STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035003	A. BUILDING _____ B. WING _____	10/17/2019

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE TERRACES OF PHOENIX	7550 NORTH 16TH STREET PHOENIX, AZ 85020

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 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident and staff interviews, and policy review, the facility failed to ensure 1 of 15 sampled residents (#35) code status was consistent in the clinical record. The deficient practice could result in residents receiving services which are not in accordance with their wishes. Findings include: Resident #35 was admitted to the facility on (MONTH) 28, 2019, with [DIAGNOSES REDACTED]. Review of a nursing health status note dated (MONTH) 28, 2019 revealed the power of attorney (POA) for the resident would be signing the admission paperwork the next day. The note included the resident was willing to sign the paperwork but was unable to. A physician's orders [REDACTED]. Review of the care plan regarding advance directive initiated (MONTH) 28, 2019 revealed the resident and the resident family stated preference is that in the event cardiac function stops initiate CPR. The goal was that the resident preference will be honored in the event of a cardiac emergency. An intervention included that in the absence of breathing and pulse to call 911 and begin CPR. The admission Minimum Data Set (MDS) assessment dated (MONTH) 30, 2019 revealed a Brief Interview of Mental Status (BIMS) score of 15 which indicated the resident had intact cognition. However, a Statement of Treatment Preferences signed (MONTH) 8, 2019 by the POA and the facility representative revealed a request that while a resident at the facility the resident will be designated a do not resuscitate (DNR). Per the form, it is understood this means no cardiopulmonary resuscitation will be employed in the plan of treatment, if necessary. A Pre-Hospital Medical Care Directive dated and signed (MONTH) 8, 2019 by the POA, Licensed Health Care Provider, and a witness revealed that in the event of cardiac or respiratory arrest, the resident refuses any resuscitation measures including cardiac compression, endotracheal intubation and other advanced airway management, artificial ventilation, defibrillation, administration or advanced cardiac life support drugs and related emergency medical procedures. Further review of the clinical record revealed no evidence the physician order [REDACTED]. During an interview conducted with the resident on (MONTH) 15, 2019 at 8:49 a.m., the resident stated that he did not want CPR. In an interview conducted on (MONTH) 16, 2019 at 12:13 p.m. with a registered nurse (RN/staff #49), she stated advance directives are completed upon admission. She stated that if the resident is a full code, the nurses will fill out the advance directive form with the resident and make sure that the electronic clinical record reflects the goals stated on the form. She further stated that if the resident's code status is DNR, the nurse will explain the DNR status before the resident, nurse and a witness signs the form. The RN stated that the physician will be notified that the resident is a DNR and will complete the pre-hospital medical care directive form with the resident. She stated the nurse that completes the form is expected to update the advance directives in the electronic clinical record. The RN stated that the day shift will usually tell the supervisor who will update the care plan, but the other shifts will update the care plan themselves. She states that this resident's code status was a mistake because the paper clinical record should be the same as the electronic clinical record, and that this could be a problem as most nurses would check the electronic clinical record and not the paper clinical record. An interview was conducted with the Director of Nursing (DON/staff #4) on (MONTH) 16, 2019 at 12:38 p.m. The DON stated that whoever put the DNR status in the paper clinical chart would be expected to change the status in the electronic clinical record as well. The DON stated that she remembers the resident's POA made this change and that it should have been updated in the electronic clinical record. Review of the facility's policy for Advance Directives revised (MONTH) (YEAR), revealed advance directives will be respected in accordance with state law and facility policy. The plan of care for each resident will be consistent with his or her documented treatment preferences and/or advance directive. The Care Plan Team should be informed of changes or revocations of a directive so appropriate changes can be made in the care plan. The DON or designee will notify the physician so that appropriate orders can be documented in the clinical record. The policy also revealed that if the resident or the resident representative refuses treatment, the facility and care providers will modify the care plan as appropriate.
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 observations, clinical record review, resident and staff interviews, and the Resident Assessment Instrument (RAI) manual, the facility failed to ensure the Minimum Data Set (MDS) assessment for one resident (#13) was accurate regarding restraints. The deficient practice could result in inaccuracies within the resident's clinical record. The census was 53 residents. Findings include: Resident #13 was admitted to the facility on (MONTH) 31, (YEAR), with [DIAGNOSES REDACTED]. A side rail usage assessment dated (MONTH) 15, 2019 revealed the resident required the assistance of one person to enter or exit the bed and was able to move and change positions in bed without assistance. The assessment included the resident preferred to have the rails in place and was able to enter and exit the bed on her own with the rails in use. A physician's orders [REDACTED]. Review of the care plan initiated (MONTH) 7, 2019 for quarter side rails as a therapeutic device to support mobility and independence revealed the goal was to enhance functional independence and promote skin integrity through the use of the right quarter rail for positioning and turning while in bed. Interventions included the resident uses the right side rail to assist with transfers. However, the quarterly MDS assessment dated (MONTH) 9, 2019 revealed resident #13 was coded as having bed rails used daily as a physical restraint. During an observation conducted of resident #13's room on (MONTH) 15, 2019 at 8:51 a.m., quarter rails was observed attached to each side of the resident's bed. An interview was conducted with resident #13 on (MONTH) 15 at 1:40 p.m. The resident stated she likes having the bed rails

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 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) and that she uses them to help her get in and out of bed. She stated she does not use them all of the time, and the rails do not prevent her from getting out of bed. Resident #13 stated she is able to transfer from her wheelchair to the bed without assistance, and she is able to walk around her room without assistance. An interview was conducted with the MDS coordinator (staff #92) on (MONTH) 17, 2019 at 9:15 a.m. Staff #92 stated resident #13 uses the bed rails to assist her with getting in and out of bed. Staff #92 stated the resident has had the bed rails for a long time, and the resident feels safer with the bed rails up. Staff #92 stated she has checked the RAI manual guidelines and believes any use of bed rails qualifies as a restraint and must be coded as such on the MDS assessment. Staff #92 stated anyone in the facility with bed rails will have a restraint coded on their MDS assessment since the resident is not able to remove the bed rail in case of an emergency. She also stated the bed rail is not used as a restraint, but for mobility assistance. Another interview was conducted with the MDS coordinator (staff #92) on (MONTH) 17, 2019 at 10:45 a.m. Staff #92 stated that after checking with other staff, she has modified the resident's MDS assessment to remove the restraint. Staff #92 stated she was informed that since the bed rails do not restrict the resident's movement or ability to get in and out of bed, they are not classified as a restraint. An interview was conducted with the Director of Nursing (DON/staff #4) on (MONTH) 17 at 10:57 a.m. The DON stated the facility is restraint free and no resident should have a restraint coded on their MDS assessment. The DON stated that the bed rail does not restrict the resident's movement, and the resident is still able to get in and out of bed without assistance with the bed rails in place. Review of the RAI manual revealed physical restraints are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body. The manual also revealed the assessors will evaluate whether or not a device meets the definition of a physical restraint and code only the devices that meet the definition; remember the decision about coding a restraint depends on the effect it has on the resident. The RAI manual included that it is required that the assessment accurately reflects the resident's status and that the importance of accuracy completing and submitting the MDS assessment cannot be overemphasized.
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **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 nutrition care plan was revised for one resident (#19). The deficient practice could result in inaccuracies regarding resident care. Findings include: Resident #19 was admitted on [DATE] with a [DIAGNOSES REDACTED]. A review of the nutrition care plan initiated 12/12/2016 revealed a goal that the resident will maintain adequate nutritional status. Interventions included providing and serving diet as ordered, providing set-up and assistance with meals in the dining room as needed/accepted. Review of the summary of physician orders [REDACTED]. However, further review of the care plan did not reveal the care plan was revised to include the order for the resident to receive 1:1 assistance with her meals. An interview was conducted with a Certified Nursing Assistant (CNA/staff #20) on 10/16/19 at 10:39 AM. She stated the resident makes up her own mind on where and how she wants to eat her meals. She stated the resident will either eat in the dining room or in her room. The CNA stated the resident will not eat sometimes unless staff leaves the room. During an interview conducted with a Licensed Practical Nurse (LPN/staff #61) on 10/16/19 at 12:44 PM., she stated staff follows the care plan for the residents' nutritional needs. The LPN stated that staff will pop in to see the resident every 15-20 minutes to ensure she is eating. During an interview conducted with the Director of Nursing (DON/staff #4) on 10/16/19 at 12:54 PM., the DON stated that the care plan should include the physician order [REDACTED]. She stated the care plans are updated by the nursing supervisor and nursing staff as new orders are written. The DON stated care plans are reviewed weekly and corrected as needed for a change in the resident's condition or if new orders are obtained. She stated she was not aware there was an order for [REDACTED]. An interview was conducted with the Dietary Manager (staff #125) on 10/16/19 at 01:18 PM. She stated she was not aware the resident had an order for [REDACTED].>The facility policy titled Care Planning with an effective date of 11/28/2016 revealed care plan for residents is a critical job function for licensed nurses when new orders are received. The policy also revealed physician orders [REDACTED].
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 review, observations, staff interviews, and policy review, the facility failed to ensure services provided met professional standards of quality by failing to follow physician orders [REDACTED].#19). The deficient practice could result in adverse clinical outcomes. Findings include: Resident #19 was admitted on [DATE] with a [DIAGNOSES REDACTED]. Review of the current care plan revised 9/4/18 revealed the resident had a potential nutritional problem related to decreased cognition as evidenced by variable meal intake around 50% and the need for assistance/coaching. The goal was for the resident to maintain adequate nutritional status. Interventions included providing set-up and assistance with meals in the dining room as needed/accepted and monitoring, documenting, and notifying the physician as needed for refusals to eat and concerns during meals. Review of the percentage of meals eaten revealed the following for (MONTH) and (MONTH) 2019: For July, 36 meals the resident consumed was 50% or less. For August, 39 meals the resident consumed was 50% or less. The quarterly admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident cognitive skills were moderately impaired for daily decision making and the resident required supervision for eating. A quarterly nutrition review dated 8/30/2019 revealed the resident had decreased her consumption of solid food to 26-50% but was not a risk for unintended weight loss. Review of the summary of physician orders [REDACTED]. The percentage of meals eaten for (MONTH) and (MONTH) 2019 revealed the following: For September, 32 meals the resident consumed was 50% or less. For (MONTH) 1-16, 20 meals the resident consumed was 50% or less. Further review of the clinical record revealed no documentation that 1:1 assistance was provided to the resident as ordered or that the care plan included this order. An observation was conducted of the resident on 10/15/19 at 09:38 AM. The resident's breakfast was sitting in front of her on a bedside table. The breakfast was a full size waffle, fries and bacon. The resident was not observed to attempt to eat the food in front of her and no staff were observed in the resident's room. During a lunch observation conducted on 10/15/19 at 12:53 PM, a Certified Nursing Assistant (CNA) was observed to deliver the resident's tray, raise the head of the bed, set up the tray, and leave the room. An observation was conducted of the resident in the north dining room on 10/16/19 at 12:10 PM. She was sitting at a table with three other residents and a CNA was sitting across from the resident assisting two other residents. The resident was observed drinking out of a cup without assistance. The resident was observed unable to grasp the spoon on the table to eat the bowl of food in front of her. The resident was unable to eat until staff assisted her. An attempt was made to interview the resident however; the resident was unable to answer questions. The resident would say one word and make facial expressions.

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F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) In interview conducted with a CNA (staff #20) on 10/16/19 at 10:39 AM., she stated the resident makes up her own mind about where and when she eats. The CNA stated that when the resident eats her meals in her room sometimes she eats by herself because if staff stays in the room, the resident will not eat. She stated that they will leave the resident alone to eat and will check back on her. The CNA stated that if they notice the resident needs help, they will help her. An interview was conducted with a Licensed Practical Nurse (LPN/staff #61) on 10/16/19 at 12:44 PM. She stated that if the staff is concerned with the resident's meal intake, they can obtain an order for [REDACTED].#61 stated staff will leave the resident alone when she eat her meals in her room but will pop in to check on her every 15-20 minutes. She stated they follow the care plan for the resident's nutritional needs. She also stated the resident is weighed monthly now because she is not a high risk for weight loss. During an interview conducted with the Director of Nursing (DON/staff #4) on 10/16/19 at 12:54 PM., she stated that if a resident is not eating more than 50% of their meals, she expects the CNA to report it to the nurse so the Interdisciplinary Team (IDT) team can address it in the morning meeting. She stated the staff should also address the lack of intake with the resident and offer other options. The DON stated that when a resident is a high risk for weight loss they are weighed weekly. She stated this resident is not at high risk and is weighed monthly. She stated she was not aware there was an order for [REDACTED]. In an interview conducted with the Dietary Manager (staff #125) on 10/16/19 at 01:18 PM., she stated this resident is not at risk for weight loss based on the resident's intake per meal, Body Mass Index (BMI), lab work, and the quarterly/annual reviews. She stated she was not aware the resident had an order for [REDACTED].>The facility's policy titled Clinical Nutrition Services: Nutrition Assessment and Monitoring revised 8/2019 revealed the individualize plan of care will be written and reviewed regularly when changes are noted. The plan of care will be shared with and agreed upon by the resident and/or representative. The nutrition assessment will include data from staff members including meal intake and appetite. Interval assessments will be completed for nutritional concerns such as poor intake of food/fluid and refusal to eat.
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, resident and staff interviews, and policy review, the facility failed to ensure oxygen tubing for one sampled resident (#8) was changed as ordered and stored consistent with professional standards of practice. The deficient practice could result in respiratory complications and infection. Findings include: Resident #8 was admitted to the facility on (MONTH) 7, (YEAR), with [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. The Treatment Administration Record (TAR) for (MONTH) 2019 revealed the oxygen tubing was changed on (MONTH) 6 and again on (MONTH) 13. During an observation conducted of the resident's room on (MONTH) 15, 2019 at 9:56 a.m., the resident was not observed using oxygen. The oxygen concentrator was on and in the bathroom shower. The tubing was connected to the concentrator and part of the tubing was lying on the floor of the shower. Another part of the tubing was looped around the grab bars next to the toilet. The tubing extended out of the bathroom, into the resident's room and was wrapped around the table next to the resident who was sitting in a chair. The tubing on the concentrator had a label with the date (MONTH) 12 on it. The nasal cannula had a separate label that had the date (MONTH) 5 on it. An interview was conducted with the resident immediately following this observation. The resident stated the oxygen concentrator was moved into the shower that morning to make room for staff to clean up an accident and that no one noticed the concentrator needed to be moved back into her room. Resident #8 stated that she does not know when the staff changes the oxygen tubing. Another observation was conducted of the resident's room was on (MONTH) 16, 2019 at 1:25 p.m. The oxygen concentrator was observed in the bathroom, but was no longer in the shower. Part of the tubing from the concentrator was wrapped around the grab bars next to the resident's toilet, and part of it was coming out of the bathroom and lying on the floor next to the resident's bed. The label on the tubing was dated (MONTH) 12. The tubing for the nasal cannula was on the table next to the resident's bed, and the label was dated (MONTH) 5. An observation was conducted of resident #8's room on (MONTH) 17 at 10:20 a.m. The oxygen concentrator was observed in the resident's bathroom. The tubing was wrapped around the grab bars behind and next to the toilet, coming out of the bathroom and lying on the table next to the resident's bed. The label on the concentrator tubing contained the date 12. The label on the nasal cannula tubing contained the date (MONTH) 19. An interview was conducted with a Registered Nurse supervisor (RN/staff #102) on (MONTH) 16, 2019 at 2:59 p.m. The RN stated the night shift staff changes the oxygen tubing for all residents who have that order. Staff #102 stated the tubing should be changed at least weekly, and should be done on schedule. She stated once the tubing has been changed and labeled it will documented on the TAR. The RN stated that the night nurse may have missed changing resident #8's oxygen tubing. She also stated that it should not have been documented as done on the TAR if it was not done. The RN stated that the date on the labels is the date the tubing is supposed to be changed. The supervisor stated that she did not want to observe the tubing at this time, and that she would ask the night nurse what happened when she reported for work. An interview was conducted with the Director of Nursing (DON/staff #4) on (MONTH) 17, 2019 at 10:38 a.m. The DON stated all oxygen tubing should be changed weekly and as ordered. She also stated the labels on the tubing should be updated when the tubing is changed, and documentation on the TAR should reflect the task was done. She stated it was brought to her attention yesterday that resident #8's oxygen tubing had not been changed as ordered. She stated the tubing was changed last night (October 16, 2019). The DON stated she did not know why it was documented on the TAR that the oxygen tubing was changed when the labels on the tubing did not reflect it was changed. She stated that the date on the tubing should be the date the tubing was last changed. During an interview conducted with a Certified Nursing Assistant (CNA/staff #68) on (MONTH) 17, 2019 at 12:58 p.m., the CNA stated the oxygen tubing should be kept in a bag in the resident's room when not in use. Another interview was conducted with the DON on (MONTH) 17, 2019 at 1:05 p.m. She stated that all oxygen tubing should be kept in a black antimicrobial bag when not in use. She stated this bag should be stored somewhere near the concentrator. She also said they change the bags every 30 days to prevent infections. The DON stated the tubing should never be stored on the floor. The DON also indicated that she was not aware of how resident #8's oxygen tubing was being stored. The facility's policy and procedure regarding Respiratory Therapy Prevention of Infection revised (MONTH) 2011 revealed the purpose of the procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment among residents and staff. The policy instructs to change the oxygen cannula and tubing every seven days or as needed, and to keep the oxygen cannula and tubing used PRN (as needed) in a plastic bag when not in use.