STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035272	A. BUILDING _____ B. WING _____	**08/30/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VI AT GRAYHAWK, A VI AND PLAZA COMPANIES COMMUNITY	**7501 EAST THOMPSON PEAK PARKWAY SCOTTSDALE, AZ 85255**

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, clinical record review, staff interviews, and policy review, the facility failed to ensure that one resident (#19) was treated with dignity and respect. The deficient practice could result in residents experiencing a negative psychosocial outcome and decrease in quality of life. Findings include: Resident #19 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Review of the care plan with a start date 5/13/2019 revealed the resident had a self-care and mobility deficit. The goal was that the resident will maintain/improve functional level. Intervention included assisting as needed and that the resident bed is placed against the wall per his choice for a sense of space. A nursing progress noted dated 5/14/2019 stated the resident has private caregiver(s) at bedside at all times. Review of quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the Brief Interview for Mental Status (BIMS) assessment had a summary score of 2, indicating the resident had severely impaired cognition. The assessment also included the resident was totally dependent for bed mobility and personal hygiene. An observation was conducted of the resident's room on 8/26/2019 at 7:40 AM from the hallway. The resident's room door was open and the bed was observed close to the center of the room. A private caregiver was providing care. The resident was observed lying on his left side with his backside towards the room entrance wearing a brief. During an observation conducted on 8/26/2019 at 10:38 AM across the hall from the resident's room, multiple staff members and visitors were observed passing by the resident's room. The resident's room door was opened and the resident was observed uncovered wearing a brief. Another observation was conducted of the resident's room from the hallway on 8/26/2019 at 11:45 AM. The resident's room door was ajar. The resident was observed lying in bed, exposed from his hips to his lower legs wearing a brief. A caregiver was observed inside the room assisting the resident. An interview was conducted on 08/27/19 at 9:45 AM with a Certified Nursing Assistant (CNA/staff #41). The CNA stated that he always provides privacy during private care, including shutting the door if the resident is exposed. An interview was conducted on 08/27/19 at 10:05 AM with a Registered Nurse (RN/staff #77). The RN stated that she shuts a resident's room door when providing private care. She stated that if she sees a caregiver or staff member not providing privacy for a resident, she pulls them aside and explains how to provide dignity to the resident. The RN stated dignity includes having the door shut to protect the resident's privacy which keeps other residents and guests from looking into the room. During an interview conducted with the Director of Nursing (DON/staff #91) on 8/28/2019 at 7:55 AM, she stated that resident #19 has a private caregiver 24 hours a day. The DON stated the resident's dignity and privacy is 100% the responsibility of the facility. She also stated that she had never seen the resident exposed. An interview was conducted on 8/28/2019 at 2:07 PM with the resident's family member, the DON, and the CNA (staff #41). Both the family member and CNA stated that the resident's room door was open and the resident was exposed because he was very hot. The CNA #41 stated that the resident is hot and then cold and that family and staff remove and add sheets or blankets as needed. The resident's family member confirmed that on 8/26/2019, the sheets had been removed because the resident was hot. The DON stated that with the bed in the middle of the room and the door open, she observed that the resident can be observed exposed from the hallway. Review of the facility's policy regarding Residents' Privacy and Confidentiality revised (MONTH) 2014, revealed the facility protects the rights of all residents, and is committed to treating residents with respect, [MEDICATION NAME], and dignity. The policy included that consistent with applicable laws and regulations, the facility expects each employee to protect residents' rights to privacy and confidentiality at all times.
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 one of two sampled residents (#4) was free from unnecessary drugs, by failing to administer drugs according to the physician ordered parameters. The deficient practice could result in low blood pressures and residents receiving drugs which may not be necessary. Findings include: Resident #4 was admitted to the facility on (MONTH) 6, 2019, with [DIAGNOSES REDACTED]. Review of the care plan dated (MONTH) 10, 2019 for Activities of Daily Living Function/Rehabilitation revealed the resident was at risk for decreased cardiac output related to increase blood pressure. The goal was that the resident's blood pressure will be maintained within acceptable range. Interventions included administering medications as ordered, and monitoring vital signs per orders and as needed. A physician's orders [REDACTED]. The Medication Administration Record [REDACTED] - on (MONTH) 11: The resident had a pulse of 53 - on (MONTH) 25: The resident had a pulse of 52 - on (MONTH) 3: The resident had a pulse of 52 - on (MONTH) 4: The resident had a pulse of 50 - on (MONTH) 27: The resident had a pulse of 50 An interview was conducted on (MONTH) 28, 2019 at 12:09 PM with a Registered Nurse (RN/staff #77). The RN stated that when giving hypertensive medications, parameters are checked before the medication is given. She stated that with parameters to hold [MEDICATION NAME] for systolic blood pressure under 110, a diastolic blood pressure under 55, and a pulse under 55, the medication should be held for any one of the three parameters. After reviewing the MAR, staff #77 stated that this medication was given in error. An interview was conducted on (MONTH) 28, 2019 at 02:05 PM with the Director of Nursing (DON/staff #91). The DON stated that for all medications, she would expect the nurses to follow the orders including any parameters ordered. She stated that she would expect the nurses to hold the medication [MEDICATION NAME] for any one of the three ordered parameters. After reviewing the clinical record, the DON stated that this medication was given in error.

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

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F 0757 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) Review of the facility's policy for Medication/Treatment Management revealed that medications require an order from a healthcare provider with prescriptive authority. Documentation and monitored parameters, e.g., taking of vital signs, documenting that a medication has been given or held, or any other documentation regarding medication administration is completed in a timely manner prior to or after the medication or treatment has been provided (depending on the type of documentation). It also stated that if for any reason a medication/treatment order cannot be followed or the resident refuses a medication or treatment that has been prescribed, the healthcare provider with the prescriptive authority is notified as soon as is reasonable, depending on the situation. The policy included the reason the medication/treatment order was not carried out is documented in their eMAR record.
F 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observations, staff interviews, facility documentation, and policy review, the facility failed to ensure that food stored in one refrigerator was in accordance with professional standards for food service safety. The deficient practice could place residents at risk for foodborne illness. Findings include: During an initial observation of the kitchen conducted on 8/26/2019 at 7:30 AM with a cook (staff #100), the thermometer on the outside of the refrigerator displayed 54 degrees Fahrenheit (F). Inside the refrigerator were various food items including milk, yogurt, and juice. No internal thermometer was located inside of the refrigerator and staff #100 was also unable to locate a thermometer inside the refrigerator. Staff #100 stated that the refrigerator temperature for that morning is recorded on the Monthly Temperature Log. Review of the Monthly Temperature Log for (MONTH) 2019 revealed the refrigerator temperature on 8/26/2019 at 7:15 AM was 45 degrees F. The log included the Critical Limit (CL) for refrigerators were up to 41 degrees F and that if the temperature registers above the CL, retake the temperature in one hour. The log also included that if the temperature again registers above the CL, immediately notify the manager, assess product integrity by taking temperatures, and initiate product removal/relocation procedure. No corrective action was recorded on the log for the 45 degree F refrigerator temperature. During an observation conducted on 8/28/19 at 11:45 AM of the same refrigerator, the external thermometer had a reading of 55 degrees F. This time, a thermometer inside of the refrigerator was observed and had a reading of 44 degrees F. The refrigerator contained various food items including milk and yogurt. The Registered Dietary Consultant (staff #117) removed two random milk cartons from the refrigerator and took the temperature of the milk. The milk temperature was 48 degrees F. The Nutrition Services Manager (Staff #95) removed one container of yogurt and checked the yogurt temperature. The yogurt temperature was 53 degrees F. The Monthly Temperature Log for (MONTH) 2019 revealed the refrigerator temperature on 8/28/2019 at 6:30 AM was 35 degrees F. Continued review of the log revealed the temperature of 45 degrees F on 8/26/2019 at 7:15 AM, now had a zero written over the 5. The log now reflects a temperature of 40 degrees F at 7:15 AM on 8/26/2019 instead of 45 degrees F. An Interview was conducted on 8/28/2019 at 12:58 PM with staff #117 and staff #95. Staff #95 stated the temperatures for the refrigerators are recorded twice a day. She stated that she checks the logs a couple of times a day. Staff #95 stated that if a temperature is out of range, she shuts the door for 30 minutes and rechecks the temperature. She said if it is still out of range, the door is kept shut for another 30 minutes. She stated that if the temperature is still out of range after an hour, the refrigerator is shut down and all services out of that refrigerator are stopped. Staff #95 stated that if the refrigerator still did not hold the correct temperature she would put a work order in, remove all products, and use everything out of main kitchen refrigerator. After the refrigerator has been repaired, she stated that she would ensure the temperature is back in range for 24 hours before using the refrigerator. She also stated that she looks at the refrigerator outside temperature reading to see if it matches with the internal temperature reading. Staff #95 stated that the changes to the (MONTH) 2019 Monthly Temperature Log for (MONTH) 26, 2019 at 7: 15 AM was made after the staff rechecked the refrigerator and that they should have documented what corrective action was taken. Review of facility's policy regarding Refrigerator Management revealed refrigerator temperatures are maintained at 41 degrees Fahrenheit or less. Temperatures are documented on the Hazard Analysis and Critical Control Points (HACCP) Temperature Log. If the temperatures fall out of recommended range, adjust the thermostat slightly and re-check every 30 minutes for one hour until temperature is within range. If unable to reach/maintain recommended temperature, a work request for repair is filled out and the Supervisor is notified. If temperature cannot be reached and/or maintained, items should be removed from the refrigerator and placed in a properly functioning refrigerator.