STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **035147**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **01/31/2019**
NAME OF PROVIDER OF SUPPLIER **VILLA MARIA CARE CENTER**		STREET ADDRESS, CITY, STATE, ZIP **4310 EAST GRANT ROAD TUCSON, AZ 85712**	

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 0550 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interviews, facility documents, clinical record review, and policies and procedures, the facility failed to ensure two residents (#s 107 and 108) were able to exercise their rights for meals without interference, coercion, discrimination, or reprisal from the facility. This deficient practice resulted in some residents receiving a meal that was inferior in quality to other residents when resident rights were exercised. Facility census was 54. Findings include: -Resident #107 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. An interview was conducted with resident #107 on 01/28/19 at 11:53 AM who stated, I was told if I don't get up and go to the dining room, then I can't eat. All I can get is a sandwich. The resident stated, I have been in a lot of pain and I don't always feel like going to the dining room and the staff here don't understand that, so all they will give me then is a sandwich. An observation was conducted on the same day of resident #107 at 01:15 PM. The resident was observed in bed and was served a sandwich and juice for lunch. Review of the menu revealed dining room residents were served a braised pork chop or potato crunch fish, wild rice blend, seasoned spinach, bread or roll and butter, black forest cake, and choice of beverage. A second observation conducted of resident #107 on 01/29/19 at 11:50 AM revealed the resident went to the dining room for lunch. -Resident #108 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. During an interview and observation with resident #108 on 01/28/19 at 1:30 PM, the resident stated that if he does not go down to the dining room the staff gives him a sandwich. He stated the regular lunch menu is not offered to him if he does not go the dining room. A plate with a sandwich was observed on the resident's bed at the time of the interview. Review of the menu revealed dining room residents were served a braised pork chop or potato crunch fish, wild rice blend, seasoned spinach, bread or roll and butter, black forest cake, and choice of beverage. A second observation conducted of resident #108 on 01/29/19 at 11:45 AM revealed the resident went to the dining room for lunch. A third observation conducted of resident #108 on 01/30/19 at 12:05 PM revealed the resident was in his room during lunch in the dining room. In an interview conducted at the same time, the resident stated he did not want lunch because he felt so bloated with fluid. An interview was conducted on 01/29/19 at 10:45 AM with the Dietary Manager (staff #89), who stated the facility has a policy that they want everyone to get out of bed and go to the dining room for meals. Staff #89 stated that if they do not want to go to the dining room; sandwiches, a drink, and maybe some yogurt are provided to the residents. An interview was conducted on 01/29/19 at 2:25 PM with a CNA (staff #37), who stated that if residents are able to go to the dining room for a meal and they do not have a reason not go to the dining room, they have been encouraged by management to give the resident a sack lunch instead of a meal tray. Staff #37 further stated that they want everybody in the dining room being social. Staff #37 stated the CNAs need the nurses' permission to have a resident get a hall tray. An interview was conducted on 01/30/19 at 09:20 AM with the Registered Dietician consultant (RD/staff #128) who stated she was not happy with some of what they have been doing with meal service. The RD stated the residents have choices and have that right to choose. The RD stated that right now the room trays are going out first, and then the dining room is served. Staff #128 stated they have been told residents may not be served the same thing if they do not eat in the dining room, the residents can get a sandwich or cottage cheese. The RD stated that it was reflected as a concern in a report she completed last week under meal service. An interview was conducted on 01/30/19 at 10:51 AM with a Registered Nurse (RN/staff #10), who stated that on the skilled unit they want to promote residents getting up. Staff #10 further stated that some residents do not like to go to the dining room for certain meals and that if they do not go to the dining room there are sandwiches that they can have. Staff #10 stated that if the resident does not want to go to the dining room, then the CNA will let her know and she will go and talk to the resident. The RN stated this is what they have been told to do, Tell the resident they can get a sandwich for lunch. Staff #10 stated that she has been told by management that the theory behind it is because the CNAs need to be in the dining room during meal service and the second theory is that so residents are not isolated and they get moving. An interview was conducted on 01/30/19 at 10:58 AM with the Director of Nursing (DON/staff #38), who stated, One of the most important things is to get to know the residents and make sure we are taking care of them the way they want to be taken care of, for example if we gave them bananas or eggs every day when they don't like them. It is about really knowing the resident and what matters to them .It is absolutely important for a resident to have choices in their daily routine. The staff need to be flexible in changing things for them (the residents). We bend over backwards for residents to get their routines the way they want. Staff #38 stated 2 years ago we had a significant issue with residents really being lazy that they did not want to go to the dining room because they wanted to eat in their rooms. Staff #38 stated it was difficult to have 23 room trays and monitor them correctly. She stated that they had wound care issues with people not getting up. The DON stated that she was told by her Corporate Leadership and the Administrator/Executive Director at the time, that residents were told that they were expected to eat in the dining room and that if they decided they did not want to eat in the dining room that was behavioral act. She further stated that if it is a behavioral thing, then the residents will have a cold sandwich. Staff #38 stated she did not know how the message was delivered to residents. The DON stated that if people asked about it, they were told nobody is being denied food; they are just not getting the tray that is in the dining room. Staff #38 stated the policy is provided to all residents at the time of admission to the facility. An interview was conducted on 01/30/19 at 11:12 AM with the Administrator/Executive Director (staff #102), who stated originally they had a few people that refused to leave their room and that to encourage residents to go to the dining room, they made the policy. The Administrator stated that residents could also go to the dining room and pick up a tray and that if they did not want to do either, they were provided a sack lunch. Review of a facility policy, untitled, that was provided on admission to all residents read: Effective (MONTH) 13, (YEAR), (facility) Long Term Care Residents are to go to the Main Dining Room for meals. There are many benefits to getting out of bed and going to the dining room. They include: Prompt serving of the food which means it will be at the correct temperature for eating.

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 0550 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) Sitting in a chair to eat helps prevent choking and facilitates proper swallowing. If you should have difficulty swallowing or have a choking event, staff are immediately available to assist you. The activity of getting out of bed helps to retain your muscle strength and helps to prevent blood clots from forming in your legs. Meal time is a time for socialization with the other residents, it get you out of your room. Being active is important for your physical and mental wellbeing. Please help us to help you by cooperating with the c.n.as to get you to the Dining Room. To be clear, eating in the Main Dining Room at all meals is not an option, it is now the policy of (facility) for all Long Term Care Residents. Thank you in advance for helping us to help you receive the high quality of care you deserve. A review of the facility's policy titled Resident Rights (December, (YEAR)) included the policy statement, Employees shall treat all residents with kindness, respect, and dignity. The policy included Federal and State laws guarantee certain basic rights to all residents which included the resident's right to exercise his or her rights without interference, coercion, discrimination or reprisal from the facility. Review of the facility policy titled Resident rights - Food and Nutrition Services Department (revised 08/31/18) included the policy statement, The Food and Nutrition Services Department should make every effort to carry out the Resident Bill of rights to its fullest extent and should follow specific guidelines pertaining to resident rights. The policy revealed residents have the right to choose when, where, what, how much and with whom they eat. Review of the facility policy titled Nursing Department Responsibilities at Mealtime (revised 08/31/18) included in the policy statement that nursing is generally responsible for distributing food trays to all residents in the community who are served in their rooms.
F 0561 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interviews, clinical record review, and policies and procedures, the facility failed to promote and facilitate resident self-determination through support of the resident choice for 5 residents (#s 107, 108, 49, 208, and 13). This deficient practice prevented the residents from self-determination regarding making choices about activities, schedules, and aspects of his or her life in the facility that were significant to the residents. The sample size was 14. Findings include: -Resident #107 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A Minimum Data Set Assessment had not been completed at the time of the review; however the resident was identified by the staff as being alert and oriented. An interview was conducted with resident #107 on 01/28/19 at 11:53 AM who stated, I was told if I don't get up and go to the dining room, then I can't eat. All I can get is a sandwich. The resident stated, I have been in a lot of pain and I don't always feel like going to the dining room and the staff here don't understand that, so all they will give me then is a sandwich. An observation conducted on the same day of resident #107 at 01:15 PM revealed the resident was in bed and was served a sandwich and juice for lunch. -Resident #108 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A Minimum Data Set Assessment had not been completed at the time of the review; however the resident was identified by the staff as being alert and oriented. During an interview and observation with resident #108 on 01/28/19 at 1:30 PM, the resident stated that if he does not go down to the dining room, the staff bring him a sandwich. He stated that he is not offered the regular lunch menu if he does not go down to the dining room. A plate with a sandwich was observed sitting on the resident's bed at the time of the interview. -Resident #13 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The quarterly MDS assessment documented the resident had a BIMS score of 13, that indicated the resident was cognitively intact. An observation conducted on 01/29/19 at 12:30 PM, revealed the resident was in the room when lunch service started at 12:30 PM in the dining room. The resident was observed lying in bed with no tray served to the resident when the other trays were served on his unit at approximately 12:10 PM. In an interview conducted with the resident at the same time as the observation, the resident stated that he did not feel like going to the dining room. When asked if he was waiting for his lunch tray he said, Yes I am and they better get it soon because I am hungry. An observation conducted at 12:50 PM revealed no lunch tray had been delivered to the resident. When the Licensed Practical Nurse (LPN/staff #57) was asked about the resident's lunch tray, the LPN went into the resident's room, pulled the curtain around the resident's bed, and engaged in a conversation with the resident that could not be overheard. Approximately 10 minutes later the LPN emerged from the room pushing the resident in a wheelchair and took the resident to the dining room. An interview was conducted on 01/31/19 at 10:11 AM with resident #13 who stated, Sometimes I don't feel like going to the dining room and want to eat in my room, but then someone comes in and convinces me to go even if I didn't want to. The resident emphasized the word convinces when he made the statement but would not elaborate on what he meant by that. An interview was conducted on 01/31/19 at 10:33 AM with the LPN (staff #57), who stated that the resident had told him earlier in the day that he wanted to go to the dining room. The LPN stated that when he was asked about the resident's tray, he went and got the resident up. -Resident #49 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the quarterly MDS assessment dated [DATE] included a Brief Interview for Mental Status (BIMS) score of 7, which indicated the resident had moderate cognitive impairment. The assessment also included the resident required supervision with set-up help only for eating. An observation of the resident conducted on 01/29/19 at 12:45 PM revealed the resident was in her bed asleep when lunch was being served in the dining room. The resident was not served a tray or meal of any type. An interview was conducted on 01/30/19 at 10:44 AM with the resident who stated, I wish they would get me up for my meals. I fall asleep quite easily and I thought I told them to get me up. I didn't have any lunch yesterday because no one got me up. The resident stated she likes to go to the dining room. -Resident #208 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The admission MDS assessment dated [DATE] documented the staff assessed the resident as being severely cognitively impaired and having short and long term memory problems. The assessment included the resident was a total assist of one person for eating. A lunch dining observation conducted on 01/29/19 at 12:50 PM revealed the resident declined to eat what was offered by a CNA assisting her with eating. The resident was not offered any alternate options, was removed from the table, and returned to her room. An interview was conducted on 01/29/19 at 02:12 PM with CNA (staff #15) who stated resident #208 is a [MEDICAL TREATMENT] patient and will sometimes say she cannot eat because she is on [MEDICAL TREATMENT] and sometimes she will say she wants peanut butter and jelly. Staff #15 stated that today the resident said she was hurting so the CNA that was feeding her took her to her room and did not offer her anything else to eat. During an interview conducted on 01/29/19 at 10:45 AM with the Dietary Manager (staff #89), staff #89 stated that the facility has a policy for everyone to get out of the bed and go to the dining room for meals. Staff #89 stated that if the residents do not want to go to the dining room, they have sandwiches made up that they can give the residents with a drink and maybe some yogurt. An interview was conducted on 01/29/19 at 2:25 PM with a CNA (staff #37), who stated that if residents are able to go to the dining room for a meal and they do not have a reason not go to the dining room, they have been encouraged by management to give the resident a sack lunch instead of a meal tray. Staff #37 further stated that they want everybody in the dining room

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F 0561

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

(continued... from page 2)
being social. Staff #37 stated the CNAs need the nurses' permission to have a resident get a hall tray.
An interview was conducted on 01/30/19 at 09:20 AM with the Registered Dietician consultant (RD/staff #128) who stated that she was not happy with some of what they have been doing with meal service. The RD stated that the residents' have choices and the right to choose. The RD stated that right now the room trays are going out first, and then the dining room is served. She stated that the residents have been told they may not be served the same meal as the residents that are in the dining room if they do not eat in the dining room. She stated the resident have been told that they can get a sandwich or cottage cheese. The RD stated that this practice was reflected as a concern in a report she that completed last week under meal service.
During an interview conducted on 01/30/19 at 10:51 AM with a Registered Nurse (RN/staff #10), the RN stated that on the skilled unit we want to promote residents getting up. Staff #10 further stated that some of the residents do not like going to the dining room for certain meals and that if they do not go to the dining room, there are sandwiches available that they can have. The RN stated that if the resident does not want to go to the dining room, the CNA will let her know and she will talk to the resident. She stated that they have been instructed to tell the resident they can get a sandwich for lunch. Staff #10 stated that she has been told by management that the theory behind this is that the CNAs need to be in the dining room during meal service and the second theory is so residents are not isolated and it gets them moving.
An interview was conducted on 01/30/19 at 10:58 AM with the Director of Nursing (DON/staff #38), who stated, One of the most important things is to get to know the residents and make sure we are taking care of them the way they want to be taken care of, for example if we gave them bananas or eggs every day when they don't like them. It is really about knowing the resident and what matters to them .It is absolutely important for a resident to have choices in their daily routine. The staff need to be flexible in changing things for them. We bend over backwards for residents to get their routines the way they want. The DON stated that 2 years ago they had a significant issue with residents really being lazy that they did not want to go to the dining room because they wanted to eat in their rooms. Staff #38 stated that it was difficult to have 23 room trays and monitor them correctly. She stated that they had wound care issues with people not getting up. The DON stated that she was told by her Corporate Leadership and the Administrator/Executive Director at the time, that residents were told that they were expected to eat in the dining room and that if they decided they did not want to eat in the dining room that it was behavioral act. She further stated that if it is a behavioral thing, then the residents will have a cold sandwich. Staff #38 stated that she did not know how the message was delivered to residents. The DON stated that if people asked about it, they were told nobody is being denied food; they are just not getting the tray that is in the dining room. Staff #38 stated the policy is provided to all residents at the time of admission to the facility.
An interview was conducted on 01/30/19 at 11:12 AM with the Administrator/Executive Director (staff #102), who stated originally they had a few people that refused to leave their room and that to encourage residents to go to the dining room, they made the policy. The Administrator stated that residents could also go to the dining room and pick up a tray and that if they did not want to do either, they were offered a sack lunch.
Review of the facility's policy, untitled, that was provided on admission to all residents read:
Effective (MONTH) 13, (YEAR), (facility) Long Term Care Residents are to go to the Main Dining Room for meals. There are many benefits to getting out of bed and going to the dining room. They include:
-Prompt serving of the food which means it will be at the correct temperature for eating.
-Sitting in a chair to eat helps prevent choking and facilitates proper swallowing.
-If you should have difficulty swallowing or have a choking event, staff are immediately available to assist you.
-The activity of getting out of bed helps to retain your muscle strength and helps to prevent blood clots from forming in your legs.
-Meal time is a time for socialization with the other residents, it gets you out of your room.
Being active is important for your physical and mental well-being. Please help us to help you by cooperating with the CNAs to get you to the Dining Room. To be clear, eating in the Main Dining Room at all meals is not an option, it is now the policy of (facility) for all Long Term Care Residents. Thank you in advance for helping us to help you receive the high quality of care you deserve.
A review of the facility's policy titled Resident Rights (December, (YEAR)) included the policy statement, Employees shall treat all residents with kindness, respect, and dignity. The policy also revealed resident rights included the right to self-determination, the right to be supported by the facility in exercising his or her rights, and the right to exercise his or her rights without interference, coercion, discrimination or reprisal from the facility.
Review of the facility's policy titled Resident rights - Food and Nutrition Services Department (revised 08/31/18) included the policy statement, The Food and Nutrition Services Department should make every effort to carry out the Resident Bill of rights to its fullest extent and should follow specific guidelines pertaining to resident rights.

F 0600

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Few

Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on clinical record review, interviews, and policy and procedure, the facility failed to ensure resident #2 and resident #44 was free from abuse by resident #207.
Findings include:
-Resident #2 was admitted to the facility on (MONTH) 26, (YEAR), with [DIAGNOSES REDACTED].
Review of the quarterly Minimum Data Set (MDS) assessment dated (MONTH) 8, (YEAR), revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact.
A nurse's note dated (MONTH) 14, (YEAR) revealed resident #2 reported being grabbed on his left forearm by another resident (#207). The note stated the resident had a bruise on his left forearm. The bruise was described as yellow discoloring and is approx. 3 x 3 remaining dark purple discoloration.
-Resident #207 was admitted to the facility on (MONTH) 19, (YEAR), with [DIAGNOSES REDACTED]. The resident was discharged
from the facility on (MONTH) 14, (YEAR).
Review of the comprehensive care plan for resident #207 revealed a focus area initiated on (MONTH) 28, (YEAR), for socially inappropriate behaviors. Interventions included attempting to de-escalate and staff intervention as necessary to protect the rights and safety of others.
Review of the quarterly MDS assessment dated (MONTH) 16, (YEAR), revealed a BIMS score of 15, which indicated resident #207 was cognitively intact.
Review of the facility's investigation report dated (MONTH) 19, (YEAR), revealed that resident #2 reported being grabbed on his left forearm by resident #207. The report stated that resident #207 initially denied the incident, but later said maybe he grabbed the other resident's arm. There were no other witnesses to the event. The report stated there was a bruise on the left forearm of resident #2. The report did not indicate the size of the bruise. The report did not include a conclusion of whether the allegation was/was not substantiated.
An interview was conducted with resident #2 on (MONTH) 28, 2019 at 1:05 p.m. He stated that as he was going down the hall in a wheelchair, he past resident #207 who reached out and hit him and grabbed his forearm. He stated that he reported the incident to the staff and that the other resident was no longer at the facility.
An interview was conducted with the Director of Nursing (DON/staff #38) on (MONTH) 30, 2019 at 1:55 p.m. She stated that she investigated the incident. She said both residents were interviewed, and that there were no other witnesses to the event. The DON stated that the other resident initially denied the incident, but later said maybe he grabbed the resident's arm. She said there was a bruise on the left forearm of resident #2.
-Resident #44 was admitted to the facility on (MONTH) 27, (YEAR), with [DIAGNOSES REDACTED].
Review of the quarterly Minimum Data Set (MDS) assessment dated (MONTH) 22, (YEAR) revealed a BIMS score of 15, indicating the resident was cognitively intact.
A nursing note dated (MONTH) 12, (YEAR) revealed resident #44 reported that she was going around resident #207 in her wheelchair when resident #207 struck out at her with an open hand hitting her left upper arm. The note also stated that there was no discoloration or swelling but that resident #44 reported that her arm was tender.

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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 0600 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) The facility's investigation report dated (MONTH) 19, (YEAR) revealed that on (MONTH) 12, (YEAR) at about 6:00 p.m. resident #44 reported to the Licensed Practical Nurse (LPN/staff #55) that when she was rolling past resident #207 in her wheelchair after leaving the dining room, resident #207 suddenly struck at her twice with an open hand and hit her upper left arm. Resident #44 said that there was no staff or other residents around when this incident occurred. In the report a statement by the Director of Nursing (DON/staff #38) revealed that when she went to talk to resident #207 he stated that when he gets anxious and nervous things like that happen. He stated that Maybe it happened when I was anxious and not feeling well. An interview was conducted with resident #44 on (MONTH) 28, 2019, at 11:53 a.m. She stated that resident #207 was mean and that he would say things about her and that he would show her the finger. She stated that he would cuss at her and say dirty things but that she always ignored it. Resident #44 said that one day as she was coming from supper, she passed resident #207 in the hallway and that he hit her left arm with his hand. She also stated that people were afraid of him because of his physical aggression and his temper. An interview was conducted with a Licensed Practical Nurse (LPN/staff #55) on (MONTH) 29, 2019 at 2:10 p.m. Staff #55 stated that she was notified about the altercation by a Certified Nursing Assistant (CNA) who no longer works there. She stated that the incident was unwitnessed. The LPN stated that once she was notified of the incident, she made sure the residents were separated. She stated that she then notified the Director of Nursing and the Nurse Practitioner. An interview was conducted with the Director of Nursing (DON/staff #38) on (MONTH) 30, 2019 at 1:55 p.m. She stated that for an allegation of abuse, the staff first responsibility is to stop the abuse and keep the residents safe. She stated that their second responsibility is to report it immediately. The DON stated that resident #207 did not have a history of physical aggression prior to this incident. Review of the facility's policy Abuse Program Policy and Procedure revealed that the residents in the facility have the right to be free from abuse, neglect, and misappropriation of resident property. The policy included residents must not be subjected to abuse by anyone, including but not limited to facility staff, other residents, consultants or volunteers.
F 0602 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Protect each resident from the wrongful use of the resident's belongings or money.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation, resident, family, and staff interviews, and policy, the facility failed to ensure one resident's (#44) coin purse and 20 dollars was not misappropriated. Findings include: Resident #44 was admitted to the facility on (MONTH) 27, (YEAR), with [DIAGNOSES REDACTED]. Review of the quarterly Minimum Data Set (MDS) assessment dated (MONTH) 22, (YEAR), revealed a 14 on the Brief Interview for Mental Status (BIMS) indicating the resident was cognitively intact. The facility's investigation report dated (MONTH) 13, (YEAR), revealed the resident's coin purse and 20 dollars was reported missing on (MONTH) 6, (YEAR). A search was conducted but the coin purse and the 20 dollars was unable to be located. Per the report, the 20 dollars were given to the resident by her family member. The report included the facility suspected that the resident from the skilled unit, who was visiting another resident near resident #44's room must have stolen it. Per the report, the resident's room was search but the coin purse and the 20 dollars was not found. During an interview conducted with resident #44 on (MONTH) 28, 2019 at 11:53 a.m., the resident stated that she had a turquoise color coin purse on her side table with 20 dollars in it and that it was stolen. An interview was conducted on (MONTH) 30, 2019 at 10:25 a.m. with the family member who confirmed that the resident had been given 20 dollars to go shopping with activities. She stated that Resident #44 had a lot of stuff missing like clothes and money. She stated that she had to replace a lot of her clothing, but that since resident #44 put the lock on her cupboard and side table nothing has been stolen since. An interview was conducted with the Director of Social Services (staff #123) on (MONTH) 30, 2019 at 11:16 a.m. She stated that it was suspected that the money and the coin purse were taken by a resident who was on the skilled unit and had a tendency of going into residents' room and taking their things. She stated that the resident on the skilled unit left Against Medical Advice and that they were unable to check his room prior to his leaving. Staff #123 stated they searched the bag the resident left behind but was unable to find anything. The Director of Social Services stated that during the investigation it was established that the money and the purse were present and went missing and that it would be considered misappropriation of resident property. During an interview conducted with a Certified Nursing Assistant (CNA/staff#20) on (MONTH) 30, 2019 at 12:22 p.m. She stated that she was told that resident #44 had her purse and money stolen by another CNA and it was then that she remembered seeing another resident from the skilled unit near resident #44's room. She stated that they had a suspicion that this resident from the skilled unit was taking other residents' belongings and going into their room. The CNA stated that she believes that they did search his room a couple of times but that they could not find anything. An interview was conducted with the Director of Nursing (DON/staff #38) on (MONTH) 30, 2019 at 1:55 p.m. The DON stated that if there is a reasonable belief that something was stolen, misappropriation of resident property should been substantiated. Review of the facility's policy Abuse Program Policy and Procedure revealed residents in the facility have the right to be free from misappropriation of resident property.
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 and procedure, the facility failed to implement their abuse policy by failing to report two allegations of abuse to the State Agency within 2 hours for four residents (#s 157, 24, 2, and 207) and by failing to conduct a thorough investigation regarding an allegation of abuse for two residents (#44 and #207). Findings include: -Resident #157 was admitted to the facility on (MONTH) 3, (YEAR), with [DIAGNOSES REDACTED]. A review of the quarterly Minimum Data Set (MDS) assessment dated (MONTH) 20, (YEAR) revealed a Brief Interview for Mental Status (BIMS) score of 8 which indicated the resident had moderate cognitive impairment. -Resident #24 was admitted to the facility on (MONTH) 2, (YEAR), with [DIAGNOSES REDACTED]. A review of the quarterly MDS assessment dated (MONTH) 24, (YEAR) revealed a BIMS score of 15 which indicated no cognitive impairment. Review of a Nurse Note dated (MONTH) 3, (YEAR) at 11:54 a.m. revealed the resident was hit in the face by another resident (#157). Review of the facility's Reportable Event Record/Report dated (MONTH) 8, (YEAR) revealed that on (MONTH) 3, (YEAR) resident #157 struck resident #24 in the face when their wheelchairs became entangled and resident #24 attempted to separate the wheelchairs. It was noted on the report that the event had been called in to the State Agency on (MONTH) 4, (YEAR) at 2:30 p.m. During an interview conducted with a LPN (staff #57) on (MONTH) 30, 2019 at 10:23 a.m., the LPN stated that he remembered the incident that occurred on (MONTH) 3, (YEAR). He stated that the residents' wheelchairs had locked up and that resident #157 struck resident #24 on the cheek. The LPN stated that he called the DON within minutes of the incident, because if somebody hits somebody it is a potential abuse situation. An interview was conducted with the Director of Nursing (DON/staff #38) on (MONTH) 30, 2019 at 1:57 p.m. The DON stated that when there is an allegation of resident to resident abuse she would report the suspicion of abuse within 2 hours. In regard to the incident involving resident #157 and resident #24 she stated the facility misunderstood the requirement of reporting to the State Agency within 2 hours. She stated at the time this incident occurred, the facility was reporting incidents such as this to the State Agency within 24 hours. -Resident #2 was admitted to the facility on (MONTH) 26, (YEAR), with [DIAGNOSES REDACTED]. Review of the quarterly Minimum Data Set (MDS) assessment dated (MONTH) 8, (YEAR), revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. A nurse's note dated (MONTH) 14, (YEAR) revealed resident #2 reported being grabbed on his left forearm by another resident (#207). The note stated the resident had a bruise on his left forearm. -Resident #207 was admitted to the facility on (MONTH) 19, (YEAR), with [DIAGNOSES REDACTED]. The resident was discharged

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F 0607

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Few

(continued... from page 4)
from the facility on (MONTH) 14, (YEAR).
Review of the quarterly MDS assessment dated (MONTH) 16, (YEAR), revealed a BIMS score of 15, which indicated resident #207 was cognitively intact.
-Resident #44 was admitted to the facility on (MONTH) 27, (YEAR), with [DIAGNOSES REDACTED].
Review of the quarterly Minimum Data Set (MDS) assessment dated (MONTH) 22, (YEAR) revealed a score of 15 on the BIMS, indicating the resident was cognitively intact.
A nursing note dated (MONTH) 12, (YEAR) revealed resident #44 reported that she was going around resident #207 in her wheelchair when resident #207 struck out at her with an open hand hitting her left upper arm. The note also stated that there was no discoloration or swelling but that resident #44 reported that her arm was tender.
The facility's investigation report dated (MONTH) 19, (YEAR) revealed that on (MONTH) 12, (YEAR) at about 6:00 p.m. resident #44 reported to the Licensed Practical Nurse (LPN/staff #55) that when she was rolling past resident #207 in her wheelchair after leaving the dining room, resident #207 suddenly struck at her twice with an open hand and hit her upper left arm. She also stated that resident #2 told her that resident #207 had grabbed his arms also when he passed him in the hallway and that it left a bruise on his arm.
Review of the facility's investigation report regarding resident #207 grabbing resident #2's arm dated (MONTH) 19, (YEAR) revealed the allegation was not reported to the State Agency until (MONTH) 14, (YEAR).
An interview was conducted with the DON (staff #38) on (MONTH) 30, 2019 at 1:55 p.m. She stated that on (MONTH) 12, (YEAR), she learned about the allegation that resident #2 was grabbed on the arm by resident #207. She stated that she did not report the allegation to the Administrator and the State Agency until (MONTH) 14, (YEAR).
Review of the facility's policy regarding abuse revealed staff must immediately report any suspected abuse to the Administrator. The policy revealed physical abuse includes hitting, slapping, pinching, and kicking. The policy also revealed all alleged violations involving abuse are reported to the State Survey Agency immediately, but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse.
Further review of the facility's investigation report regarding resident #44 and resident #207 revealed resident #44 stated that there was no staff or other residents around when this incident occurred. The report included interviews with resident #44 and resident #207, but did not include interviews with other residents who may have been in contact with resident #207.An interview was conducted with the DON (staff #38) on (MONTH) 30, 2019 at 1:55 p.m. Staff #38 stated that during the investigation they should have interviewed other residents who may have been in similar situations with resident #207. The DON stated that if the interviews were not in the investigation report then she must have forgotten to do them.
Review of the facility's policy Abuse Program Policy and Procedure revealed all reports of resident abuse shall be promptly and thoroughly investigated by facility management. The policy included the staff conducting the investigation will at a minimum interview other residents as medically appropriate.

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 reviews, staff interviews, facility documentation, and policy and procedure, the facility failed to ensure two allegations of abuse were reported to the State Agency within two hours regarding residents (#s 157, 24, 2, 44, and 207).
Findings include:
-Resident #157 was admitted to the facility on (MONTH) 3, (YEAR), with [DIAGNOSES REDACTED].
A review of the quarterly Minimum Data Set (MDS) assessment dated (MONTH) 20, (YEAR) revealed a Brief Interview for Mental Status (BIMS) score of 8 which indicated the resident had moderate cognitive impairment.
-Resident #24 was admitted to the facility on (MONTH) 2, (YEAR), with [DIAGNOSES REDACTED].
A review of the quarterly MDS assessment dated (MONTH) 24, (YEAR) revealed a BIMS score of 15, which indicated no cognitive impairment.
Review of a Nurse Note dated (MONTH) 3, (YEAR) at 11:54 a.m. revealed the resident was hit in the face by another resident (#157).
Review of the facility's Reportable Event Record/Report dated (MONTH) 8, (YEAR) revealed that on (MONTH) 3, (YEAR) resident #157 struck resident #24 in the face when their wheelchairs became entangled and resident #24 attempted to separate the wheelchairs. It was noted on the report that the event was called in to the State Agency on (MONTH) 4, (YEAR) at 2:30 p.m. During an interview conducted with a LPN (staff #57) on (MONTH) 30, 2019 at 10:23 a.m., the LPN stated that he remembered the incident that occurred on (MONTH) 3, (YEAR). He stated that the residents' wheelchairs had locked up and that resident #157 struck resident #24 on the cheek. The LPN stated that he called the Director of Nursing (DON) within minutes of the incident, because if somebody hits somebody it is a potential abuse situation.
In an interview with the DON (staff #38) on (MONTH) 30, 2019 at 1:57 p.m., the DON stated that they misunderstood the requirement of reporting to the State Agency within 2 hours. She stated that at the time this incident occurred, the facility was reporting to the State Agency within 24 hours.
-Resident #2 was admitted to the facility on (MONTH) 26, (YEAR), with [DIAGNOSES REDACTED].
Review of the quarterly Minimum Data Set (MDS) assessment dated (MONTH) 8, (YEAR), revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact.
A nurse's note dated (MONTH) 14, (YEAR) revealed resident #2 reported being grabbed on his left forearm by another resident (#207). The note stated the resident had a bruise on his left forearm.
-Resident #207 was admitted to the facility on (MONTH) 19, (YEAR), with [DIAGNOSES REDACTED]. The resident was discharged
from the facility on (MONTH) 14, (YEAR).
Review of the quarterly MDS assessment dated (MONTH) 16, (YEAR), revealed a BIMS score of 15, which indicated resident #207 was cognitively intact.
-Resident #44 was admitted to the facility on (MONTH) 27, (YEAR), with [DIAGNOSES REDACTED].
Review of the quarterly Minimum Data Set (MDS) assessment dated (MONTH) 22, (YEAR) revealed a score of 15 on the BIMS, indicating the resident was cognitively intact.
A nursing note dated (MONTH) 12, (YEAR) revealed resident #44 reported that she was going around resident #207 in her wheelchair when resident #207 struck out at her with an open hand hitting her left upper arm. The note also stated that there was no discoloration or swelling but that resident #44 reported that her arm was tender.
The facility's investigation report dated (MONTH) 19, (YEAR) revealed that on (MONTH) 12, (YEAR) at about 6:00 p.m. resident #44 reported to the Licensed Practical Nurse (LPN/staff #55) that when she was rolling past resident #207 in her wheelchair after leaving the dining room, resident #207 suddenly struck at her twice with an open hand and hit her upper left arm. She also stated that resident #2 told her that resident #207 had grabbed his arms also when he passed him in the hallway and that it left a bruise on his arm.
Review of the facility's investigation report regarding resident #207 grabbing resident #2's arm dated (MONTH) 19, (YEAR) revealed the allegation was not reported to the State Agency until (MONTH) 14, (YEAR).
An interview was conducted with the DON (staff #38) on (MONTH) 30, 2019 at 1:55 p.m. She stated that on (MONTH) 12, (YEAR), she learned about the allegation that resident #2 was grabbed on the arm by resident #207. The DON stated that she wanted to confirm the allegation with resident #2 and that she did not speak with resident #2 until (MONTH) 14, (YEAR). She stated that she did not report the allegation to the Administrator and the State Agency until (MONTH) 14, (YEAR).
Review of the facility's abuse prevention policy revealed that staff must immediately report any suspected abuse to the Administrator. The policy further stated that the Administrator would report an allegation of abuse to the State Survey Agency within 2 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 clinical record reviews, facility documentation, staff interview, and policy and procedure, the facility failed to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **035147**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **01/31/2019**
NAME OF PROVIDER OF SUPPLIER **VILLA MARIA CARE CENTER**		STREET ADDRESS, CITY, STATE, ZIP **4310 EAST GRANT ROAD TUCSON, AZ 85712**	

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

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F 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 5) ensure an allegation of resident to resident abuse was thoroughly investigated for two residents (#44 and #207). Findings include: -Resident #207 was admitted to the facility on (MONTH) 19, (YEAR), with [DIAGNOSES REDACTED]. The resident was discharged from the facility on (MONTH) 14, (YEAR). Review of the quarterly MDS assessment dated (MONTH) 16, (YEAR), revealed a BIMS score of 15, which indicated resident #207 was cognitively intact. -Resident #44 was admitted to the facility on (MONTH) 27, (YEAR), with [DIAGNOSES REDACTED]. Review of the quarterly Minimum Data Set (MDS) assessment dated (MONTH) 22, (YEAR) revealed a BIMS score of 15, indicating the resident was cognitively intact. A nursing note dated (MONTH) 12, (YEAR) revealed resident #44 reported that she was going around resident #207 in her wheelchair when resident #207 struck out at her with an open hand hitting her left upper arm. The note also stated that there was no discoloration or swelling but that resident #44 reported that her arm was tender. The facility's investigation report dated (MONTH) 19, (YEAR) revealed that on (MONTH) 12, (YEAR) at about 6:00 p.m. resident #44 reported to the Licensed Practical Nurse (LPN/staff #55) that when she was rolling past resident #207 in her wheelchair after leaving the dining room, resident #207 suddenly struck at her twice with an open hand and hit her upper left arm. Resident #44 said that there was no staff or other residents around when this incident occurred. The report included interviews with resident #44 and resident #207, but did not include interviews with other residents who may have been in contact with resident #207. An interview was conducted with the DON (staff #38) on (MONTH) 30, 2019 at 1:55 p.m. Staff #38 stated that during the investigation they should have interviewed other residents who may have been in similar situations with resident #207. The DON stated that if the interviews were not in the investigation report then she must have forgotten to do them. Review of the facility's policy Abuse Program Policy and Procedure revealed all reports of resident abuse shall be promptly and thoroughly investigated by facility management. The policy included the staff conducting the investigation will at a minimum interview other residents as medically appropriate.
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, staff interviews, clinical record review, and policies and procedures, the facility failed to ensure services meet professional standards for one resident (#208) regarding notifying the physician about refusal of care and for one resident (#42) regarding administering medication according to the physician's orders [REDACTED].>Findings include:-Resident #208 was admitted on (MONTH) 17, 2019 with [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. An admission Minimum Data Set (MDS) assessment dated (MONTH) 23, 2019 revealed the resident's cognitive skills for daily decision making were severely impaired and that resident was totally dependent on staff for activities of daily living (ADLs), such as mobility and transfers. Review of the Medication Administration Record [REDACTED]. An observation was conducted of the resident on (MONTH) 29, 2019 at 8:42 a.m. The resident was observed in the dining room not wearing the C-collar. During an observation of the resident conducted on (MONTH) 29, 2019 at 12:43 p.m., the resident was observed without the C-collar in place. Multiple observations were conducted of the resident on (MONTH) 30 and 31, 2019. The resident was not observed with the C-collar in place during any observation. Review of the clinical record revealed no documentation that the physician was notified that the resident was not wearing the C-collar. An interview was conducted on (MONTH) 30, 2019 at 9:36 a.m. with a Licensed Practical Nurse (LPN/staff #57) who stated that the resident refuses to wear the C-collar daily. Staff #57 stated that when resident #208 refuses, he will approach the resident later in the day to see if he will wear the C-collar. The LPN stated that he has documented the refusal but he has not notified the physician regarding the resident refusing to wear the C-collar. During an interview conducted on (MONTH) 30, 2019 at 12:22 p.m. with a Nurse Practitioner (NP/staff #128), she stated that she had been made aware that the resident has often refused to eat and take some medication. The NP further stated that she was not aware of the resident refusing any other physician's orders [REDACTED].>An interview was conducted on (MONTH) 31, 2019 at 10:49 a.m. with the Director of Nursing (DON/staff #38) who stated that the expectation is for the nurses to make several attempts to administer a medication or treatment when a resident has initially refused the medication or treatment. The DON stated that if the resident still refuses, the nurse should notify the physician and document the refusal and the physician notification in a progress note. Review of a facility's policy titled Change in Residents Status or Condition Policy revealed the nurse will notify the resident's attending physician or physician on call when there has been a (an): -refusal of treatment or medications two (2) or more consecutive times. -Resident #42 was admitted to the facility on (MONTH) 14, (YEAR), with [DIAGNOSES REDACTED]. Review of the admission Minimum Data Set (MDS) assessment dated (MONTH) 20, (YEAR), revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. Review of the current comprehensive care plan revealed the resident had pain related to a [MEDICAL CONDITION]. Interventions included to administer pain medications as ordered. The physician's orders [REDACTED]. Further review of the physician's orders [REDACTED]. The Medication Administration Record [REDACTED]. Review of the clinical record revealed the resident was discharged from the facility on (MONTH) 16, 2019, and readmitted to the facility on (MONTH) 17, 2019. The physician's admitting orders revealed an order dated (MONTH) 17, 2019, for [MEDICATION NAME] (Tylenol) 325 milligrams, 1 tablet every 4 hours as needed for a pain level of 1-4 out of 10. Further review of the physician's admitting orders revealed no order for as needed pain medication for a pain level of 5-10 out of 10. Review of the Medication Administration Record [REDACTED]. An interview was conducted on (MONTH) 29, 2019 at 2:31 p.m. with a Licensed Practical Nurse (LPN/staff #55). She stated that she would administer pain medication according to the pain parameters ordered by the physician. The LPN stated that if an order was not available for a medication for the resident's reported level of pain, she would call the physician to obtain an appropriate order. An interview was conducted on (MONTH) 30, 2019 at 1:17 p.m. with the Director of Nursing (DON/staff #38). She stated that pain medications should not be administered outside of the physician ordered pain parameters. The DON stated that if an order was not available for a medication for the resident's reported level of pain, she would expect the nurse to call the physician to obtain an appropriate order. Review of the facility's policies for pain management and medication administration revealed the following: -Pain management interventions should reflect the severity of pain. -Medications must be administered in accordance with the orders.
F 0697 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide safe, appropriate pain management for a resident who requires such services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, clinical record review, and policies and procedures, the facility failed to ensure one resident (#208) was provided pain management consistent with professional standards of practice and the person-centered care plan. Findings include: Resident #208 was admitted on (MONTH) 17, 2019 with [DIAGNOSES REDACTED]. A physician's orders [REDACTED].

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035147	A. BUILDING ______ B. WING _____	01/31/2019

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VILLA MARIA CARE CENTER	4310 EAST GRANT ROAD TUCSON, AZ 85712

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

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F 0697 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 6)

Further review of the physician's orders [REDACTED].#208 for pain.
The admission pain assessment dated (MONTH) 17, 2019 revealed a pain interview should not be conducted with the resident. The staff assessment for the resident's pain did not reveal any indicators of pain or possible pain
Review of the Certified Nursing Assistant (CNA) task list report revealed the CNAs should report any signs or symptoms of pain to the nurse every shift.
Review of the care plan dated (MONTH) 18, 2019 revealed the resident had potential for generalized pain related to a chronic physical disability. The goal was that the resident will voice a level of comfort through the review date. Interventions included:
-Anticipate need for pain relief and respond immediately to any complaint of pain.
-Monitor/record/report to nurse any signs of symptoms of non-verbal pain: changes in breathing (noisy, deep/shallow, labored), Vocalizations (grunting, moans, yelling out), mood/behavior (changes, more irritable, restless, aggressive, squirmy, constant motion), eyes (glazed, tearing, no focus), face (sad, scared, worried, crying, grimacing), body (tense, rigid, thrashing, curled up).
-Monitor/record/report to nurse loss of appetite, refusal to eat, and weight loss.
-Monitor/record/report to nurse resident complaints of pain or requests for pain treatment.
A nursing progress note dated (MONTH) 19, 2019 revealed the resident was spitting out food during lunch stating that she did not want to eat anymore.
An admission Minimum Data Set (MDS) assessment dated (MONTH) 23, 2019 revealed the resident's cognitive skills for daily decision making were severely impaired. The MDS assessment included that the resident had not received any PRN (as needed) pain medication or non-medication interventions for pain during the 5 day look-back period. The assessment also included that staff reported the resident had vocal complaints of pain such as that hurts, ouch, stop for 1-2 days during the 5 day look-back period. The assessment further revealed the resident was interviewed and reported yes to pain being present.
A nursing progress note dated (MONTH) 29, 2019 revealed staff had a difficult time trying to get the resident to eat in the dining room.
Review of the Medication Administration Record (MAR) for (MONTH) 2019 revealed [MEDICATION NAME] was not administered to the resident. The MAR also included the resident had behaviors on the following days:
- (MONTH) 18: afraid
-January 20: screaming/yelling (each shift)
Review of the MAR and Treatment Administration Record for (MONTH) 2019 did not reveal documentation that the resident was assessed for pain.
During an observation conducted of the resident on (MONTH) 29, 2019 at 12:43 p.m. in the dining room, the resident was observed sitting in her wheel chair with her feet off the foot pedals. The resident was yelling it's hurting. No staff member was observed to respond to the resident. Resident #208 then stated call the paramedics and get medicine, it hurts. A CNA (staff #29) near the resident was not observed to respond to the resident. At 12:50 p.m., the resident stated repeatedly please take the pain away; I can't stand the pain anymore. Two CNAs repositioned the resident, but was not observed to report the resident's verbalization of pain to the nurse. At 1:00 p.m., resident #208 was refusing to eat and was yelling. A CNA (staff #51) removed resident #208 from the dining room. Resident #208's nurse (staff #57) was present. Staff #51 was not observed to notify staff #57 of resident #208's verbalization of pain and staff #57 was not observed to intervene in any way regarding the resident yelling out during removal from the dining room.
An interview was conducted on (MONTH) 30, 2019 at 9:09 a.m. with the CNA (staff #51) who stated that resident #208 does not eat well and will complain of pain sometimes. Staff #51 stated that resident #208 complained of pain yesterday and that she reported it to the nurse (staff #57).
An interview was conducted on (MONTH) 30, 2019 at 9:36 a.m. with the Licensed Practical Nurse (LPN/staff #57) who stated that resident #208 is assessed for pain daily and that there were no complaints of pain yesterday. Staff #57 stated that if a pain assessment is on the MAR that is where he would document it. The LPN stated that no staff member reported any complaints of pain to him regarding resident #208. He also stated that the resident has a poor appetite most of the time. Staff #57 stated that he reviewed the MAR and that the resident had not received [MEDICATION NAME] for pain. The LPN further stated that he had not read the care plan for resident #208.
An interview was conducted on (MONTH) 31, 2019 at 10:49 a.m. with the Director of Nursing (DON/staff #38) who stated that the expectation is for the nurses to assess each resident for pain and complete a pain assessment every shift. Staff #38 stated that when there is a resident complaining of pain to a CNA, the CNA staff are aware they are required to report it to the resident's nurse. The DON stated that both the CNA and the nursing staff are aware to look for non-verbal signs and symptoms of pain, especially for the residents who have severe cognitive impairment. The DON also stated that pain should be assessed frequently, as it is the 5th vital sign and that there are many non-verbal signs of pain such as changes in behaviors like restlessness, yelling, and poor appetite.
Review of the facility's policy titled Pain Assessment and Management Policy revealed the purpose is to help staff identify pain in the resident, and to develop interventions that are consistent with the residents goals and needs that address the underlying cause of pain. Pain Management is identified as the process of alleviating the resident's pain to a level that is acceptable to the resident and is based on his or her clinical condition and established treatment goals. Pain management is a multidisciplinary care process that includes the following:
- assessing for potential pain
- effectively recognizing the presence of pain
- identify characteristics of pain
- address underlying causes of pain
- develop and implement approaches to pain management
- identifying and using specific strategies for a different levels and sources of pain
- monitor effectiveness of interventions
- modify approaches as necessary
- recognize residents' ability to verbalize pain
- conduct comprehensive pain assessment
- observe resident for verbal and non-verbal signs of pain
- verbal expressions: moaning, groaning, crying, screaming, facial expressions, grimacing, jaw clenching,
Monitoring for pain includes:
-re-assess resident pain at least each shift
-monitor by performing basic assessment with enough detail as needed, with standardized assessment tools
-Document pain with adequate detail in accordance with pain management program.
-record information on pain assessment in medical record.