MEDICAL CONDITION] bladder and artificial openings of the urinary tract. The urinary Care Area Assessment (CAA) included that the indwelling catheter would be care planned, with an overall objective to avoid complications. Review of the TAR for (MONTH) (YEAR) revealed the following: -no documentation that the suprapubic catheter was cleansed on (MONTH) 3, 17, 28 and 31. -no documentation that the peri suprapubic catheter site was monitored for signs and symptoms on (MONTH) 3, 17, 28 and 31 on the 7 a.m. to 7 p.m. shift. Review of the TAR for (MONTH) 2019 revealed the following: -no documentation that the suprapubic catheter was cleansed on (MONTH) 1, 5, 6, and 12. -no documentation that the peri suprapubic catheter site was monitored for signs and symptoms of infection on (MONTH) 1, 5, 6 and 12 on the 7 a.m. to 7 p.m. shift. An interview was conducted with the resident (#19) on (MONTH) 14, 2019 at 9:57 a.m. He stated that the dressing for the suprapubic catheter does not get changed as ordered, and that the catheter gets clogged which causes spasms, leakage and pain. An interview was conducted with a Licensed Practical Nurse (LPN/staff #11) on (MONTH) 18, 2019 at 9:09 a.m. She stated that there should not be blanks in the MAR indicated [REDACTED]. She stated that a blank could mean the treatment or medication was provided but the nurse forgot to sign it off, or it could mean that the nurse did not provide the medication or treatment. She stated if the nurse was unable to provide the medication or treatment, the system will give the nurse options to indicate why the service was not provided, including refusal, held or to see the nurse notes. She stated that if the nurse chooses the option to see the nurses note, there should be some kind of documentation that explains what happened. She said if there is no progress note and the area was left blank on the MAR indicated [REDACTED]. An interview was conducted with the Director of Nursing (DON/staff #1) on (MONTH) 18, 2019. She stated if there is no entry on the MAR/TAR and it was not addressed in any other documentation, then it does not follow facility expectations, as the staff have not documented that a treatment has been done or that the medication was given. On review of the MARS/TARS from (MONTH) (YEAR) to (MONTH) 2019 for resident #19, the DON stated that staff did not follow her expectation for documentation. Regarding the blanks in the MAR/TAR for suprapubic catheter care, flushing the catheter and catheter site monitoring there was no documentation that the care was given. Review of the policy on Nursing Documentation revealed that documentation must be accurate and complete, including medications and treatments. The policy further indicated that documentation should be completed at soon as possible after care is given. According to the Catheter Care protocol, direct care staff are responsible for ensuring that a resident with an indwelling urinary catheter receives appropriate infection control prevention and practices at all times. The protocol noted to check the area for signs of infections, such as irritated, swollen, red or tender skin at the insertion site or drainage around the catheter and to report any signs of infection or changes in urine condition to the physician. The protocol included that all resident with indwelling catheters will have twice daily routine catheter care documented on the TAR. The protocol did not address suprapubic catheter care specifically.
F 0757 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **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 each resident's drug regimen is free from unnecessary drugs, by failing to administer pain medication per the physician ordered parameters for one resident (#7). Findings include: Resident #7 was admitted to the facility on (MONTH) 3, (YEAR), with [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. The admission MDS (Minimum Data Set) assessment dated (MONTH) 10, (YEAR) revealed the resident scored a 15 on the Brief Interview for Mental Status, which indicated that the resident was cognitively intact. Review of the resident's eMAR (electronic medication administration record) for the month of (MONTH) (YEAR) revealed the resident was administered [MEDICATION NAME]-[MEDICATION NAME] 10/325 for pain outside of the physician ordered parameters six times. (The resident's pain level documented was less than 6 out of 10). Review of the resident's eMAR for (MONTH) (YEAR) revealed the resident was administered [MEDICATION NAME]-[MEDICATION NAME] 10/325 four times for pain levels less than 6 out of 10. The pharmacy review report dated (MONTH) 19-November 20, (YEAR) revealed resident #7's medications had been reviewed. An interview was conducted with a LPN (licensed practical nurse/staff #11) on (MONTH) 18, 2019 at 8:44 a.m. She stated that she follows the physician's orders [REDACTED]. An interview was conducted on (MONTH) 18, 2019 with the DON (Director of Nursing/staff #1). She stated that the physician's orders [REDACTED].