STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035106	A. BUILDING _____ B. WING _____	**06/21/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WESTCHESTER CARE CENTER	**6100 SOUTH RURAL ROAD TEMPE, AZ 85283**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0578 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policy, the facility failed to ensure one of four sampled residents (#289) advance directive was offered and completed upon admission. The deficient practice could result in residents receiving services which are not in accordance with their wishes. The census was 44. Findings include: Resident #289 was admitted on (MONTH) 16, 2019, with [DIAGNOSES REDACTED]. Review of the clinical record revealed the advance directive paperwork had not been completed upon admission. An interview was conducted on (MONTH) 19, 2019 at 1:20 p.m. with a Registered Nurse (RN/staff #37). She stated, the advance directive is to be completed upon admit because if the resident codes prior to advance directives being offered there is a possibility that their wishes might not be followed. The RN also stated that if the resident refused to formulate the advance directive at that time, then the nurse would document it in their progress notes. During an interview conducted on (MONTH) 19, 2019 at 1:34 p.m. with the Director of Nursing (DON/staff #22), she stated the advance directive form is to be offered upon admission, not days after the admission. The DON stated that if the resident or the resident's representative refuses to formulate an advance directive, the resident would be considered a full code until the paperwork is completed. She stated the Health Information Manager (staff #47) completes the new admission paperwork and is responsible for getting the advance directive form signed. An interview was conducted with the Health Information Manager (staff #47) on (MONTH) 16, 2019 at 2:05 p.m. She stated she usually completes the admission paperwork and that the advance directive form is flagged in the resident's chart for the nurses to complete. Staff #47 stated her goal is to complete the admission paper the next day. She stated that chart audits are conducted every 48 hours and 72 hours to make sure that all new admit paperwork is complete including the advance directives. Staff #47 stated that if during her audit, she finds the advance directive has not been completed; she gives it to the nurses. She stated that if the resident does not want to formulate an advance directive, it has to be documented in the nurses' progress notes. The facility's policy Advance Directives revised 12/2018 revealed staff will inquire during the admission process whether or not a resident has an advance directive. Information and forms will be provided to those individuals wanting to develop an advance directive. The policy also included staff will provide written information about advance directive policies upon admission.
F 0641 **Level of harm -** Potential for minimal harm **Residents Affected -** Some	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and the Resident Assessment Instrument (RAI) manual, the facility failed to ensure a discharge MDS (Minimum Data Set) assessment was accurate for one of three sampled residents (#40). This deficient practice could affect continuity of care. Findings include: Resident #40 was admitted on (MONTH) 10, 2019, with [DIAGNOSES REDACTED]. The resident was discharged (MONTH) 15, 2019. A nursing note dated (MONTH) 12, 2019, revealed the resident was scheduled for transfer to a memory care facility next week. A physician's orders [REDACTED]. However, review of the discharge MDS assessment dated (MONTH) 15, 2019, revealed the resident was discharged to an acute hospital. An interview was conducted on (MONTH) 21, 2019 at 9:25 a.m. with the MDS/Assistant Director of Nursing (staff #52). After reviewing the clinical record, staff #52 stated that the MDS assessment was inaccurate and it should have been coded as discharge to the community not discharge to hospital. During an interview conducted with the Director of Nursing (staff #22) on (MONTH) 21, 2019 at 9:30 a.m. Staff #22 stated that the MDS assessment should have been coded as transfer to the community. The RAI manual instructs to review the medical record including the discharge plan and discharge orders for documentation of discharge location and code MDS assessment accordingly. The RAI manual also included that it is required that the assessment accurately reflects the resident's status and that the importance of accurately completing and submitting the MDS assessments cannot be over-emphasized.
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, facility documentation, resident and staff interviews, and policy review, the facility failed to ensure one sampled resident (#23) received an adequate number of showers. The universe was 14. The deficient practice could result in hygiene needs not being met. Findings include: Resident #23 was readmitted to the facility on (MONTH) 26, (YEAR), with [DIAGNOSES REDACTED]. Review of the care plan dated (MONTH) 12, 2019, revealed the resident needed assistance with Activities of Daily Living related to a [MEDICAL CONDITION] disorder and impaired vision. Interventions included the resident needed one person assistance for showering. Review of the facility's shower schedule located in the staffing book revealed residents are scheduled at least 2 times a week for showers and to document it in the electronic record. The quarterly Minimum Data Set assessment dated (MONTH) 2, 2019, revealed a Brief Interview for Mental Status score of 15, which indicated the resident had intact cognition. The assessment also included the resident required the assistance of one person for bath/showers. Review of the shower assignment sheet for resident #23 revealed showers were scheduled every Tuesday and Friday on the p.m. shift.

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

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F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) Review of the Point of Care documentation (P[NAME]) for showers revealed that from (MONTH) 22 to (MONTH) 20, 2019, resident #23 was provided showers on (MONTH) 24, 31 and (MONTH) 11. The documentation also revealed the resident did not refuse any showers. During an interview conducted with the resident #23 on (MONTH) 18, 2019 at 9:56 a.m., the resident was observed to be wearing clothes with stains and untrimmed nails. The resident stated that he has not been provided showers twice a week that showers are mostly missed. An interview was conducted with a Certified Nursing Assistant (CNA/staff #77) on (MONTH) 20, 2019 at 9:16 a.m. She stated that all residents are scheduled to be offered a shower at least two times a week and that the schedule is located at the nurse's station. The CNA stated that they document the showers and refusals in P[NAME]. The CNA stated that the expectation is that showers be offered to the residents as scheduled and documented. She stated that when they are short staffed, they are unable to provide all of their scheduled showers. During an interview conducted with a Licensed Practical Nurse (LPN/staff #27) on (MONTH) 20, 2019 at 9:33 a.m., she stated that they have a shower schedule and each resident is scheduled for two showers a week. She stated that the CNA is expected to offer the shower as scheduled and to document the showers and any refusals in P[NAME]. The LPN stated that when they are short staff the CNAs might not be able to offer all their scheduled showers. She stated that if that happens, the CNA will notify the LPN and report it to the oncoming shift and that the next shift can give the shower. An interview was conducted with the Director of Nursing (DON/ staff #22) on (MONTH) 20, 2019 at 3:13 p.m. She stated that she expects staff to offer showers to the residents on their scheduled shower days. She stated that when a shower is given or a shower is refused by a resident it should be documented in P[NAME]. The DON stated that when a shower is missed because of staffing issues, it should be offered on the next shift and documented. Review of the facility's policy regarding Shower Assignments revealed each resident will be provided a shower/bath two times a week and as needed.
F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, clinical record review, and policy and procedures, the facility failed to ensure two sampled residents (#8 and #6) with an indwelling catheter received the appropriate care and services. The deficient practice could result with residents having urinary complications. Findings include: -Resident #8 was admitted to the facility on (MONTH) 12 2019 and readmitted on (MONTH) 29, 2019, with [DIAGNOSES REDACTED]. Review of the admission Minimum Data Set (MDS) assessment dated (MONTH) 19, 2019 revealed a Brief Interview for Mental Status (BIMS) score of 3 which indicated the resident had severe cognitive impairment. The assessment also included the resident had an indwelling urinary catheter and an ostomy, Review of the care plan regarding the catheter/[MEDICATION NAME] revised on (MONTH) 7, 2019, revealed a goal that the resident would not sustain injury secondary to catheter manipulation. Interventions included educating the resident on the importance of fluids, keeping the drainage bag below the level of the bladder, monitoring/recording output every shift, providing adequate fluids, and securing the catheter to the leg or abdomen to avoid tension. Review of the physician's orders dated (MONTH) 23, 2019 revealed an order for [REDACTED].>The Treatment Administration Record (TAR) for (MONTH) 2019 revealed documentation routine catheter care was provided twice daily (MONTH) 23 through (MONTH) 30, 2019 except when the resident was out of the facility. A Nursing Progress Note dated (MONTH) 28, 2019 revealed documentation the resident was sent to the hospital for pulling out the suprapubic catheter and that the resident was being admitted to the hospital. Review of the Nursing Progress Note dated (MONTH) 29, 2019 revealed the resident returned from the hospital with a dressing over what was the suprapubic catheter. The note also included that the Foley catheter, size 20 gauge French with a 10 cubic centimeter (cc) balloon was intact and draining yellow urine. Review of the physician's orders dated (MONTH) 29, 2019 revealed an order to replace the Foley catheter if the resident pulls it out. The order contained no instructions regarding the catheter size, balloon size, catheter care, or when to routinely change the catheter. Review of the clinical record revealed no documentation that catheter care was provided (MONTH) 1 through (MONTH) 19, 2019. The TAR did include documentation the catheter was replaced on (MONTH) 5, 2019 at 11:40 p.m. An interview was conducted with a Certified Nursing Assistant (CNA/staff #8) on (MONTH) 19, 2019 at 9:30 a.m. The CNA stated that she empties the urine bag and cleans the outlet tip at least twice a shift. She stated that the resident wears leg bags which do not hold large quantities of urine, so she has to empty the bag more frequently. An interview was conducted with a Licensed Practical Nurse (LPN/staff #55) on (MONTH) 20, 2019 at 10:20 a.m. The LPN stated the resident used to have a suprapubic catheter but he kept pulling it out, so the urologist surgically inserted a urethral catheter. She stated that the nurses do not routinely change his catheter because of the difficulty of insertion. She further stated that she provides catheter care daily and that she was unaware that there were no orders for catheter care. During an interview conducted with the Director of Nursing (DON/staff #22) on (MONTH) 19, 2019 at 10:50 a.m., the DON stated that she expects the nurses to follow physician orders and facility policy in regard to residents with catheters. Review of the facility's policy regarding Indwelling Catheter Care revealed the purpose of catheter care is to prevent infection and reduce irritation. The policy also included the indwelling catheter care procedure. -Resident #6 was readmitted to the facility on (MONTH) 6, (YEAR) with [DIAGNOSES REDACTED]. Review of the quarterly MDS assessment dated (MONTH) 12, 2019 revealed a BIMS score of 12 which indicated the resident had moderate cognitive impairment. The assessment also included the resident had an indwelling urinary catheter and an ostomy. The care plan regarding the indwelling suprapubic catheter revealed a goal that the resident would remain free from complications related to an indwelling catheter. Interventions included instructions to see physician's orders for care. Review of the physician recap orders for (MONTH) 2019, revealed an order with an initial date of (MONTH) 7, (YEAR) to cleanse the suprapubic site with soap and water, pat dry, and apply split drainage gauze twice daily. On (MONTH) 20, 2019 at 10:10 a.m., an observation was conducted of suprapubic catheter care. The Licensed Practical Nurse (LPN/staff #55) washed her hands and donned gloves. She removed the dressing from the suprapubic catheter site, cleaned the area around the catheter and down the catheter away from the stoma using sterile water. She then applied split gauze dressing, removed her gloves and washed her hands. Immediately following this observation, the LPN stated that she always uses sterile water for this procedure. Review of the facility policy regarding Suprapubic Catheter Care revealed the purpose of suprapubic catheter care was to keep the area clean and prevent infection. The policy included instructions to check the physician's order for catheter care and clean the area around the catheter well with soap and warm water.
F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident representative and staff interviews, clinical record review, and policy and procedure, the facility failed to ensure nutritional care and services were provided and documented for two of two sampled residents (#10 and #88). The deficient practice places residents at risk for potential nutritional decline and/or dehydration. Findings include: -Resident #10 was admitted to the facility on (MONTH) 9, (YEAR), with [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS) assessment dated (MONTH) 5, 2019, revealed a Brief Interview for Mental Status (BIMS) score of 4, which indicated the resident had severe cognitive impairment. Review of a care plan for nutrition revised on (MONTH) 9, 2019, revealed the resident was at nutritional risk with an intervention to monitor meal intakes. A hydration care plan revised on (MONTH) 9, 2019, revealed the resident was at risk for alteration in hydration related to a [DIAGNOSES REDACTED].

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F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) Review of the resident's meal and fluid intake documentation for (MONTH) 1, 2019 through (MONTH) 19, 2019, revealed no documentation of meal or fluid intake for 21 out of the 57 meals. An observation of the resident's room was conducted on (MONTH) 19, 2019 at 9:06 a.m. There no water pitcher observed at the resident's bedside. An interview was conducted on (MONTH) 19, 2019 at 2:43 p.m. with a Certified Nursing Assistant (CNA/staff #49). He stated the CNA was responsible for documenting the resident's meal and fluid intake. He stated that every resident should have a water pitcher in their room. The CNA said there was also a self-serve beverage cart in the hallway which was available for residents and guests; however, he stated residents did not use the cart very often. Another observation of the resident's room was conducted on (MONTH) 20, 2019 at 8:29 a.m. No water pitcher was observed at the resident's bedside. An interview was conducted on (MONTH) 20, 2019 at 9:18 a.m. with a CNA (staff #58). She stated the CNA was responsible for documenting meal and fluid intake. She said if the resident did not eat a meal, it would be documented as refused. She stated that meal and fluid intake documentation should not be left blank. She stated that if a resident did not have a water pitcher in their room, she would wait for the resident to request one before replacing it. -Resident #88 was admitted to the facility on (MONTH) 17, 2019, with [DIAGNOSES REDACTED]. Review of the admission nursing assessment dated (MONTH) 17, 2019, revealed the resident was confused and was dependent on staff for eating. Review of the care plan for nutrition dated (MONTH) 18, 2019, revealed the resident was at nutritional risk, with an intervention to monitor meal intake. The care plan regarding activities of daily living dated (MONTH) 20, 2019 revealed the resident was dependent on staff for eating. Review of the resident's meal intake documentation for (MONTH) 17, 2019 through (MONTH) 19, 2019, revealed no documentation for 5 out of the 7 meals. A meal observation and interview was conducted on (MONTH) 19, 2019 at 12:27 p.m. A staff member brought a meal tray into the resident's room and set it on a table that was out the resident's reach. The staff member left the room. When asked about the tray left away from the resident, the staff member said the resident was sleeping and the resident's representative said it was okay to leave the tray until the resident woke up. An interview was conducted on (MONTH) 20, 2019 at 10:55 a.m. with the resident's representative. She stated she had told staff that the resident could not eat on her own. She said staff would not feed the resident. She said the only time the resident ate was when she fed the resident herself. A meal observation was conducted on (MONTH) 20, 2019 at 12:24 p.m. A staff member brought a meal tray into the resident's room and set it on a bedside table that was two to three feet away from the resident's bed. The staff member left the food covered and exited the room. At 1:02 p.m., a staff member removed the meal tray from the resident's room and placed it on the kitchen cart. All of the food was still on the tray, including the main dish, salad and dessert. An interview was conducted on (MONTH) 20, 2019 at 2:15 p.m. with the Director of Nursing (DON/staff #22). She stated the CNA was responsible for documenting meal and fluid intake. She said meal documentation was reviewed by the nurse on duty. She said that ideally, meal documentation would also be audited weekly for completion by herself and the Assistant Director of Nursing. She said if the CNA was not documenting meal intake, then we have an issue. She further stated her expectation is that interventions on the care plan should be followed as long as they were reasonable and doable. She said it may not be reasonable to include an intervention to keep a water pitcher at the bedside for a resident with dementia. Review of the facility's policy for meal service revealed the purpose is to ensure each resident received the amount of assistance necessary and to record the percentage of food the resident consumed. Procedures included to place food containers within easy reach of the resident, assist as necessary, return periodically to determine if the resident required further assistance, and take note of the percentage of food consumed. The facility's policy regarding Hydration revealed each resident will be provided with sufficient fluid intake to maintain proper hydration. The policy included fluids will be offered during meals, between meals, and at bedside unless contraindicated. The policy also included fresh water is delivered to applicable residents three times a day and as needed.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** Based on observation, interview, and policy review, the facility failed to ensure that medications and biologicals were stored in locked compartments and under proper temperature controls and that expired medical supplies were not available for resident use. The deficient practice could result in failure to prevent loss, inaccurate laboratory results, and ineffective vaccines. Findings include: -An observation of a medication storage room was conducted on (MONTH) 20, 2019 at 1:55 p.m., with a Licensed Practical Nurse (LPN/staff #55). The observation revealed two culture swabs with an expiration date of (MONTH) 2019. There was also a refrigerator in the room that contained vaccines and medications. Review of the refrigerator temperature log for (MONTH) 2019, revealed spaces to record the temperature twice daily, however, review of the log revealed missing documentation for the following dates: -May 1st a.m. and p.m. -May 2nd a.m. -May 4th a.m. and p.m. -May 5th a.m. -May 6th a.m. -May 9th a.m. -May 10th p.m. -May 11th a.m. and p.m. -May 12th p.m. -May 14th a.m. -May 15th a.m. Review of the refrigerator temperature log for (MONTH) 2019 revealed missing documentation for the following dates: -June 1st p.m. -June 2nd p.m. -June 6th a.m. and p.m. -June 7th p.m. -June 11th p.m. -June 12th a.m. and p.m. -June 13th p.m. -June 14th a.m. and p.m. -June 15th p.m. -June 17th p.m. -June 18th p.m. -June 19th p.m. -June 20th a.m. An interview was conducted with staff #55 at the time of the observation. She stated that she would not be able to tell if the vaccines in the refrigerator were still effective if the temperature log had blank spaces. An interview was conducted on (MONTH) 20, 2019 at 2:15 p.m. with the Director of Nursing (DON/staff #22). She stated that

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F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) the pharmacy conducted a full audit of the medication room and medication carts checking for expired medications, over-the-counter medications, and supplies. She said medication rooms and carts should also be checked by the nurses and the unit manager. The DON stated that expired medications and supplies should be stored separately in the medication room until destroyed or returned to the pharmacy. She said the expired culture swabs should have been removed from the inventory in the medication room. She stated the refrigerator temperature log should be recorded daily and that she believed the temperature log was maintained and audited by maintenance. She also made a follow-up comment on (MONTH) 21, 2019 at 9:54 a.m. regarding the refrigerator temperature log, stating that based on the trending of the refrigerator temperature logs, she believed the temperature had been maintained and did not exceed the recommended range. -An observation of an unlocked, unattended medication cart was conducted on (MONTH) 20, 2019 from 2:58 p.m. to 3:16 p.m. During this time, five staff members, three visitors, and one resident passed by the cart, however, no one was observed opening the cart. At the end of the time period, the nurse was observed returning to the cart, opening a drawer, closing a drawer, and locking the cart. An interview was conducted with the LPN (staff #55) on (MONTH) 20, 2019 at 3:25 p.m. She stated the only time the medication cart should be unlocked is when the nurse is preparing medications. Otherwise, the cart should be locked. She stated that she did not realize she left the cart unlocked until she returned to the cart. An interview was conducted on (MONTH) 21, 2019 at 9:54 a.m. with the DON (staff #22). She stated her expectation was that medications carts would be secured when not in sight of the nurse. Review of the facility's Medication Storage policy revealed medications should be securely stored in a locked cart or locked medication room that is inaccessible by residents and visitors. The facility should ensure that medications and supplies have an expiration date on the label, and that expired products are stored separate from other medications until destroyed or returned to the pharmacy. The policy also included the facility should monitor the temperature of vaccines twice daily and store at the appropriate temperature according to the United States Pharmacopoeia guidelines, including refrigeration temperatures ranging from 36 to 46 degrees Fahrenheit.
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 personnel record review, observations, staff interviews and policy review, the facility failed to ensure that 4 of 10 sampled staff (#24, #34, #40, and #59) had evidence of freedom from [MEDICAL CONDITION] and failed to ensure infection control practices were implemented during a medication administration observation and during a wound observation. The deficient practice could result in the potential exposure of infectious TB disease, cross contamination, spreading infections to others, and potential contamination of wounds. The facility census was 44. Findings include: -Review of the personnel record for the Activities Director (staff #24) revealed a hire date of (MONTH) 9, (YEAR). The file did not contain evidence that staff #24 was free of TB. -Review of the personnel record for Registered Nurse (RN/ staff #34) revealed a hire date of (MONTH) 11, 2011. The file did not contain evidence that staff #34 was free of TB -Review of the personnel record for Certified Nursing Assistant (CNA/staff #40) revealed a hire date of (MONTH) 25, (YEAR). The file did not contain evidence that staff # 40 was free of TB. -Review of the personnel record for Licensed Practical Nurse (LPN/staff #59) revealed a hire date of (MONTH) 18, (YEAR). The filed did not contain evidence that staff #59 was free of TB. An interview was conducted with the Administrator (staff #62) on (MONTH) 20, 2019 at 1:30 p.m. She stated she did not have any further documentation showing the above staff received a TB test. She stated that she has been unable to locate the files for TB tests that had been completed in the past. The Administrator stated the leadership team has only been at the facility for three months and that they are trying to make sure all staff have evidence of being free from TB. An interview was conducted on (MONTH) 21, 2019 at 10:18 a.m. with the Director of Nursing (DON/staff #22). The DON stated that they currently have a process in place to ensure staff are receiving the TB test prior to working at the facility. -During a medication administration observation conducted on (MONTH) 20, 2019 at 7:40 a.m., a LPN (staff #55) was observed to push four different medication tablets out of their containers into her bare hand and then place the tablets into a medication cup. The nurse dropped a fifth tablet onto the surface of the medication cart, picked it up with her bare hand, and placed it in the medication cup. An interview was conducted with staff #55 following the medication administration at 7:59 a.m. The LPN stated that it was difficult to control the tablets when popping them out of their containers. She said the pills tend to fall on the cart and the floor. The LPN stated that she prefer to pop the tablets into her hand to catch them before placing them in the medication cup. She said she could wear gloves, but that she made it a point to have clean hands before preparing each resident's medications. The LPN stated that it was better than having a tablet land on a dirty surface such as the medication cart. She said the cart would be considered dirty because multiple residents' medications were prepared on that surface. She stated that she did not realize she dropped a tablet onto the medication cart surface, picked it up, and put it in the cup. The LPN stated she should not have done that. She said she was not aware of the facility's policy regarding touching resident medications. -During an observation conducted of a medication cart with a LPN (staff #27) on (MONTH) 20, 2019 at 12:44 p.m., two canisters of supplement powder were observed in a drawer of the cart. The seal of the canisters had been removed and the canisters contained a scoop with a handle that was touching the powder. An interview was conducted at the time of the observation with staff #27. The LPN stated that she did not know how it would be possible to remove the scoop from the canisters without touching the powder. An interview was conducted with the DON (staff #22) on (MONTH) 20, 2019 at 2:15 p.m. The DON stated that if a medication was touched or dropped, it should be discarded in the sharps container or destroyed. Review of the facility's infection control and medication administration policies revealed no policy that addressed touching or contaminating medications with bare hands, medication scoops, or the surface of the medication cart. -An observation of wound care was conducted on 06/20/19 at 10:41 a.m. with a LPN (staff #27). Staff #27 gathered the necessary supplies and entered the resident's room. After cleaning the resident's wound, the LPN washed her hands, put on gloves, picked up a bottle of Dakins solution with her right hand and removed the cap with her left hand. The LPN then picked up a gauze pad in her left hand and poured the Dakins solution over the gauze pad. Staff #27 was then observed to transfer the gauze to her right hand and proceed to pack the gauze into the resident's wound with her right hand fingers. The bottle of Dakins solution was not observed being wiped down or cleaned before use. In an interview with the LPN conducted on 06/20/19 at 11:02 AM., the LPN stated that she did not think the wound could be contaminated by her touching the bottle of Dakins solution and then using her fingers to pack the wound. She admitted that the risk of potential bacterial transfer from the bottle to the wound would be reduced if she had of poured the Dakins solution into a clean cup and pre-soaked the gauze before starting the procedure and used Q-tips to pack the wound. An interview was conducted with the DON (staff #22) on 06/20/19 at 11:40 AM. The DON stated that as a matter of best practice, pre-soaking the dressing would have been the better choice to prevent wound contamination. Review of the facility's infection control policy revealed the policy did not include the possible contamination that can occur during wound treatment.
F 0883 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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 review, staff interviews, and policy and procedures, the facility failed to ensure two of five sampled residents (#139 and #289) received information regarding the benefits and potential side effects of pneumococcal vaccines and failed to offer the vaccination on admission according to their policy. The deficient practice could maximize the risk of residents acquiring, transmitting, or experiencing complications from pneumococcal disease. Findings include: -Resident #139 was admitted to the facility on (MONTH) 11, 2019, with [DIAGNOSES REDACTED]. Review of the Admission Nursing Data Collection form dated (MONTH) 11, 2019, revealed the resident was alert and oriented.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035106	A. BUILDING _____ B. WING _____	**06/21/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WESTCHESTER CARE CENTER	**6100 SOUTH RURAL ROAD TEMPE, AZ 85283**

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 0883 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 4) Review of the resident's 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 the pneumococcal vaccines. -Resident #289 was admitted to the facility on (MONTH) 14, 2019 with [DIAGNOSES REDACTED]. Review of the Admission Nursing Data Collection form dated (MONTH) 14, 2019, revealed the resident was alert and forgetful. Review of the resident's 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 the pneumococcal vaccines. In an interview with the Director of Nursing (DON/staff #22) on (MONTH) 19, 2019 at 10:52 a.m., the DON stated that she expects the nurses to follow the facility's policy and procedure and that the facility uses the Centers for Disease Control and Prevention (CDC) algorithm for determining who is eligible for pneumococcal vaccination. In an interview conducted on (MONTH) 19, 2019 at 12:10 PM with a Registered Nurse (RN/staff #37), the RN stated pneumococcal vaccination education and the offer of the vaccine should be documented in the clinical record. She stated that the nurses review the pneumococcal vaccination informed consent form on admission and then if the resident wants the vaccine, the nurse will enter the order and administer the vaccine. During an interview conducted with the Health Information Manager (HIM/staff #48) on (MONTH) 19, 2019 at 12:21 PM, the HIM stated the pneumococcal vaccination information should be in the clinical record. She also stated that there would be an entry on the Medication Administration Record [REDACTED] Review of the facility's policy regarding the Pneumococcal Vaccine Program revealed residents will be offered immunization against pneumococcal disease. Every admission is screened using the criteria contained within the standing protocol and given the vaccine if indicated after receiving education regarding the vaccine. The resident or the resident's representative has the opportunity to refuse the immunization. If the immunization is refuse, document the education and refusal in the clinical record. The policy also included that if the resident chooses to be immunized after education is provided, give the vaccine and document it in the resident's clinical record and on the immunization record.