STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035296	A. BUILDING _____ B. WING _____	**11/22/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WELBROOK SENIOR LIVING FLAGSTAFF LLC	**1521 NORTH PINE CLIFF DRIVE EAST FLAGSTAFF, AZ 86001**

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 -** Some	**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 reviews, resident and staff interviews, facility documentation and policy review, the facility failed to ensure that six (#15, #21 #128, #23, #179, and #131) of seven sampled residents were informed and provided written information regarding advance directives. The deficient practice could result in the facility not being aware of resident choices during an emergency. Findings include: -Resident #15 was admitted to the facility on (MONTH) 3, 2019 with [DIAGNOSES REDACTED]. Review of the baseline care plan dated (MONTH) 3, 2019 revealed the resident wished to be a full code, with a goal to meet the resident's advance directive choices. Interventions included to perform Cardiopulmonary Resuscitation (CPR) as per resident wishes, to review and discuss the resident's choices upon admission, and social services to review or execute upon admission scope of treatment orders, to include but not limited to CPR, medical interventions, artificially administered nutrition and to document who this was discussed with. Review of a physician's orders [REDACTED]. A psychosocial admission form dated (MONTH) 7, 2019 revealed a section regarding advance directives, which indicated the resident had a durable power of attorney for health care decisions and had a primary agent and a secondary agent related to advance directives. The form included that an advance directive was on file. However, the form was left blank regarding whether resident rights were reviewed and if a copy was left for the resident, their responsible party and/or a family member. Review of the resident's advance directive comprehensive care plan dated (MONTH) 7, 2019, revealed the resident wished to be a full code with a goal to meet the resident's advanced directive choices. Care plan interventions included to review and discuss choices regarding advance directives upon admission and for social services to review or execute upon admission scope of treatment orders to include but not limited to CPR, medical interventions, artificially administered nutrition and to document who this was discussed with. Review of the admission Minimum Data Set (MDS) assessment dated (MONTH) 9, 2019 revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident's cognition was intact. Review of the clinical record revealed an advance directive form which was not dated. This form included the resident's name and that the resident had not executed any advance directives in the facility. The form was signed by an admissions staff member (#44). There was no documentation in the clinical record to indicate that the resident was informed about her choices and preferences regarding advance directives. There was also no documentation that the resident chose to be a full code. An interview was conducted with the resident on (MONTH) 20, 2019 at 9:40 a.m. She stated that she did not recall anyone at the facility discussing advance directives with her. She said she never indicated to staff that she did not want to formulate advance directives. -Resident #21 was admitted to the facility on (MONTH) 10, 2019 and readmitted on (MONTH) 17, 2019, with [DIAGNOSES REDACTED]. Review of the baseline care plan dated (MONTH) 10, 2019 revealed the resident wished to be a full code, with a goal to meet the resident's advance directive choices. The care plan included interventions as follows: review and discuss choice of advance directives upon admission; and for social services to review or execute upon admission the scope of treatment orders to include but not limited to cardiopulmonary resuscitation, medical interventions, artificially administered nutrition and to document who this was discussed with. A physician's orders [REDACTED]. An admission MDS assessment dated (MONTH) 17, 2019 revealed the resident had a BIMS score of 12, which indicated moderate cognitive impairment. A psychosocial admission form dated (MONTH) 17, 2019 revealed a section regarding advance directives, which indicated the resident had a durable power of attorney for health care decisions. The form was left blank regarding whether the resident had further needs related to advance directives. The form indicated that an advance directive was on file. The form also indicated that resident rights had not been reviewed with the resident and/or their responsible party. A social service progress note dated (MONTH) 17, 2019 stated that advance directives were in place. However, review of the clinical record revealed no documentation that the resident was informed about advance directive choices or that he was given the opportunity to establish advance directives. The resident was readmitted to the facility on (MONTH) 17, 2019. A new baseline care plan, a new psychosocial admission form, and a new physician's orders [REDACTED]. Review of a social service progress note for dated (MONTH) 1, 2019 revealed that advance directives were in place. An undated advance directives form revealed the facility was told that advance directives existed, but the resident had not produced copies. In addition, the form noted the resident acknowledged that it is his responsibility to provide the copies of the advance directives for incorporation into the resident's chart. The form was signed by the admissions staff member (#44). The resident's signature was not on the form and there was no place for the resident to sign on the form. Review of the clinical record revealed there was no documentation that the resident was informed about advance directive choices or that he was given the opportunity to establish advance directives. An interview was conducted with the resident on (MONTH) 20, 2019 at 12:54 p.m. He stated that none of the staff members had spoken to him about advance directives or given him an opportunity to formulate advance directives. -Resident #128 was admitted to the facility on (MONTH) 7, 2019 with [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. A social service progress note dated (MONTH) 8, 2019 stated the resident's advance directives were in place. Review of a psychosocial admission form dated (MONTH) 10, 2019 revealed the form was blank for advance directives and was blank regarding social service needs related to advance directives. A question on the form asked if advance directives were on file and the response was coded as not applicable. The form was also blank regarding if resident rights were reviewed and if a copy was provided to the resident or the resident's representative. Review of the admission MDS assessment for resident #128 dated (MONTH) 13, 2019 revealed the resident had a BIMS score of

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

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F 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) 15, which indicated intact cognition. Review of the advance directives care plan dated (MONTH) 19, 2019 revealed the resident wished to be a full code, with a goal to meet the resident's advance directive choices and to provide CPR per resident wishes. However, review of the clinical record revealed there was no documentation that the resident was informed about her choices and preferences in regards to advance directives. There was also no documentation of the resident's choice of code status. An interview was conducted with the resident on (MONTH) 20, 2019 at 12:04 p.m. She stated that facility staff had not talked to her about advance directives. -Resident #23 was admitted to the facility on (MONTH) 29, 2019, with [DIAGNOSES REDACTED]. Review of the advance directive paperwork dated (MONTH) 29, 2019, revealed the form was left blank except for the resident's name. A physician's orders [REDACTED]. Review of the resident's 5-day MDS assessment dated (MONTH) 4, 2019 revealed a BIMS score of 13, indicating the resident was cognitively intact. Review of the resident's advance directive care plan dated (MONTH) 10, 2019, revealed the resident was a full code. The goal was to meet the resident's advance directive choices. The intervention was that social services will review or execute upon admission the scope of treatment orders to include CPR, medical interventions, artificially administered nutrition, and to document who this was discussed with. However, there was no evidence in the clinical record that advance directives had been discussed with the resident and there was no advance directive paperwork indicating the resident's choices and preferences regarding emergency care. An interview was conducted with the resident on (MONTH) 18, 2019 at 1:54 p.m. The resident stated that he has no recollection of anyone speaking with him about advance directives. -Resident #179 was admitted on (MONTH) 28, 2019, with [DIAGNOSES REDACTED]. Review of the physician's orders [REDACTED]. The admission MDS assessment dated (MONTH) 4, 2019 revealed a BIMS score of 12, indicating mild cognitive impairment. Review of the resident's care plans revealed no care plan was created regarding advance directives. In addition, there was no evidence in the clinical record that advance directives had been discussed with the resident and there was no advance directive paperwork completed. -Resident #131 was admitted to the facility on (MONTH) 16, 2019, with [DIAGNOSES REDACTED]. Review of the advance directive paperwork dated (MONTH) 16, 2019, revealed the form was left blank except for the resident's name. Review of the resident's advance directive care plan dated (MONTH) 18, 2019, revealed that the resident was a full code. The goal was to meet the resident's advance directive choices. The interventions included to perform CPR as per the resident's wishes, review and discuss the resident's choices of advance directives upon admission, and that social services will review or execute upon admission the scope of treatment orders to include CPR, medical interventions, artificially administered nutrition and to document who this was discussed with. Review of the (MONTH) 2019 physician's orders [REDACTED].>However, there was no evidence in the clinical record that advance directives had been discussed with the resident and there was no advance directive paperwork completed regarding the resident's choices and preferences regarding emergency care. An interview was conducted with the Director of Nursing (DON/staff #55) on (MONTH) 19, 2019 at 10:31 a.m. She stated it is her expectation that when a resident is admitted to the facility, the admissions staff would obtain the information of whether the resident has or has not formulated an advance directive, and would document that information on the advance directive form. The DON stated that within the first 48 hours of the resident's stay, the Social Worker should be addressing advance directives with the resident by explaining what they are, determining the resident's choices, and documenting this in the clinical record. She stated the decision should be communicated to the physician and an order obtained for the resident to be a full code or DNR. She said that while completing paperwork on (MONTH) 18, 2019, she discovered concerns with advance directives in resident charts. She said she was unable to consistently locate completed advance directive forms regarding code status for residents in the building. She said that her staff conducted an audit and found inappropriate and incomplete advance directive information, lack of documentation to show that a resident chose to be a DNR, one record with documentation that screening had been done but no screening could be found, and one record stating that there were advance directives on file but were unable to be located. She said that she spoke to the Social Worker who said she did not know that she needed to follow up with resident's desires related to advance directives and said that she was not explaining advance directives or offering to assist the resident to formulate advance directives. She said that as a result of these issues, the resident may not have known that they had the option to formulate advance directives and therefore; were not made aware of their rights/options. An interview was conducted with a Licensed Practical Nurse (LPN/staff#12) on (MONTH) 19, 2019 at 1:14 p.m. Staff #12 stated that all disciplines are involved with the advance directives, but the primary person responsible is the Social Worker. She stated that if there is a question, all residents are treated as a full code. She concluded by saying that she is not sure why so many resident's advance directives are incomplete or missing. An interview was conducted with the Director of Admissions (staff #44) on (MONTH) 20, 2019 at 8:44 a.m. She stated that after a new resident arrives, she goes over the information contained in the admission agreement packet, with the resident or their representative. She stated that the packet contains information regarding advance directives and an advance directive registration agreement. She stated that a resident does not have to formulate an advance directive at that time and that if a resident indicated that they had formulated an advance directive previously, she would request a copy for the resident's record. She stated if the resident had not formulated an advance directive, she would instruct them to speak with social services for more information. She said that she documents this information on the advance directive form. She said the resident will then meet with social services and that during this meeting, the resident will be given more information and an opportunity to formulate/execute an advance directive. An interview was conducted with the Social Worker (Staff #18) on (MONTH) 20, 2019 at 12:24 p.m. She stated that it is her understanding that when a resident is admitted it is her responsibility to ask the resident the questions contained in the psychosocial assessment and check the boxes of whether the resident does or does not have advance directives. She stated that she does not routinely provide education on advance directives/treatment options to the resident, nor does she follow up with the resident when they respond that they do not have an advance directive. She said that she does follow up with residents who have questions about advance directives. An interview was conducted with a LPN (staff #77) on (MONTH) 21, 2019 at 10:10 a.m. Staff #77 stated that advance directives are to be completed by the Social Worker on the day of, or shortly after admission. She added that advance directives are important because a nurse needs to know the resident's code status in case of an emergency. Review of the facility's admission packet revealed that residents have the right to formulate advance directives. The packet also indicates that additional information can be found at exhibit 13, however there was no exhibit 13 in the packet. Review of the Advance Directive policy revealed that advance directives will be respected in accordance with state law and facility policy, and the social services director or designee will provide written information to the resident concerning his/her right to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment, and the right to formulate advance directives upon admission. The policy included that a plan of care for each resident will be consistent with his or her advance directive. Even if the resident or representative declines to formulate an advance directive, the facility will document this in the clinical record. The policy stated that in accordance with current Omnibus Budget Reconciliation Act (OBRA) definitions and guidelines governing advance directives, the facility has defined advance directives as preferences regarding treatment options and include, but are not limited to: DNR; Do Not Hospitalize; Organ Donation; Life-Sustaining Treatment; Feeding Restrictions; Medication Restrictions; and other Treatment Restrictions.
F 0655 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted** **Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted**

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F 0655 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed clinical record review, staff interviews and policy review, the facility failed to develop a baseline care plan within 48 hours after admission for one resident (#28). The facility census was 16 residents. The deficient practice could result in a lack of care and services being provided to residents. Findings include: Resident #28 was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of the nursing admission assessment dated [DATE] revealed the resident required extensive assistance with walking both on and off the unit, bed mobility, dressing, transfers, toilet use and personal hygiene and required total dependence with bathing. The assessment indicated that the resident was admitted due to recent falls and dizziness and was in the facility for strengthening and conditioning. Review of the admission orders [REDACTED]. Review of the Medication Administration Record [REDACTED]. Continued review of clinical record revealed no baseline care plan had been developed regarding the resident's immediate care needs related to pain. Resident #28 was discharged from the facility on 10/16/19. An interview was conducted with the Director of Nursing (DON/staff #55) on 11/20/19 at 1:04 PM. Staff #55 stated that baseline care plans are initiated by the admission nurse when a resident is being admitted . She stated that a baseline care plan should have been created for this resident. She stated that it is her expectation that all newly admitted residents would have a baseline care plan completed. An interview was conducted with a Registered Nurse (staff #16) on 11/20/19 at 2:15 PM. Staff #16 stated that she completed the admission for resident #28. She stated that she does not remember initiating the care plan and believes that she did not complete one for this resident. Review of the Baseline Care Plan policy revealed that in order to assure that a resident's immediate needs are met and maintained, a baseline care plan will be developed within 48 Hours of the resident's admission.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, staff interviews and policy review, the facility failed to ensure that care plans were developed and implemented timely for two residents (#15 and #21). The facility census was 16 residents. The deficient practice could result in unmet resident needs. Findings include: -Resident #15 was admitted to the facility on (MONTH) 3, 2019, with [DIAGNOSES REDACTED]. Review of an activity admission assessment dated (MONTH) 4, 2019, revealed the resident would need her glasses to be successful in visual activities and an assistant to get to activities. The assessment documented that the resident wished to participate in activities while in the facility, including group activities, outings, one on one with staff and independent activities. Review of the admission Minimum Data Set (MDS) assessment dated (MONTH) 9, 2019 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The activity assessment resident interview indicated the following items were somewhat important to the resident: to have books, newspapers, and magazines to read, to listen to music she likes and to keep up with the news. The assessment included the following items were very important to the resident: to do things with groups of people, to do her favorite activities, to get fresh air when the weather is good and to participate in religious services or practices. However, review of the resident's care plans revealed there was no care plan developed to address the resident's activity needs/preferences. An interview was conducted with the Director of Recreational Services (staff #36) on (MONTH) 21, 2109 at 11:20 a.m. She stated that she does a recreational assessment on each resident within 3 days of admission and an initial preference assessment for the MDS. She stated that she documents the assessments in the electronic record and updates the care plan with the resident's interests. She stated that every resident should have an activity care plan in the electronic record, however, on review of the resident's care plan, she said she did not find a care plan addressing the activity status/needs for resident #15. An interview was conducted with the Executive Director (staff #40) on (MONTH) 21, 2019 at 2:03 p.m. He stated that every resident should have a care plan that addresses the activity needs. -Resident #21 was admitted to the facility on (MONTH) 10, 2019 and re-entered on (MONTH) 17, 2019, with [DIAGNOSES REDACTED]. Review of the admission history and physical dated (MONTH) 10, 2019 revealed that resident #21 had a non-pressure wound to the left buttock. Review of the physician's orders [REDACTED]. Review of the admission MDS for resident #21 dated (MONTH) 17, 2019, revealed that resident #21 had a BIMS score of 12, indicating moderate cognitive impairment. The assessment also included a [DIAGNOSES REDACTED]. Review of a re-admission history and physical for resident #21 dated (MONTH) 17, 2019 included the resident had a left gluteal abscess. Review of a skin and wound evaluation dated (MONTH) 14, 2019, revealed the resident had a surgical wound to the right buttock. Review of the resident's care plans revealed that a care plan was not developed for the resident's left buttock wound until (MONTH) 19, 2019. An interview was conducted with the Director of Nursing (DON/staff #55) on (MONTH) 22, 2019 at 9:19 a.m. She stated that the wound to the left buttock was a surgical wound and was present on the resident's initial admission. She stated a care plan should have been initiated on admit and should have included interventions. She stated this did not meet their policy or her expectation regarding care planning. Review of the facility's care plan policy revealed that a comprehensive, person centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident by the Interdisciplinary Team (IDT), in conjunction with the resident and his/her representative. In addition, the care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The policy included that the comprehensive, person-centered care plan will incorporate identified problem areas; incorporate risk factors associated with identified problems; timetables and objectives in measurable outcomes; and aide in preventing or reducing decline in the resident's functional status and/or functional levels. The policy further included that identifying problem areas, and their causes, and developing interventions that are targeted and meaningful to the resident, are the endpoint of an interdisciplinary process and that assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.
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 reviews, interviews, and review of policy and procedures, the facility failed to ensure care plans were revised for two residents (#20 and #15). The deficient practice could result in resident care needs not being revised and interventions implemented. Findings include: -Resident #20 was admitted on (MONTH) 15, 2019 with [DIAGNOSES REDACTED].

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F 0657 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) Review of a care plan dated (MONTH) 15, 2019 revealed the resident had a self-care performance deficit related to weakness and deconditioning associated with recent hospitalization . The goal was to improve current level of function in balance, strength, transfers, toileting, dressing, bathing, and gait through the review date. Interventions included to assist the resident with set up of meals and to monitor for need for encouragement. A physician's orders [REDACTED]. Review of resident's weight summary dated (MONTH) 16, 2019 revealed the resident's weight was recorded as 172.4 pounds. A mini nutritional assessment completed on (MONTH) 16, 2019 revealed the resident had been assessed to have a normal nutritional status. Review of the resident's weight summary dated (MONTH) 19, 2019 at 10:55 a.m. revealed the resident's weight was recorded as 168.2 pounds; which was a weight loss of 2.44%. The 5-day Minimum Data Set (MDS) assessment dated (MONTH) 21, 2019 revealed the resident scored 10 on the Brief Interview for Mental Status, indicating moderate cognitive impairment. The assessment included that the resident required extensive assistance of 2 plus staff for most ADLs, and required set up and supervision for meals. Review of resident's weight summary dated (MONTH) 22, 2019 at 1:59 p.m. revealed the resident's weight was recorded as 167 pounds; for a total weight loss of 3.13%. However, further review of the resident's clinical record did not include for a revision or update to the resident's care plan that would reflect the resident's continuing weight loss or changing needs. A physician's orders [REDACTED]. Review of the resident's weight summary dated (MONTH) 30, 2019 at 12:58 p.m. revealed the resident's weight was recorded as 152.2 pounds; for a total weight loss of 11.72%. Review of the resident's weight summary dated (MONTH) 6, 2019 at 8:30 a.m. revealed the resident's weight was recorded as 150.4 pounds; for a total weight a loss of 12.6%. A nutrition/dietary note dated (MONTH) 9, 2019 stated the resident had a significant weight loss of 10% in 3 weeks. The note stated that the weight loss had been discussed in Weight Intervention and Nutrition Support (WINS) and the recommendation was for weekly weights, Med Pass (supplement) twice daily and fortified foods. A physician's orders [REDACTED]. Review of the resident's weight summary dated (MONTH) 13, 2019 at 8:43 a.m. revealed the resident's weight was recorded as 149.8 pounds. Further review of the resident's care plans revealed that none were revised to reflect the problem of continuing weight loss, along with any new interventions from (MONTH) 19, through (MONTH) 19, 2019. Review of the resident's weight summary dated (MONTH) 20, 2019 at 1:59 p.m. revealed the resident's weight was recorded as 148.2 pounds. The nutritional problem/potential nutritional problem care plans were initiated on (MONTH) 20, 2019, which included the resident had anorexia and biting/chewing/swallowing problems due to inability to consume regular texture as evidenced by a mechanically altered diet. The goal was for the resident to tolerate a mechanically altered diet without signs or symptoms of choking through the review date. Interventions included to provide and serve supplements as ordered, provide and serve diet as ordered, monitor intake every meal, and registered dietitian to evaluate and make diet change recommendations as needed. On (MONTH) 20, 2019 at 1:42 p.m., an interview was conducted with the Registered Dietitian (staff #78). She stated that a 14.04% weight loss in 5 weeks would be considered significant. She stated that she wasn't sure if she knew about the resident's weight loss from (MONTH) 19, 2019 to (MONTH) 30, 2019. She stated she wrote a nutrition/dietary note on (MONTH) 9, 2019 and added Med Pass 2.0 to address the weight loss, but she didn't know if she missed it prior to that date. She stated that she did not know if the physician had been notified about the resident's weight loss. On (MONTH) 20, 2019 at 2:10 p.m., an interview was conducted with a Licensed Practical Nurse (LPN/staff #14). She stated that if a resident had a significant weight loss, she would anticipate that the provider or the Registered Dietician would be notified. She stated that she would expect a resident's care plan to be updated with any significant weight loss or gain. She stated she did not know the resident had been losing so much weight. On (MONTH) 20, 2019 at 3:01 p.m, an interview was conducted with the Director of Nursing (DON/staff #55). She stated she would expect nursing to obtain the residents' weight as ordered by the physician. She stated that if a resident was having a significant weight loss, she would expect that a care plan be in the record for weight loss, and that it would be updated with current interventions. She said the care plan would be reviewed during the WINS meeting. She stated that the resident's care plan dated (MONTH) 20, 2019 did not meet her expectation to reflect the resident's weight loss sooner. -Resident #15 was admitted to the facility on (MONTH) 3, 2019 with [DIAGNOSES REDACTED]. Review of the admission Minimum Data Set (MDS) assessment dated (MONTH) 9, 2019 revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 15 which indicated that the resident had intact cognition. The MDS was coded to reflect that the resident had not sustained a significant weight gain or loss. Review of the weight history for resident #15 revealed that the resident had a significant weight loss of 12.73% between (MONTH) 6 and (MONTH) 11, 2019, a re-weigh on (MONTH) 15, 2019 which still demonstrated a significant weight loss of 6.98% between (MONTH) 6 and (MONTH) 15, 2019, and a significant weight loss of 6.99% between (MONTH) 3, 2019 and (MONTH) 6, 2019.The resident's nutrition care plan dated (MONTH) 5, 2019 revealed that the resident was overweight/obese related to physical inactivity. The care plan included goals and interventions, but none of them were in regards to the resident's weight loss. This care plan was not revised to include the resident's weight loss until (MONTH) 19, 2019. An interview was conducted with resident #15 on (MONTH) 18, 2019 at 11:44 a.m. and she stated that she had experienced weight loss in the facility. An interview was conducted with a Licensed Practical Nurse (LPN/staff #77) on (MONTH) 21, 2019 at 1:35 p.m. She reviewed the weight history for resident #15 and identified that the resident had significant weight loss. An interview was conducted with a Registered Dietitian (RD/staff #78) on (MONTH) 21, 2019 at 1:44 p.m. She reviewed the weight history for the resident and acknowledged that the resident had significant weight loss between (MONTH) 6 and 11, 2019 and that when the resident was re-weighed on (MONTH) 15, 2019 and there was still significant weight loss. She said that there was significant weight loss between (MONTH) 3 and (MONTH) 6, 2019 as well. She stated that she could not see care planning of the identified weight loss before (MONTH) 19, 2019 and she did not see any interventions related to the identified weight loss. She stated that, in this case, the expectation/policy was not followed for when weight loss occurs in the facility. An interview was conducted with the Director of Nursing (DON/staff #55) on (MONTH) 22, 2019 at 9:40 a.m. She stated that resident #15 had experienced a significant weight change and that the weight loss should have been included on the care plan at the time it occurred. She stated that her expectations/as well as facility policy were not met in relation to the identified weight loss. Review of a facility policy titled, Weight Assessment and Intervention revealed the multidisciplinary team will strive to prevent, monitor and intervene for undesirable weight loss for the residents. The policy stated that any weight change of 5% or more since the last weight assessment would be retaken the next day for confirmation. The policy stated that if the weight was verified, nursing would immediately notify the dietician in writing, and that verbal notification must be confirmed in writing. The policy stated that the dietician would respond within 24 hours of receipt of written notification. Additionally, the policy stated that care planning for weight loss or impaired nutrition would be a multidisciplinary effort to include the physician, nursing staff, the dietician, the consultant pharmacist, and the resident or resident's legal surrogate. The policy included that individualized care plans shall address, to the extent possible: the identified cause of weight loss, goals and benchmarks for improvement, and timeframes and parameters for monitoring and reassessment. Review of the facility care plan policy revealed that a comprehensive, person centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident by the Interdisciplinary Team (IDT), in conjunction with the resident and his/her representative. The policy included that identifying problem areas, and their causes, and developing interventions that are targeted and meaningful to the resident, are the endpoint of an interdisciplinary process and that assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.

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	035296	A. BUILDING _____ B. WING _____	11/22/2019

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WELBROOK SENIOR LIVING FLAGSTAFF LLC	1521 NORTH PINE CLIFF DRIVE EAST FLAGSTAFF, AZ 86001

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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 0657 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 4)
F 0677 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews and review of policy and procedures, the facility failed to ensure that one resident (#178) who was unable to carry out activities of daily living (ADL) received the necessary services to maintain good personal hygiene. The deficient practice could result in hygiene needs not being met. Findings include: Resident #178 was admitted on (MONTH) 8, 2019, with [DIAGNOSES REDACTED]. The resident was discharged on (MONTH) 22, 2019. Review of an activity of daily living (ADL) deficit care plan dated (MONTH) 9, 2019 included the resident had a right shoulder fracture. The goal was to improve the current level of function. Interventions included for physical therapy (PT) and occupational therapy (OT). A limited physical mobility care plan dated (MONTH) 9, 2019 related to a right shoulder fracture included goals to increase level of mobility, maintain current level of mobility, and remain free from complications related to immobility, including skin breakdown. Interventions were for PT and OT referrals as ordered, as needed. Review of the Certified Nursing Assistant (CNA) task documentation for (MONTH) 2019 regarding ADL-bathing, revealed that the resident did not receive any showers. A physician's orders [REDACTED]. Review of the 14-day Minimum Data Set (MDS) assessment dated (MONTH) 22, 2019 revealed the resident scored 15 on the Brief Interview for Mental Status, indicating intact cognition. The MDS also indicated the resident required limited one-person physical assistance for ADLs, including personal hygiene. Review of the CNA task documentation for (MONTH) 2019 revealed that the resident only received one shower on (MONTH) 22. The facility was unable to provide any additional documentation that the resident was provided at least two showers per week in (MONTH) and (MONTH) 2019. On (MONTH) 19, 2019 at 1:47 p.m., an interview was conducted with the Director of Nursing (DON/staff #55). She stated that shower and bed bath documentation is located in the electronic record, in the CNA task documentation. She said that her expectation is that residents will be offered 3 showers per week. She stated that if a resident refuses a shower, her expectation would be that the refusal should be documented in the nurses' notes. She stated that during the time that resident #178 was in the facility, she was not sure that showers were being completed according to her expectation. On (MONTH) 20, 2019 at 12:01 p.m., an interview was conducted with a CNA (staff #22), who stated that his protocol was to administer showers to residents 2-3 times per week, or more if they request it. He said he documents the shower every time he gives one. An interview was conducted on (MONTH) 20, 2019 at 12:16 p.m., with a Registered Nurse (staff #16). She stated that her expectation is that residents receive showers every other day or as requested. She stated that the CNAs usually tell her when they have assisted a resident in the shower or she could look in the electronic record under task documentation to ensure the resident had received their shower. Review of the facility's policy titled, Shower/Tub Bath revealed the purpose was to provide comfort to the resident and to observe the condition of the resident's skin. The policy stated that the information that should be recorded in the resident's ADL record and/or the resident's medical record should include the date and time the shower/tub bath was performed, the name and title of the individual(s) who assisted the resident, all assessment data obtained during the shower/tub bath, and if the resident refused the shower/tub bath, the reason(s) why and the intervention taken. Additionally, the supervisor should be notified if the resident refused the shower/tub bath, and other information should be reported in accordance with facility policy and professional standards of practice.
F 0679 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide activities to meet all resident's needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, and staff and resident interviews, the facility failed to ensure activities that supported one resident's (#15) choice were consistently offered on the weekends. The deficient practice could result in residents not having the choice to participate in activities. Findings include: Resident #15 was admitted to the facility on (MONTH) 3, 2019, with [DIAGNOSES REDACTED]. The admission activity assessment dated (MONTH) 4, 2019 revealed the resident wished to participate in activities while at the facility and that participating in religious services or practices and group activities were very important to the resident. The assessment also revealed the resident required assistance to activities. The admission Minimum Data Set (MDS) assessment dated (MONTH) 9, 2019 revealed a score of 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident had intact cognition. The assessment included doing things with groups of people and participating in religious services or practices were very important to the resident. Review of the care plan revealed no care plan for activities. Review of the clinical record revealed multiple activity progress notes. However, only 3 weekend days (October 26, 2019, (MONTH) 2, 2019, and (MONTH) 3, 2019) revealed documentation that the resident participated in weekend activities. The monthly schedule of activities for (MONTH) 2019 revealed a matinee movie was scheduled every Saturday and church TV was scheduled every Sunday. During an interview conducted with resident #15 on (MONTH) 18, 2019 at 11:31 a.m., the resident stated there were not enough activities offered on the weekend. The resident stated activities planned for the weekend did not always occur because there was no staff to provide the activities. She also stated that she would like to see a movie or attend a church service on the weekend. An interview was conducted with the Director of Recreational Services (staff #36) on (MONTH) 21, 2019 at 11:20 a.m. She stated that when a resident is admitted , she conducts an activities assessment and updates the care plan to include the resident's interests. Staff #36 stated the resident is given a monthly activity calendar. She stated that on Saturday she schedules a matinee movie and on Sunday staff is supposed to turn on the television to the morning church service. She also stated that the residents have a pursuit box available to them on the weekends that contains activities they can do independently. She stated residents have reported to her that the movie scheduled on Saturdays did not always occur because the staff were too busy. Staff #36 also stated that she is working with the weekend manager to ensure the movie scheduled for Saturday occurs. In an interview conducted with the Executive Director (staff #40) on (MONTH) 21, 2019 at 2:03 p.m., staff #40 stated that he expects the activities scheduled 7 days a week and one evening a week to occur as scheduled. He stated due to residents reporting planned activities did not always occur; they have tracked the weekend attendance of activities. He stated that they identified residents were not always provided scheduled, meaningful, individualized activities. Staff #40 further stated that the expectation of providing residents scheduled activities was not met.
F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record reviews, staff interviews and policies and procedures, the facility failed to ensure treatment and services were provided in accordance with professional standards of practice for two residents (#21 and #15). The deficient practice could result in a delay in identifying wound deterioration and implementing additional treatment, and a worsening of a skin fungal infections. Findings include: -Resident #21 was admitted to the facility on (MONTH) 10, 2019 and readmitted on (MONTH) 17, 2019 with [DIAGNOSES REDACTED].

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F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 5) Review of the physician admission orders [REDACTED]. Review of a nurse progress note dated (MONTH) 10, 2019 revealed the resident had skin impairment to the left buttock and to see the admission/readmission nursing evaluation for further information. Review of the admission/readmission nursing history and physical dated (MONTH) 10, 2019, revealed the resident was admitted with a left gluteal abscess. However, there was no description of the wound bed or surrounding skin, if any drainage was present, nor were there any measurements of the wound or any documentation if the wound was open. A baseline admission care plan dated (MONTH) 10, 2019 revealed the resident had an infection to the left gluteus/buttock, with a goal that the resident would be free from complications through the review date. An intervention included to administer antibiotics as ordered. Another baseline care plan identified that the resident had actual skin impairment to the sacrum/buttocks related to impaired mobility, with a goal that the resident would maintain or develop clean and intact skin. The interventions included to keep skin clean and dry, and for the weekly treatment documentation to include measurements of each area of skin breakdown's for width, length, depth, type of tissue and exudate, and any other notable changes or observations. A physician's orders [REDACTED]. with tape, change twice daily, and watch for signs and symptoms of infection every day and night shift. A nurse progress note dated (MONTH) 11, 2019 revealed the resident had an abscess on the left gluteal that required incision and drainage times two and closure at the hospital. An skin wound note dated (MONTH) 11, 2019 stated that the provider was called due to a change in appearance of the resident's left buttock surgical incision. The note included there were openings between sutures, with a moderate amount of light pink drainage and that the resident was on antibiotics. However, the wound note did not contain any further description of the wound or any measurements. Review of a nurse progress note dated (MONTH) 12, 2019 revealed that the surgeon was notified of the change in appearance of the wound and facility was advised to keep the scheduled follow up appointment on (MONTH) 21, 2019 and if there were concerns for infection, then go to the emergency room . Review of the Treatment Administration Record (TAR) for (MONTH) 2019 revealed the treatment to the left gluteal wound was not completed on the night shift on (MONTH) 12. A nurse progress note dated (MONTH) 13, 2019 revealed the dressing change was done to the resident's right gluteal wound (although the above documentation indicated the wound was on the left gluteal). Per the note, the incision had three sutures with openings between sutures with minimal amount of serosanguinous clear drainage, no redness or swelling, no foul odor and the width of the wound was smaller than the tip of a q-tip. The note did not include any measurements of the left gluteal wound. Review of a Consultation Request form dated (MONTH) 16, 2019 revealed a follow up of the left buttock wound, with recommendations for daily wound care and dressing changes. An admission Minimum Data Set (MDS) assessment dated (MONTH) 17, 2019 revealed a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. The assessment included the resident had an abscess to the buttock/surgical wound and was receiving wound care. Further review of the clinical record revealed there was no documentation of a thorough assessment of the left gluteal abscess/surgical wound from (MONTH) 14 through 22. A nurse progress note dated (MONTH) 23, 2019 revealed the dressing to the left buttock was changed and there were no signs or symptoms of infection, redness or swelling. A provider progress note dated (MONTH) 23, 2019 revealed the resident presented to the hospital on (MONTH) 30, 2019, with complaints including a red and painful left buttock which the patient reported was from doing a transfer and possibly sitting down hard on a chair and possible developing a wound or a bruise to the left buttock. Per the note, the hospital records and the history and physical included septic shock and that the resident was taken to the operating room emergently for a washout and delayed primary closure of the wound with three interrupted vertical mattress sutures, with dry gauze packing between the sutures. The note included the resident had a second incision and debridement procedure on (MONTH) 5, 2019 and had to go back to the operating room on (MONTH) 6, 2019, due to bleeding at the wound base at which time a hematoma was evacuated. The physician note included that the left buttock incision was healing well, with well approximated wound edges with three sutures and no drainage, however, there is still induration around the wound without redness and the wound was minimally tender on palpation. In the assessment section, the provider [MEDICAL CONDITION], secondary to a left buttock abscess that cultured positive for [MEDICAL CONDITION] Sensitive Staphylococcus Aureus and to continue local wound care and follow up with general surgery on (MONTH) 25, 2019. The note did not include any measurements. Review of the (MONTH) 2019 TAR revealed that wound treatment to the left gluteal wound was not provided on the night shift on (MONTH) 23, or on the day and night shift on (MONTH) 26. A nurse's progress note dated (MONTH) 27, 2019 included the resident was went to the surgery clinic, but was transported back to the facility as the clinic reported that the resident did not have an appointment at that clinic. The note included the resident's appointment had been at a clinic which was at a different location. Further review of the (MONTH) 2019 TAR revealed that wound care was not provided on the night shift on (MONTH) 29 and 30. Review of a provider progress note dated (MONTH) 1, 2019 revealed a right buttock wound (later in the note it referred to the left buttocks abscess). The note included that the resident has a follow-up with general surgery tomorrow. The note included the buttock had significantly less induration, there was no [DIAGNOSES REDACTED] or warmth, there was a moderate amount of serous sanguinous drainage on the dressing, three sutures were still in place, and the wound was superficially open. The plan included to continue wound care and offloading. The note did not include any measurements. A nurse progress note dated (MONTH) 3, 2019 revealed the dressing to the left buttock was changed by the wound nurse and there was a moderate amount of yellow serous drainage on the old dressing. A provider progress note dated (MONTH) 4, 2019 revealed the incision on the left buttock continues to have serous drainage on the dressing, there are sutures in place, and that minimal induration and [DIAGNOSES REDACTED] remained. No measurements were documented. The note also included that the resident was due to see surgery for [REDACTED]. The note included to continue wound care until that appointment. Review of the (MONTH) 2019 TAR revealed the same order from (MONTH) 9 to cleanse the left gluteal wound with wound cleanser, pat dry, cover with 2 by 2's, then 4 by 4's, secure with tape, change twice daily, and watch for signs and symptoms of infection every day and night shift. Per the TAR, the wound treatment was not documented as completed on the night shift on (MONTH) 1 and 6. Nurse's progress notes dated (MONTH) 10, 2019 revealed the resident appeared tired and was not interested in eating and orders were received to transfer the resident to the emergency room and was admitted to the hospital. Review of the entry tracking record revealed the resident was readmitted back to the facility on (MONTH) 17, 2019. Review of the hospital documentation revealed the resident had an incision and drainage [MEDICAL CONDITION] bacteremia of a left buttock wound and included daily treatment/dressing instructions and to keep the wound clean and dry. Review of an admission/readmission nursing History and Physical with an effective date of (MONTH) 17, 2019 revealed the resident had an admitting [DIAGNOSES REDACTED]. The assessment did not include any further description of the wound. Further review of the admission/readmission nursing History and Physical revealed it was signed on (MONTH) 13, 2019. In an interview with the Director of Nursing on (MONTH) 22, 2019 at 9:19 a.m., she stated that on the resident's return from the hospital on (MONTH) 17, 2019, the re-admission history and physical for resident #21 was not done as expected on the resident's return. She said that when she found out it had not been completed she tried to complete the assessment in November. As a result, the left gluteal abscess/surgical wound was not thoroughly assessed on readmission to the facility on (MONTH) 17, 2019. Physician orders [REDACTED]. A nurse progress note dated (MONTH) 20, 2019 revealed that wound care was done, the sites look good and are healing well. A physician's orders [REDACTED]. A care plan dated (MONTH) 24, 2019 included the resident had a potential for nutritional problems due to increased nutrient needs related to wound healing. However, there was no further documentation regarding the buttock wound. Review of the clinical record revealed there was no documentation that the left gluteal abscess/surgical wound was

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F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 6) thoroughly assessed by a nurse or the provider for 11 days, from (MONTH) 18 through (MONTH) 28, which included a description of the wound, any measurements, if any drainage was present, the condition of the surrounding skin or if the wound was open. A nurse skin wound progress note dated (MONTH) 29, 2019 documented that the resident returned from a wound appointment regarding the buttock and that undermining was noted at approximately 5 cm and new orders were received for dressing changes. This is the first documentation that the wound had any undermining and it was the first documentation of any measurements of the left gluteal wound. Review of a nursing note dated (MONTH) 29, 2019 revealed the resident had an appointment for the buttock wound. The note included there was no foul odor and no drainage. There was no further description of the buttock wound, nor any measurements. A physician's orders [REDACTED]. A nurse progress note dated (MONTH) 4, 2019 revealed that wound care was done and the site had brownish yellow drainage. Review of a provider's note dated (MONTH) 7, 2019 revealed the resident had a left buttock wound, with packing in place. The note included the resident was admitted to the hospital from the facility where he was recovering from an Incision and Drainage of a buttocks abscess. The documentation included a [DIAGNOSES REDACTED]. The note did not include a description of the wound, any measurements or if undermining was present. Review of the TAR for (MONTH) 2019 revealed no documentation that the wound care was completed on (MONTH) 12. A nurse progress note dated (MONTH) 13, 2019 revealed the wound to left buttock continues to receive daily dressing changes, the peri-wound is pink and dry, and there were no signs or symptoms of infection. The note did not included a description of the wound, any measurements, if any drainage was present or if any undermining or tunneling was present. Further review of the clinical record revealed no evidence that a thorough assessment of the left gluteal abscess/incision wound had been completed from (MONTH) 29, 2019 (when the undermining was first documented) through (MONTH) 13, 2019. A provider note dated (MONTH) 14, 2019 revealed the resident was seen as a consultation for evaluation of a wound to the left buttock, which was present at the time of the resident's admission. The note included the resident had been hospitalized for [REDACTED]. The wound was described as a surgical wound that measured 0.19 centimeters (cm) in length by 2.34 cm in width by 0.9 cm depth, with undermining at 3:00 to 9:00 with a maximum distance of 6.5 cm. The note included there was a moderated amount of green drainage and the wound bed had 76-100% pink granulation tissue. The plan included for a culture of the wound and for follow up in one week. This was the first assessment which included the length, width and depth of the wound and the location of the undermining. According to a skin and wound evaluation dated (MONTH) 14, 2019, the resident had a surgical wound with dehiscence to the right buttock, (instead of the left). The size of the wound was 0.2 cm in length by 2.3 cm in width by 0.9 cm depth with 6.5 cm undermining and the wound bed was 100% granulation, with moderate serous drainage with a faint odor, and that the wound was slow to heal and was improving. Review of the physician's orders [REDACTED]. Despite the resident having a left gluteal abscess/incision wound with undermining, there was no comprehensive care plan developed that addressed the resident's care, treatment and needs related to the presence of a wound. An interview was conducted with resident #21 on (MONTH) 18, 2019 01:20 p.m. He stated that the wound on his left buttock happened prior to his (MONTH) admission to the facility and was a result of him sitting on something sharp, causing a wound that got infected and needed surgery. A wound care observation was conducted on (MONTH) 20, 2019 at 1:40 p.m. with a Licensed Practical Nurse (LPN/staff # 77) and a Registered Nurse (RN/staff #16). The wound on the left buttock was open with serous drainage, the wound bed was red with no slough or eschar, the wound edges were rolled, and the peri wound was intact without redness. During the observation, the nurse was observed probing under the wound edges with a Qtip and undermining was present. The nurse did not measure the wound at this time. Clarification with a Licensed Practical Nurse (LPN/staff #77) was conducted on (MONTH) 21, 2019. Staff #77 said the wound location on the skin and wound evaluation dated (MONTH) 14 was in error, as the wound was on the left buttock, not the right. Another interview was conducted with staff #77 on (MONTH) 21, 2019 at 1:19 p.m. She stated that nursing should complete a history and physical within two hours of the resident's admission and the assessment should identify and include an assessment of any wounds present. She stated that resident #21 should have had a wound evaluation done on admission on (MONTH) 10, which included a description of the wound. She also stated that the history and physical should have been completed within two hours of the resident's re-admission on (MONTH) 17, and not done on (MONTH) 13, 2019, as reflected by the nurse signature. She stated there should be weekly assessments of the wound starting with the (MONTH) admission. She further stated that treatments should be done as ordered by the floor nurse or the wound nurse and they are expected to be documented on the TAR/MAR or there should be documentation of why the care was not done. She stated that if the nurse did not document the care, then the care was not given. She stated if wound care was not done as ordered, it would put the resident at risk for infection, worsening wound status and increased pain. On review of the resident's clinical record she said that it did not meet facility policy/expectations for documentation, wound care or wound assessments. An interview was conducted with the Director of Nursing (DON/staff #55) on (MONTH) 22, 2019 at 9:19 a.m. She stated that she expects a head to toe assessment to be completed on the admission/readmission nursing history and physical within 2 hours, but not later than 24 hours of admission. She stated the assessment should identify any wounds present on admission and that a skin and wound evaluation should be initiated with the identification of any wounds. She stated that once a wound is identified, the wound should be assessed every seven days and documented on a skin and wound evaluation. She stated the nurses do the wound treatments and are expected to sign off the treatment in the TAR. She stated if the care was not documented, the care was not done. She stated the admission history and physical for resident #21 for (MONTH) was not done correctly, as it should have had a description of the left buttock wound that was present on admission. She stated that there should be weekly skin and wound evaluations for resident #21 since the (MONTH) admission, but she was only able to locate one evaluation and that the location of the wound was inaccurate. The DON said that on review of the (MONTH) MAR/TAR there were areas without documentation of dressing completion. She stated that any identified wounds should be included in the comprehensive care plan, along with interventions, which were added during the survey process. She stated that care planning, documentation and wound assessments did not meet her expectations or facility policies and that as a result, the wound got worse. She stated that on admit it was a clean surgical wound and on (MONTH) 21, 2019, she went with the nurse practitioner and on assessment of the wound, it had green drainage and adherent slough and required order changes. -Resident #15 was admitted to the facility on (MONTH) 3, 2019, with [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. Review of the admission MDS assessment dated (MONTH) 9, 2019 revealed a BIMS score of 15, which indicated the resident had intact cognition. Review of the TAR for (MONTH) 2019 revealed no documentation that the [MEDICATION NAME] ointment was administered at 8:00 a.m. on (MONTH) 15 and 28, and at 8:00 p.m. on (MONTH) 10, 11, 13, 16, 17, 18, 19, 24, 25, 30 and 31. Review of the TAR for (MONTH) 2019 revealed no documentation that the [MEDICATION NAME] ointment was administered at 8:00 a.m. on (MONTH) 13, and at 8:00 p.m. on (MONTH) 5, 7, and 8. An interview was conducted with the DON on (MONTH) 22, 2019 at 9:37 a.m. She stated the expectation is that medications and treatments be administered as ordered by the physician and documented on the Medication Administration Record (MAR) and TAR. She stated that if the documentation was not done on the MAR or TAR or on a progress note, the facility would be unable to prove that the care was given. Review of a policy titled, Conformity with Laws and Professional Standards revealed the facility operates and provides services in compliance with current federal, state, and local laws, regulations, codes and professional standards of practice that apply to our facility and types of services provided. A policy for pressure ulcers/skin breakdown revealed that staff will examine the skin of a new admission for ulcerations or alterations in skin. Review of a policy for wound care revealed to review the resident's care plan to assess for any special needs of the resident. The documentation requirements included to document: the type of wound care given; the day and time the wound care was given; the name and title of the individual performing the wound care; and all assessment data (i.e. wound bed

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F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 7) color, size, drainage, etc.) obtained when inspecting the wound. Review of a policy for Charting and Documentation revealed that all services provided to the resident shall be documented in the resident's medical record and the medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. The policy included that medications administered and treatments or services performed are to be documented in the medical record. In addition, the policy stated that documentation of procedures and treatments will include care-specific details including the assessment data obtained during the procedure/treatment. According to a policy on administering medications, all medications shall be administered in a safe and timely manner and as prescribed. The policy included the individual administering the medication will record in the resident's medical record the signature and title of the person administering the drug, and topical medications used in treatments must be recorded on the resident's treatment record.
F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, staff and resident interviews and policy review, the facility failed to ensure care and services were provided timely for two residents (#20 and #15) experiencing significant weight loss. The deficient practice places residents at risk for potential nutritional decline. Findings include: -Resident #20 was admitted on (MONTH) 15, 2019, with [DIAGNOSES REDACTED]. The care plan initiated (MONTH) 15, 2019 revealed the resident was at risk for aspiration related to difficulty swallowing. Interventions included a mechanical soft texture diet and observing for pocketing food. Review of the clinical record revealed a physician order [REDACTED]. Review of the Treatment Administration Record (TAR) dated (MONTH) 2019 revealed the resident was to be weighed for 3 days, then weekly for 3 weeks and then monthly with a start date of (MONTH) 16, 2019. Continued review of the (MONTH) 2019 TAR revealed the resident's weight was 172.4 pounds on (MONTH) 16. Additional review of the clinical record did not reveal evidence the resident's weight was obtained on (MONTH) 17 and 18, 2019. Review of the weight summary revealed the resident's weight was 168.2 pounds on (MONTH) 19, 2019. The admission Minimum Data Set (MDS) assessment dated (MONTH) 21, 2019 revealed a Brief Interview for Mental Status score of 10 which indicated the resident had moderate cognitive impairment. The assessment included the resident required set up help and supervision for eating and complained of difficulty or pain with swallowing. The assessment also included the resident's weight was 168 pounds and height was 69 inches and that it was either unknown or the resident did not experienced a weight loss of 5% or more in the last month or 10% or more in the last 6 months. Continued review of the weight summary revealed the resident weighed 167 pounds on (MONTH) 23, 2019, a weight loss of 3.13% in one week. Review of the clinical record revealed no evidence the resident was on a planned weight loss program or that the physician or the dietician was notified of the weight loss. Review of the record for the percentage of meals eaten from (MONTH) 23 - 29, 2019 revealed 10 times the resident ate 0 - 50% of the meal and 13 times the resident ate 51% - 100% of the meal and 2 times the resident refused the meal. A physician's orders [REDACTED]. Review of the record for the percentage of meals eaten from (MONTH) 30, 2019 through (MONTH) 6, 2019 revealed the resident ate 0 - 50% of the meal 14 times, 51% - 100% of the meal 9 times, and refused the meal 2 times. The weight summary revealed the resident weighed 152.2 pounds on (MONTH) 30, 2019 and 150.4 pounds on (MONTH) 6, 2019 which indicated a weight loss of 12.76% since admission. Further review of the clinical record revealed no evidence the physician or the dietician was notified of the severe weight loss or that a care plan was developed regarding the weight loss. A dietician note dated (MONTH) 9, 2019 included the resident had a significant weight loss of 10% in 3 weeks with recommendations for weekly weights, Medpass 2 ounces twice daily, and fortified foods. A physician order [REDACTED]. However, review of the Medication Administration Record [REDACTED]. The weight summary revealed the resident weighed 149.8 pounds on (MONTH) 13, 2019, a weight loss of 13.11%. Review of the record for the percentage of meals eaten from (MONTH) 7 - 18, 2019 revealed the resident ate 0 - 50% of the meal 17 times, 51% - 100% of the meal 17 times, and refused the meal 4 times. A physician order [REDACTED]. Review of the MAR for (MONTH) 2019 revealed the Resource was administered. The weight summary revealed the resident's weight was 148.2 pounds on (MONTH) 20, 2019, a weight loss of 14.04% since admission. On (MONTH) 20, 2019 at 1:42 p.m., an interview was conducted with the Registered Dietitian (RD/staff #78). She stated that a 14.04% weight loss in 5 weeks would be considered significant. She stated that she was not sure if she knew about the resident's weight loss from (MONTH) 19 to 30, 2019. The RD stated she wrote a nutrition/dietary note on (MONTH) 9, 2019 and added Med Pass 2.0 to address the weight loss. The RD also stated she did not know if the physician had been notified about the resident's weight loss. On (MONTH) 20, 2019 at 2:10 p.m., an interview was conducted with a Licensed Practical Nurse (LPN/staff #14). She stated that if a resident has a significant weight loss, she would anticipate the provider and/or the Registered Dietician would be notified and the care plan updated to reflect the weight loss. The LPN stated she did not know the resident was losing so much weight. An interview was conducted with the Director of Nursing (DON/staff #55) on (MONTH) 20, 2019 at 3:01 p.m. She stated her expectation for a resident experiencing a significant weight loss would be for nursing to verify the weights by reweighing the resident, review pertinent [DIAGNOSES REDACTED]. She stated that together they would review the resident's fluid and food intake and document all of the gathered information on a Situation, Background, Assessment, Recommendation (SBAR) report for the physician. The DON stated none of that happened for resident #20, and that it did not meet her expectation for resident care. -Resident #15 was admitted to the facility on (MONTH) 3, 2019 with [DIAGNOSES REDACTED]. Review of the clinical record revealed physician orders [REDACTED]. The physician order [REDACTED]. Review of the weight summary report revealed the resident's weight was 191.6 pounds on (MONTH) 3, 194.6 on (MONTH) 4, no weight for (MONTH) 5, and 194.8 pounds on (MONTH) 6, 2019. Review of the physician progress notes [REDACTED]. The note included the goal for [MEDICATION NAME] was 2-3 bowel movements a day. The note included the resident was eating less than she normally does because the [MEDICATION NAME] makes her feel nauseated. The note included the [MEDICATION NAME] would be reduced to once daily instead of two times a day. The note also included the resident was morbid obese and that the dietary recommendations were discussed with the resident and the resident was agreeable. The note did not include what the dietary recommendations were. The physician order [REDACTED]. Review of the care plan initiated (MONTH) 6, 2019 revealed the resident was overweight/obese related to physical inactivity, has a nutritional problem or the potential for a nutritional problem related to obesity, and that the resident chooses to self-direct therapeutic diet. The goal was that the resident would consume greater than 65% of meals. Interventions included providing and serving diet as ordered. Further review of the clinical record revealed no care plan regarding the [MEDICATION NAME] making the resident nauseous causing her to eat less. Review of the admission Minimum Data Set (MDS) assessment dated (MONTH) 9, 2019 revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident had intact cognition. The assessment revealed the resident was independent for eating, on a mechanically altered diet, and had complaints of difficulty or pain when swallowing. The assessment included the resident's weight was 192 pounds and height was 61 inches and that it was either unknown or the resident did

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F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 8) not experienced a weight loss of 5% or more in the last month or 10% or more in the last 6 months. Review of the weight summary report revealed the resident's weight was 170 pounds on (MONTH) 11, 2019, which indicated a weight loss of 12.73% since (MONTH) 6, 2019. In a review of the clinical record, no evidence was revealed the physician or the dietician was notified of the significant weight loss or that the weight loss was desirable. Review of a nutrition/dietary note dated (MONTH) 13, 2019 revealed to change the diet to a regular diet with minced texture, regular consistency, low sodium preferences, and bite sized for dysphagia. The note included that the resident chooses to self-direct diet and is on a select menu. The note did not address the significant weight loss. The physician order [REDACTED]. Review of the care plan regarding the resident being overweight/obese revealed interventions initiated (MONTH) 13, 2019 included the risks versus the benefits were discussed with the resident, the resident was educated on the diet, and to provide the diet as requested by the resident. The weight summary report revealed the resident weighed 181.2 pounds on (MONTH) 15, 2019. Review of a nutrition/dietary note dated (MONTH) 15, 2019 revealed the resident's current body weight was 181.2 indicating a 7% loss since (MONTH) 6, 2019. The note included the resident's meal intake was around 75%. The note also included a recommendation to re-weigh the resident as the resident's weight has varied greatly. The weight summary report revealed the resident's next weight was 179.2 pounds on (MONTH) 18, 2019. A SBAR (Situation Background Assessment Recommendations) progress note dated (MONTH) 19, 2019 revealed the resident feels nauseated when taking [MEDICATION NAME] and would like to have the [MEDICATION NAME] decreased to every other day if possible. The note included the resident was eating small amounts and that it was mostly jello. The weight summary report revealed the resident weighed 177.6 pounds on (MONTH) 22, 2019. Review of a Nutrition/Dietary note dated (MONTH) 24, 2019 revealed the resident's current body weight was 177.6 pounds indicating a significant weight loss of 2% in one week. The note included the resident had a potential for weight fluctuations related to [MEDICAL CONDITION] and to continue to monitor. The note also included the resident intake of meals was around 75%. The physician order [REDACTED]. Review of the Treatment Administration Record (TAR) for (MONTH) 2019 revealed the time for administering the [MEDICATION NAME] was changed from 8:00 a.m. to 4:00 p.m. The weight summary report revealed the resident's weight was 178 pounds on (MONTH) 30, 2019. The physician progress notes [REDACTED]. The physician progress notes [REDACTED]. Review of the physician progress notes [REDACTED]. The note did not include any documentation about the resident's weight loss. The physician progress notes [REDACTED]. The weight summary report revealed the resident weighed 178.2 pounds on (MONTH) 6, 2019. The physician progress notes [REDACTED]. Review of the physician progress notes [REDACTED]. has been stable. The weight summary report revealed the resident's weight was 175 pounds on (MONTH) 13, 2019. Review of a Nutrition/Dietary note dated (MONTH) 13, 2019 revealed the resident's current weight was 175 pounds and that the resident was eating greater than 75% of meals. The note included the resident has had weight fluctuations related to [MEDICAL CONDITION] (per nursing). The note also included the resident was happy with her weight loss and did not want more food and was not interested in supplements. The note included the resident complained of diarrhea from taking [MEDICATION NAME]. Review of the care plan regarding the resident being overweight/obese was revised on (MONTH) 19, 2019 to include the resident had a 7.5% weight loss. Interventions included the resident was educated on the risks and benefits of the diet. During an interview conducted with resident #15 on (MONTH) 18, 2019 at 11:44 a.m., the resident stated her weight went from 200 pounds to 178 pounds and that she was pleased with the weight loss. An interview was conducted with a Licensed Practical Nurse (LPN/staff #77) on (MONTH) 21, 2019 at 1:35 p.m. She stated that the electronic record will alert the nurse in red if a resident has a significant weight change. She stated the nurse would notify the dietician and the physician and document the communication in the progress note. After reviewing resident #15's clinical record, she stated the resident had a significant weight loss and that the nurse should have documented communication with the dietician and the physician and what the plan was regarding the weight loss. An interview was conducted with the Registered Dietician (staff #78) on (MONTH) 21, 2019 at 1:44 p.m. She stated a resident should be weighed once a week or as ordered by the physician. She stated that the director of nursing or staff would let her know if a resident had a weight change. Staff #78 stated that she would then do an assessment and recommend some interventions. She reviewed the weight changes for resident #15 and stated the resident had a significant weight loss as of (MONTH) 11, 2019 but that the weight loss was not care planned until (MONTH) 19, 2019. She acknowledged that there was no documentation of an assessment or determination of whether interventions were needed after she requested a re-weigh. Staff #78 stated there was no documentation of physician involvement at the time of the weight loss. An interview was conducted with the Director of Nursing (DON/staff #55) on (MONTH) 22, 2019 at 9:40 a.m. She stated that the electronic record alerts her and the staff on the dashboard of any significant weight change. She stated that when alerted to the weight change, documentation should be seen that communication occurred with the dietician, the dietician's assessment and recommendations, and the communication with the physician. She stated resident #15 should have had documentation of an assessment of the weight loss, communication to the dietician and physician, and a care plan with potential interventions. The DON stated the expectation and the facility's policy was not followed related to this significant weight loss. The facility's policy for weight assessment and intervention revised (MONTH) 2008, revealed the multidisciplinary team will strive to prevent, monitor, and intervene for undesirable weight loss for their residents. The policy included that any weight change of 5% or more since the last weight assessment will be retaken the next day for confirmation. If the weight loss is verified, nursing will immediately notify the dietician in writing. Verbal notification must be confirmed in writing. The dietician will respond within 24 hours of receipt of written notification. If the weight change is desirable, this will be documented and no change in the care plan will be necessary. Assessment information shall be analyzed by the multidisciplinary team and conclusions shall be made regarding the relationship between current medical condition or clinical situation and recent fluctuations in weight and whether and to what extent weight stabilization or improvement can be anticipated. The physician and the multidisciplinary team will identify conditions and medications that may be causing anorexia, weight loss or increasing the risk of weight loss such as medication-related adverse consequences. Individualized care plans shall address to the extent possible the identified causes of weight loss, goals and benchmarks for improvement and time frames and parameters for monitoring and reassessment.
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews and review of policy and procedures, the facility failed to provide respiratory care in accordance with professional standards for one resident (#179). The deficient practice could result in respiratiory care needs not being met. Findings include: Resident #179 was admitted on (MONTH) 28, 2019 with [DIAGNOSES REDACTED]. Review of a physician's order dated (MONTH) 28, 2019 revealed for oxygen 3 liters per minute (LPM) per nasal cannula every day and night shift for aspiration pneumonia and to monitor oxygen (O2) saturation levels twice daily. The order did not include any oxygen saturation level parameters. The end date was listed as indefinite. Review of a care plan dated (MONTH) 28, 2019 revealed the resident had a potential for altered respiratory status/difficulty breathing related to pneumonia/use of a chest physiotherapy (CPT) pneumatic vest. The goal was to maintain normal breathing pattern as evidenced by normal respirations, normal skin color, and regular respiratory rate/pattern. Interventions included for nebulizer treatments every 4 hours while awake, monitor/document changes in orientation, increased

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F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 9) restlessness, anxiety, and air hunger, monitor for signs and symptoms of respiratory distress and report to medical doctor as needed. However, the care plan did not include for the use of oxygen via nasal cannula or to monitor O2 saturation levels. A nursing admission history and physical assessment dated (MONTH) 29, 2019 revealed the resident had diminished breath sounds on both sides and that the resident utilized oxygen at 3 LPM via nasal cannula and antibiotics for a community acquired infection. Review of the Medication Administration Record [REDACTED]. The admission Minimum Data Set (MDS) assessment dated (MONTH) 4, 2019 revealed the resident scored a 12 on the Brief Interview for Mental Status (BIMS), indicating moderate cognitive impairment. The MDS also indicated the resident had used oxygen within the last 14 days. A physician's order dated (MONTH) 5, 2019 included to wean the resident off of the oxygen every day and night shift. According to the (MONTH) 2019 MAR, there was no documentation on (MONTH) 24 and 26, if the resident was being weaned off of the oxygen on those two days. In addition, the (MONTH) 2019 MAR indicated [REDACTED]. A physician's progress note dated (MONTH) 1, 2019 included that the resident was using oxygen intermittently and that the resident's pulse oximeter oxygen saturation level was 91% on room air. The note stated the resident was weaning off of oxygen. The (MONTH) 2019 MAR indicated [REDACTED]. Further review of the clinical record revealed no documentation as to why the resident was not provided oxygen on the above dates in (MONTH) or October. Review of the (MONTH) and (MONTH) 2019 MARs revealed no documentation to indicate whether the resident was being weaned off oxygen or not on (MONTH) 10, 11,12, 13, 15, 16, 17, 18, 22, 24, 25, 30, and 31 and on (MONTH) 5, 7, and 8. Further review of the clinical record revealed no documentation as to why the resident was not being weaned off the oxygen on the above dates in (MONTH) or November. On (MONTH) 20, 2019 at 11:24 a.m., an interview was conducted with a Licensed Practical Nurse (LPN/staff #14). She stated that her understanding of the oxygen order for resident #179 meant that if the resident's O2 saturations dropped below 90%, she was to administer oxygen. She acknowledged that the order did not specify if the resident's O2 saturation was above 90% that he did not need oxygen. On (MONTH) 21, 2019 at 10:27 a.m., an interview was conducted with the Director of Nursing (DON/staff #55). She stated the way the physician's order was written, she would anticipate the resident would be receiving continuous oxygen at 3 LPM via nasal cannula, and that the person who put the order into the system probably typed it in wrong. She stated that she would expect that orders for oxygen would state whether residents with oxygen saturation levels above 90% may be on room air. She said that resident #179's orders needed clarification. She stated that according to the way the oxygen order was written, her expectation would be for the resident to wear the nasal cannula at all times. She stated that if the nurses are unsure of an order, they are to get clarification. She stated this did not meet her expectation. She also said that the missing documentation in the resident's MAR indicated [REDACTED]. Review of the facility policy titled, Administering Medications revealed that medications shall be administered in a safe and timely manner, and as prescribed. The policy stated that medications must be administered in accordance with the orders, including any required timeframe. A policy titled Medication Orders stated the purpose of the procedure was to establish uniform guidelines in the receiving and recording of medication orders. The policy stated that oxygen orders should be recorded with a specified rate of flow, route, and rationale for example: oxygen 3 LPM per nasal cannula as needed for shortness of breath. A policy titled Charting and Documentation included that information to be documented in the resident's medical record was to include medications administered.
F 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** Based on resident and staff interviews, facility documentation and policy review, the facility failed to ensure there was sufficient nursing staff to meet the needs of the residents. The deficient practice resulted in resident needs not being met timely. The resident census was 16. Findings include: During the initial phase of the survey 2 out of 8 residents reported concerns of not having enough staff. Residents reported they had to wait from 45 minutes to over an hour for staff to answer their call light during the night shift. They stated that they have had incontinent episodes due to the wait time and have been left sitting on the toilet for 15-30 minutes or longer than needed. Review of the Facility Assessment Tool dated (MONTH) 15, 2019 revealed the approach to staffing was to ensure that sufficient staff is meeting the needs of residents at any given time. The assessment included the staffing ratio for the Certified Nursing Assistants (CNAs) was: Days 1 (CNA):8 (residents), Evenings 1:8-10, and Nights 1:12-15. Review of the facility's staffing documentation and staff sign-in sheets revealed the following: September 1, 2019: one CNA on the night shift who left at 3:15 a.m.; census was 24. September 8, 2019: two CNAs on the day shift; census was 27. September 9, 2019: one CNA on the night shift; census was 28. September 22, 2019: two CNAs on the day shift; census was 23. An interview was conducted with the Staffing Coordinator/Central supply (staff #54) on (MONTH) 21, 2019 at 2:25 p.m. She stated that she did not know about a nursing staff to resident ratio and that she had never seen the facility assessment. Additionally, she stated that frequent call-offs from staff have created an on-going staffing concern. On (MONTH) 21, 2019 at 3:09 p.m., an interview was conducted with the Director of Nursing (DON/staff #55). She stated she was aware that the facility had been short staffed on occasion and that her expectation is for the facility to be fully staffed on a daily basis. Review of the facility's policy titled Nursing Services Policy and Procedure Manual revised (MONTH) 2006 revealed services provided to the residents are performed in accordance with current acceptable standards of clinical practice.
F 0727 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.** Based on review of facility documentation, staff interviews and policy review, the facility failed to use the services of a registered nurse (RN) for at least 8 consecutive hours a day, seven days a week. Findings include: Review of the nurse staffing records for (MONTH) 2019 revealed that on (MONTH) 14, 15, 22, 28, and 29, there was no RN scheduled who provided services for at least eight hours. Review of the Facility Assessment Tool dated (MONTH) 15, 2019 revealed the general staffing plan for nursing staff providing direct care was to provide one RN for each shift/10-12 residents. An interview was conducted on (MONTH) 21, 2019 at 2:25 p.m. with the Staff Scheduling Coordinator/Central supply (staff #54). She stated that she can only schedule staff that have been hired. She stated that if Licensed Practical Nurses (LPNs) are the nurses that are hired, there will not be an RN scheduled. On (MONTH) 21, 2019 at 3:09 p.m., an interview was conducted with the Director of Nursing (DON/staff #55). She stated that she is working towards having an RN on every shift. She stated that they have fulfilled the mandatory requirement because she is an RN and the RNs scheduled work 12 hour shifts. However, she did not provide documentation that an RN provided

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F 0727 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 10) services on the above dates. The facility policy titled Nursing Services Policy and Procedure Manual revised (MONTH) 2006 revealed all policy and or processes will be based on review of state and federal regulations. State and/or federal Standard Operation Manual (SOM) will be utilized to refer to guidance on delivery of services.
F 0732 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Post nurse staffing information every day.** Based on facility documentation and staff interviews, the facility failed to consistently maintain the posted daily nurse staffing data. The deficient practice could result in the public not being aware of current staffing information. Findings include: Review of the POS [REDACTED]. An interview was conducted on (MONTH) 21, 2019 at 2:25 p.m., with the Staff Scheduling Coordinator/Central supply (staff #54). She stated that up until recently, the night shift nurses filled out the staff posting sheets. She stated that about 1 1/2 weeks ago, the Director of Nursing (DON) asked her to do it. She stated that the staff postings are left all over the facility, and thought that was part of the problem of not being able to produce them. She stated that she could not say if they were misplaced or if they were ever done. An interview was conducted with the DON (staff #55) on (MONTH) 21, 2019 at 3:09 p.m. She stated that staff #54 constructs the nursing schedules and the staff posting sheets. She stated that her expectation is that the nurse staff postings are completed and posted on a daily basis. She stated that the missing documentation did not meet her expectation.
F 0759 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure medication error rates are not 5 percent or greater.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of the clinical record, staff interviews and policy review, the facility failed to ensure the medication error rate was not 5% or greater, by failing to administer medications as ordered to one resident (#15). The medication error rate was 6.67%. The deficient practice could result in further medication errors. Findings include: Resident #15 was admitted to the facility on (MONTH) 3, 2019, with [DIAGNOSES REDACTED]. During a medication administration observation conducted on (MONTH) 19, 2019 at approximately 8:00 a.m. with a Licensed Practical Nurse (LPN/staff #12), the LPN was observed to administer calcium [MEDICATION NAME] plus vitamin D3 630 milligrams (mg)/500 international units (iu) to resident #15. However, review of the physician orders [REDACTED]. An interview was conducted with the LPN (staff #12) on (MONTH) 19, 2019 at 2:38 p.m. After reviewing the bottle of medication, she stated that the label indicated the dose of calcium [MEDICATION NAME] plus vitamin D3 was 630 mg/500 iu despite the handwritten information on the bottle cap that the dose was 500 mg/200 iu. The LPN stated that the expectation is to follow the physician's orders [REDACTED]. She stated that she should have read the medication bottle label for the dose. During a medication administration observation conducted on (MONTH) 20, 2019 at 8:35 a.m., a Registered Nurse (RN/staff #16) was observed to crush an [MEDICATION NAME] coated aspirin 81 mg tablet, with the resident's other medications and mix them in applesauce. The nurse indicated that she was going to administer the medications to the resident when the surveyor intervened. An interview was conducted immediately with the RN (staff #16), who stated that the [MEDICATION NAME] coated aspirin should not have been crushed but that she crushed it and intended to administer it to the resident. Review of a physician's orders [REDACTED]. An interview was conducted with the Director of Nursing (DON/staff #55) on (MONTH) 20, 2019 at 10:55 a.m. She stated the expectation is for the nurses to administer medications according to the physician order. Regarding the calcium-vitamin D, she stated the nurse should have checked the medication label on the bottle to determine the correct dose to be administered. The DON stated that in regards to the [MEDICATION NAME] coated aspirin, the resident did not have a physician's orders [REDACTED]. She stated the nurse should know that an [MEDICATION NAME] coated medication should not be crushed. Review of the facility's policy titled, Administering Medications revealed that medications must be administered in accordance with the orders. The policy included the individual administering the medication must check the label three times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication. The facility's policy regarding adverse consequences and medication errors revealed that a medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders [REDACTED]. Examples of medication errors included: wrong dose, wrong dosage form, and failure to follow manufacturer instructions and/or accepted professional standards (e.g. crushing a medication on the do not crush list without an order).
F 0838 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies.** Based on review of the facility assessment and a staff interview, the facility failed to conduct and thoroughly complete a facility-wide assessment to determine what resources were necessary to care for its residents competently during both day-to-day operations and emergencies, and failed to update the facility assessment when there were changes that would require a substantial modification to the assessment. The deficient practice could result in a lack of resources to assure resident care provision. The facility census was 16. Findings include: Review of the facility's assessment revealed there were areas which were not fully complete or updated as follows: Regarding the section to indicate the average daily census, the response was N/Aalong with the following documentation: The average daily census will build in increments with a new opening. Will begin with five and will advance census as staffing allows until meet capacity. However, the facility has been providing patient care for over one year. Under the Acuity section which requires the facility to provide an overall picture of analysis of acuity, the facility's response included that all ranges or averages will be updated past admission of initial guest. However, the information for this section was not fully completed or updated by the facility. An interview was conducted with the Executive Director (staff #40) on (MONTH) 21, 2019 at 2:14 p.m. He stated that the purpose of the facility assessment is to put into writing the facility's role in the health care continuum and to keep the facility staff focused on what they need to do. He stated the assessment should include who the facility is taking care of and what they need to take care of the residents. He said that the facility assessment information should be current for the facility and should be complete. He said the assessment was not complete or current, as they have had residents in the building. He stated the assessment should contain average census and acuity information and be updated for changes in the facility. He also stated that he did not notice those errors, prior to the survey
F 0867 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.** Based on concerns identified during the survey, review of the facility assessment, a staff interview and policy review, the Quality Assessment and Assurance (QA) committee failed to identify quality concerns related to advance directives and implement corrective action and monitoring to correct the issue. The deficient practice could result in quality concerns

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F 0867 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 11) not being identified and corrected. Findings include: During the survey, concerns were identified regarding a lack of documentation of advance directives for six of seven sampled residents. During multiple resident interviews, residents stated that they were not being given an opportunity to formulate their wishes in case of emergency care. Social service staff responsible for advance directives stated that assistance with completing advance directives had only been provided on a case by case basis, when there was need for clarification or if a resident asked for assistance. An interview was conducted with the Executive Director (staff #40) on (MONTH) 22, 2019 at 8:30 a.m. He stated that the advance directive process in the building had not been working properly and did not meet the requirement to proactively ask the residents about advanced directives. He stated the issue was identified by the survey team and that the QA committee had not identified the issue. He said the facility should have identified the issue and brought it to the committee, prior to survey. He said that resident rights were not being ensured related to residents having the opportunity to formulate advance directives. Review of the facility assessment dated (MONTH) 15, 2019 revealed that facility services and care are based on the resident's needs and would include offering and assisting resident and family caregivers to be involved in person centered care planning and advanced care planning. Review of the Quality Assurance Performance Improvement (QAPI) policy revealed the purpose of QAPI was to take a proactive approach that continually improves the way we care and engage with our guests. The policy stated that QAPI includes all employees, all departments, and all services provided and focuses on systems and processes to identify gaps. The policy included that the QAPI program encompasses analysis of all segments of the services offered. The policy further stated the monitoring process will continuously draw information from multiple sources and performance improvement projects identified and will be a concentrated effort on a specific problem in one area of the nursing center or on a facility wide basis.
F 0868 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Have the Quality Assessment and Assurance group have the required members and meet at least quarterly** Based on facility documentation, staff interview and policy review, the facility failed to ensure required members consistently attended the Quality Assurance (QA) meetings, and failed to ensure that the committee met at least quarterly. The deficient practice could result in an ineffective Quality Assurance Performance Improvement (QAPI) program. Findings include: Review of the QAPI/Quality Assessment and Assurance (QAA) meeting sign in sheets for the 3rd quarter of (YEAR) (July, (MONTH) and September), did not reveal any staff signatures of attendance for the (MONTH) 25, (YEAR) meeting, and there were no notes/sign in sheets for (MONTH) or (MONTH) (YEAR). Review of the QAPI/QAA meeting sign in sheets for the 4th quarter of (YEAR) did not reveal any notes/sign in sheets for October, (MONTH) or (MONTH) (YEAR). Review of the QAPI/QAA meeting sign in sheets for the 2nd quarter of 2019 revealed a meeting was held on (MONTH) 16, 2019, however the Director of Nursing (DON) was not present. Review of the QAPI/QAA meeting sign in sheets for the 3rd quarter of 2019 revealed no medical director was in attendance. An interview was conducted with the Executive Director (staff/#40) on (MONTH) 22, 2019 at 8:30 a.m. He stated that the QA committee meets monthly on the third Thursday of the month and that the committee members include the DON, the director of environmental services, the office manager, the Executive Director, the Medical Director, staff development, transitional care, and all department heads. He stated that he expects the facility staff to be present every month. He stated that he expects the Medical Director to attend monthly, but at least quarterly. He stated that the quarters for the year are separated into the calendar months with (MONTH) starting the first quarter of the year. He stated that when he came in (MONTH) 2019 he found no documentation of any meetings held from (MONTH) (YEAR) to (MONTH) 2019, and that he believes the (MONTH) 2019 meeting was missed. He said that he was unable to locate the sign in sheet for (MONTH) 2019. On review of the sign in/sheets from (MONTH) 2019 to (MONTH) 2019 he stated that unfortunately the Medical Director did not come that quarter. He stated the facility expectations/policy had not been met in regards to the QA meetings and attendance.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and policy and procedures, the facility failed to ensure that contaminated laundry was processed appropriately. The deficient practice could result in an increased risk for transmitting infectious diseases to residents and staff. Findings include: On (MONTH) 21, 2019 at 10:25 a.m., an observation of laundry services was conducted with a member of the laundry staff (staff #47). She stated that contaminated/infectious linens and laundry are brought to the dirty laundry room in a red biohazard bag, by Certified Nursing Assistants (CNAs). She said the CNAs place the biohazard bags into a large yellow container that is designated for contaminated laundry only. She stated that prior to processing infectious laundry she dons a gown, gloves, mask and shoe covers. She stated that she then sorts the laundry, looking for items which are heavily soiled with feces/solid matter. She stated she places those items into the hopper sink, which is located in the dirty laundry room, and rinses off the feces/solid matter. She stated that she then separates the colored items from the linens. She said she then bags the items according to their color, and carries the bags into the next room where the washing machines are located. She stated her process is to use the Infectious load (cycle #3) for laundering the linens, towels and other bleachable items from isolation rooms. She said she uses the Colors load (cycle #2) for laundering resident clothing and/or other colored items from the isolation rooms. She stated the facility uses laundry products from a company and pointed to the chart on the wall that identified the laundry cycles which were designated for the different types of laundry loads. On (MONTH) 21, 2019 at 3:41 p.m., an interview was conducted with a representative from the company that provides laundry products to the facility. He stated that only laundry cycle #3, (the Infectious cycle) is designed for contaminated laundry. He stated the product in this cycle contains a low temperature chlorine sanitizer. He said that cycle #3 is the only cycle that utilizes a product that is designed to disinfect infectious laundry. He said neither of the two chemicals that are utilized in laundry cycle #2 (the colored cycle), contain infection control properties. He said laundry cycle #2 does not contain chlorine and therefore; would not be appropriate for processing laundry that contained [MEDICAL CONDITION] or other infectious materials. An interview was conducted on (MONTH) 22, 2019 at 9:16 a.m., with the Director of Nursing (DON/staff #55). She stated that all laundry coming from isolation rooms should be considered contaminated. She stated that all contaminated/infectious laundry from the isolation rooms should be washed in the same load, using the cycle for infectious loads. She stated that laundry soiled with infectious material should not be rinsed out in the hopper sink, but should be placed directly into the washing machine and laundered on the appropriate cycle. An interview was conducted on (MONTH) 22, 2019 at 9:24 a.m., with the facility's Infection Preventionist (staff #41). She stated that she could not speak to what the laundry personnel were educated to do prior to her being here. She said that she has only been the Infection Preventionist for two months and that she was not fully certified at that time. She stated that she was not sure of the entire process or which laundry cycle should be used. Review of the facility's Laundry and Bedding, Soiled policy revealed that soiled laundry/bedding shall be handled in a manner that prevents gross microbial contamination of the air and persons handling the linen. Soiled laundry and bedding (e.g., personal clothing, gowns, bed sheets, blankets, towels, etc.) contaminated with blood or other potentially infectious materials must be handled as little as possible and with a minimum of agitation. A policy titled, Infection Control included the policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage the transmission of diseases and infections. The objectives included providing guidelines for the safe cleaning and reprocessing of reusable resident-care equipment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035296	A. BUILDING _____ B. WING _____	11/22/2019

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WELBROOK SENIOR LIVING FLAGSTAFF LLC	1521 NORTH PINE CLIFF DRIVE EAST FLAGSTAFF, AZ 86001

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 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 12) Additionally, the policy stated that all personnel will be trained on infection control policies and practices upon hire and periodically thereafter, including where and how to find pertinent procedures and equipment related to infection control. The depth of employee training shall be appropriate to the degree of direct resident contact and job responsibilities.
F 0883 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Develop and implement policies and procedures for flu and pneumonia vaccinations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, staff interviews and policy and procedures, the facility failed to ensure four of five sampled residents (#'s 15, 20, 21 and 179) received information regarding the benefits and potential side effects of influenza and/or pneumococcal immunizations, and failed to offer the vaccinations according to their policy. The deficient practice could maximize the risk of residents acquiring, transmitting or experiencing complications from influenza and/or pneumococcal disease. Findings include: -Resident #21 was admitted to the facility on (MONTH) 9, 2019, with [DIAGNOSES REDACTED]. Review of the admission Minimum Data Set (MDS) assessment dated (MONTH) 17, 2019 revealed the resident scored 12 on the Brief Interview for Mental Status (BIMS), indicating moderate cognitive impairment. Review of the clinical record revealed no documentation that the resident was provided information regarding the benefits and potential side effects of influenza and pneumococcal vaccines or that the resident was offered or refused the vaccines. -Resident #15 was admitted to the facility on (MONTH) 3, 2019, with [DIAGNOSES REDACTED]. The admission MDS assessment dated (MONTH) 9, 2019 revealed the resident scored 15 on the BIMS, which indicated intact cognition. Review of the clinical record revealed no documentation that the resident was provided information regarding the benefits and potential side effects of pneumococcal vaccines or that the resident was offered or refused the vaccines. -Resident #20 was admitted to the facility on (MONTH) 15, 2019, with [DIAGNOSES REDACTED]. The admission MDS assessment dated (MONTH) 21, 2019 revealed the resident scored a 10 on the BIMS, indicating moderate cognitive impairment. Review of the clinical record revealed no documentation that the resident was provided information regarding the benefits and potential side effects of pneumococcal vaccines or that the resident was offered or refused the pneumococcal vaccines. -Resident #179 was admitted to the facility on (MONTH) 28, 2019, with [DIAGNOSES REDACTED]. The admission MDS assessment dated (MONTH) 4, 2019 revealed the resident scored a 12 on the BIMS assessment, indicating moderate cognitive impairment. Review of the clinical record revealed no documentation that the resident was provided information regarding the benefits and potential side effects of pneumococcal vaccines or that the resident was offered or refused the pneumococcal vaccines. On (MONTH) 21, 2019 at 9:05 a.m., an interview was conducted with the Infection Preventionist (staff #39). She stated that residents' immunization history is gathered upon admission by the admitting nurse. She said residents are offered immunizations if they are not up to date. She stated that information regarding the benefits and potential side effects of influenza and pneumococcal immunizations should be provided to each resident and/or their representative. She said a signed consent, indicating whether they accepted or refused the vaccines, should be scanned into each resident's record. On (MONTH) 22, 2019 at 9:12 a.m., an interview was conducted with a Licensed Practical Nurse (LPN/staff #77). She stated that when the admitting nurse completes an admission assessment, the nurse should take in the information regarding the benefits and potential side effects of influenza and pneumococcal immunizations along with the consent form to obtain signatures at that time. She stated that if there are no consents/signatures it should be flagged in the chart for completion. An interview was conducted on (MONTH) 22, 2019 at 9:16 a.m. with the Director of Nursing (DON/staff #55). She stated her expectation is for nursing to obtain immunization information/consents upon admission. She stated that all of the immunization history should be gathered and documented into the resident's record. The DON said that information regarding the benefits and potential side effects of influenza and pneumococcal immunizations should be provided to each resident in addition to obtaining a signed consent, before administering immunizations. She said the facility had not offered pneumoccocal vaccines prior to last week, which was a big problem. The facility policy titled, Pneumococcal Vaccine stated that all residents will be offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. The policy stated that prior to or upon admission, residents will be assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, will be offered the vaccine series within 30 days of admission to the facility, unless medically contraindicated or the resident has already been vaccinated. The policy included that assessments of pneumococcal vaccination status will be conducted within 5 working days of the resident's admission if not conducted prior to admission. The policy further included that before receiving a pneumococcal vaccine, the resident/representative shall receive information and education regarding the benefits and potential side effects of the vaccine. The policy also stated residents/representatives have the right to refuse vaccination. If refused, appropriate entries will be documented in each resident's medical record indicating the date of the refusal of the pneumococcal vaccination. The policy further included for residents who receive the vaccines, the date of vaccination, lot number, expiration date, person administering, and the site of vaccination will be documented in the resident's medical record. Review of a policy titled Influenza, Prevention and Control revealed the facility follows current guidelines and recommendations for the prevention and control of seasonal influenza. The policy stated that the Infection Preventionist will promote and administer the seasonal influenza vaccine. Unless contraindicated, all residents will be offered the vaccine.