STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **035152**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **10/10/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
YUMA NURSING CENTER	**1850 WEST 25TH STREET YUMA, AZ 85364**

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 0583

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Few

Keep residents' personal and medical records private and confidential.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on observation, clinical record review, family and staff interviews, and policy review, the facility failed to ensure one sampled resident (#73) had the right to personal privacy during visits with family by allowing another resident (#38) to wander into resident #73's room. The deficient practice could result in residents not having privacy when visiting with family.

Findings include:

-Resident #73 was readmitted to the facility on (MONTH) 21, 2019, with [DIAGNOSES REDACTED].

-Resident #38 was admitted on [DATE], with [DIAGNOSES REDACTED].

Review of nursing notes from 9/4/19 - 10/9/19 revealed multiple entries of resident #38 pacing, going into other residents' rooms, pulling blankets off of sleeping residents, pushing residents in wheelchairs down the hall, and hitting a Certified Nursing Assistant (CNA) in the face causing the CNA's lip to bleed.

An interview was conducted with resident #73's family member on (MONTH) 7, 2019 at 3:14 p.m., who stated that she had concerns involving resident #38. The family member stated that she observed resident #38 pulling resident #73's blouse. The family member stated that resident #38 walks into resident #73's room and will not leave. The family member also stated that if she closes resident #73's room door, resident #38 keeps pushing the door. The family stated that she has reported these incidents to the nurse (Licensed Practical Nurse/staff #10) and to some of the Certified Nursing Assistants (CNAs). The family member stated that she was told staff will keep an eye on resident #38.

During an observation conducted on (MONTH) 9, 2019 at 10:33 a.m., resident #38 was observed pacing up and down the hallway and entering resident #73s room. No staff members were observed present to redirect the resident.

An interview was conducted on (MONTH) 9, 2019 at 2:56 p.m. with a CNA (staff #48), who stated that resident #38 pushes residents in their wheelchairs down the hall and keeps going into other residents' rooms. The CNA stated that one resident kept asking resident #38 to leave her room and that resident #38 pushed the resident. The CNA also stated that she has seen resident #38 in resident #73's room and resident #73's family members have complained. She said the CNAs try to redirect resident #38 when she is in another resident's room, but that resident #38 gets angry and she has behaviors. She said that she has witnessed resident #38 getting into other residents' faces.

An interview was conducted with a Registered Nurse (RN/staff #6) on 10/7/19 at 2:00 PM. The RN stated that she is aware resident #38 goes in and out of other residents' rooms. The RN stated the resident is on a dementia unit and that is expected behavior. She stated that the other residents did not mind resident #38 going into their rooms. The RN was unable to say if the residents who are unable to communicate objected to resident #38 going into their rooms.

Review of the facility's Resident's Rights policy revised (MONTH) (YEAR), revealed that a resident has the right to personal privacy. The policy included personal privacy shall include accommodations, and visits and meetings with family.

The facility's policy titled Confidentiality of Information and Personal Privacy revised (MONTH) (YEAR) revealed the facility will strive to protect the resident's privacy regarding his or her visits and accommodations.

F 0609

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Few

Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on clinical record review, staff interviews and policies and procedures, the facility failed to report an injury of an unknown source involving one resident (#73) to the State Survey Agency, within 2 hours as required. The deficient practice could result in additional incidents regarding injuries of an unknown source not being reported to the State Agency; resulting in the State Agency not being informed of possible abuse situations.

Findings include:

Resident #73 was admitted to the facility on (MONTH) 12, (YEAR) and readmitted on (MONTH) 21, 2019, with [DIAGNOSES REDACTED].

Review of the Significant Change Minimum Data Set (MDS) assessment dated (MONTH) 19, 2019, revealed a Brief Interview for Mental Status (BIMS) score of 3, indicating the resident had a severe cognitive impairment. The MDS also revealed the resident was totally dependent on staff assistance when moving from one place to another on the unit.

Review of a progress note dated (MONTH) 4, 2019 revealed the resident was observed lying on her left side on the floor by her wheelchair. The resident had left hip and groin pain and the left leg was shorter than the right leg when extended. Per the note, the resident was transferred to the hospital and was admitted due to a femoral neck fracture.

The facility was unable to provide any evidence that the incident regarding an injury of an unknown source was reported to the State Agency.

On (MONTH) 9, 2019 at 10:13 a.m., an interview was conducted with a LPN (staff #10), who stated that a male activities volunteer found the resident on the floor next to her wheelchair in the 300 hall by the (RNA) room. She said that she was at the nurse's station when staff called her. She said that when she arrived, she found the resident lying on the floor by her wheelchair which was by the RNA door on the 300 unit. She said that she does not know how the resident got there, as the resident is not able to self-propel herself. She said if a CNA assists the resident with leaving her room, the CNA usually takes the resident to the area where the TV is located.

On (MONTH) 9, 2019 at 10:30 a.m., an interview was conducted with an activities volunteer (staff #139), who stated that he remembered that he was taking a resident from the dining hall back to the room, when he saw a woman lying on the floor by the RNA door on the Unit 300. He said that her wheelchair was next to her. He said he could hear her moaning and asked her what happened, but she kept saying Please help me. He said that he did not witness the incident and did not know what had happened to her.

An interview was conducted on (MONTH) 9, 2019 at 11:27 a.m. with the Director of Nursing (DON/staff #65), who stated that when there is an injury of unknown origin, the nurse is to report the incident to DON as soon as possible. She said it is her responsibility to notify the State agency, within 2 hours. She said that she was notified about the resident being found lying on the floor and that no one was around when it occurred, but it was thought that the resident fell . At this time, the facility's Abuse policy was reviewed and staff #65 stated that the incident should have been reported to the State Agency.

Review of the facility's Abuse policies revealed that allegations of abuse, neglect, mistreatment, exploitation, including injuries of unknown source, are to be immediately reported to a supervisor/charge nurse, who will report the incident to the Administrator/designee. All alleged violations of abuse, neglect, exploitation, mistreatment, including injuries of

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) unknown source will be reported immediately to the State Survey agency, but no later than 2 hours if involves abuse or has resulted in serious bodily injury.
F 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews and policies and procedures, the facility failed to ensure that an injury of an unknown source was thoroughly investigated for one resident (#73) and failed to report the results of the investigation to the State Agency, within 5 working days of the incident as required. The deficient practice could result in causative factors related to injuries of an unknown source not being identified, including possible abuse and not implementing corrective action to prevent further occurrences. Findings include: Resident #73 was admitted to the facility on (MONTH) 12, (YEAR) and readmitted on (MONTH) 21, 2019, with [DIAGNOSES REDACTED]. Review of the Significant Change Minimum Data Set (MDS) assessment dated (MONTH) 19, 2019, revealed a Brief Interview for Mental Status (BIMS) score of 3, indicating the resident had a severe cognitive impairment. The MDS also revealed the resident was totally dependent on staff assistance when moving from one place to another on the unit. Review of a progress note dated (MONTH) 4, 2019 revealed the resident was observed lying on her left side on the floor by her wheelchair. The resident had left hip and groin pain and the left leg was shorter than the right leg when extended. Per the note, the resident was transferred to the hospital and was admitted due to a femoral neck fracture. The facility was unable to provide any evidence that a thorough investigation was completed for this incident regarding an injury of unknown source. On (MONTH) 9, 2019 at 10:13 a.m., an interview was conducted with a LPN (staff #10), who stated that a male activities volunteer found the resident on the floor next to her wheelchair in the 300 hall by the (RNA) room. She said that she was at the nurse's station when staff called her. She said that when she arrived, she found the resident lying on the floor by her wheelchair which was by the RNA door on the 300 unit. She said that she does not know how the resident got there, as the resident is not able to self-propel herself. She said if a CNA assists the resident with leaving her room, the CNA usually takes the resident to the area where the TV is located. On (MONTH) 9, 2019 at 10:30 a.m., an interview was conducted with an activities volunteer (staff #139), who stated that he remembered that he was taking a resident from the dining hall back to the room, when he saw a woman lying on the floor by the RNA door on the Unit 300. He said that her wheelchair was next to her. He said he could hear her moaning and asked her what happened, but she kept saying Please help me. He said that he did not witness the incident and did not know what had happened to her. An interview was conducted on (MONTH) 9, 2019 at 11:27 a.m. with the Director of Nursing (DON/staff #65), who stated that when there is an injury of unknown origin, the nurse is to report the incident to DON as soon as possible. She said it is her responsibility to notify the State Agency, within 2 hours. She said that she was notified about the resident being found lying on the floor and that no one was around when it occurred, but it was thought that the resident fell . At this time, the facility's Abuse policy was reviewed and staff #65 stated that the incident should have been investigated by the facility. Review of a policy regarding Accidents and Incidents revealed that all accidents or incidents involving residents occurring on their premises must be investigated and reported to the Administrator. Regardless of how minor an accident or incident may be, including injuries of an unknown source, it must be reported to the department supervisor as soon as discovered or when the information is learned. Review of the facility's Abuse policies revealed that allegations of abuse, neglect, mistreatment, exploitation, including injuries of unknown source, are to be immediately reported to a supervisor/charge nurse, who will report the incident to the Administrator/designee. All alleged violations of abuse, neglect, exploitation, mistreatment, including injuries of unknown source will be reported immediately to the State Survey agency, but no later than 2 hours if involves abuse or has resulted in serious bodily injury. If an incident or suspected incident of abuse, neglect, exploitation, mistreatment, including injuries of unknown source is reported, the Administer will assign the investigation to an appropriate individual. The incident shall be thoroughly investigated and include reviewing all events leading up to the incident, clinical record review, interviews with the resident and the roommate, any witnesses and staff on all shifts who had contact with the resident. The policy also included a written report of the investigation will be sent to the State Agency.
F 0625 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policy review, the facility failed to ensure one resident (#73) and/or the resident's representative was provided written information regarding the facility's bed hold policy before transfer to the hospital. The deficient practice could result in residents not being informed of the facility's bed hold policy. Findings include: Resident #73 was readmitted on (MONTH) 21, 2019, with [DIAGNOSES REDACTED]. Review of a nursing progress note dated (MONTH) 4, 2019, revealed the resident was observed lying on her left side on the floor by her wheelchair. The note included the resident was transferred to the hospital and admitted due to a femoral neck fracture. However, review of the clinical record including the progress notes dated (MONTH) 4, 2019, did not reveal the resident or the resident's representative had been informed of the facility's bed hold policy. A copy of the discharge summery for (MONTH) 4, 2019, was requested, but staff said the summary was not available. During an interview conducted with a registered nurse (RN/staff #118) on (MONTH) 9, 2019 at 12:47 p.m., the RN stated that when a resident is transferred to the hospital, she contacts the family to let them know about the transfer and that she also tells the family about the bed hold policy at that time. The RN stated that she would then document the conversation with the family in the progress notes. An interview was conducted on (MONTH) 9, 2019 at 2:48 p.m. with a licensed practical nurse (LPN/staff #10), who stated that she completes a discharge summary when a resident is discharged to the hospital. The LPN stated that the transfer summary includes the reason the resident is being transferred to the hospital, an explanation of what happened to the resident, vital signs, the resident's level of activities of daily living (ADLs), known allergies [REDACTED]. The LPN stated that she did not discuss the bed hold policy with the resident/representative when resident #73 was transferred to the hospital on (MONTH) 4, 2019. She stated that she has never discussed the bed hold policy when a resident was transferred to the hospital. An interview was conducted with the assistant director of nursing (ADON/staff #43) on (MONTH) 10, 2019 at 9:10 a.m. The ADON stated that the bed hold policy is given to residents during the admission process. The ADON stated that when a resident is transferred to the hospital, the resident is told by staff that he or she can leave their belongings in the room. The ADON further stated that if they need the room, social services or admissions would contact the resident and/or the hospital. She stated that the nurses do not inform a resident that is transferred to the hospital about the bed hold policy because the nurses do not have anything to do with payments. On (MONTH) 10, 2019 at 9:17 a.m., an interview was conducted with the Admissions Coordinator (staff #95). Staff #95 stated that when a resident is admitted to the facility, she goes over the admission packet with the resident and/or representative. Staff #95 said that she did not know if the bed hold policy was included in the admission packet. During the interview, she reviewed an admission packet and was not able to locate the bed hold policy. She said that she was not aware of the bed hold policy being reviewed and signed with residents when they are admitted to the facility. Staff #95 stated that it was the nurses' responsibility to go over the bed hold policy with resident #73. The facility's bed hold policy revised (MONTH) 2009 revealed that the facility shall inform residents upon admission and

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NAME OF PROVIDER OF SUPPLIER **YUMA NURSING CENTER**		STREET ADDRESS, CITY, STATE, ZIP **1850 WEST 25TH STREET YUMA, AZ 85364**	

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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 0625 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) prior to a transfer or discharge home, hospital, or for therapeutic leave of their bed hold policy. Upon any discharge/transfer, including emergency transfer, a discharge/transfer packet will be provided that includes the facility's bed hold policy. The policy also revealed that a copy of the bed hold policy will be reviewed upon admission and provided each time the resident is transferred or discharged .
F 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**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 observations, staff interview, clinical record review, and policy review, the facility failed to consistently implement the care plan for one sampled resident (#38) with wandering behavior. The deficient practice could result in residents' care plan not being implemented resulting in avoidable incidents. Findings include: Resident #38 was admitted [DATE], with [DIAGNOSES REDACTED]. The admission Minimum Data Set ((MDS) dated [DATE] revealed the resident was severely impaired regarding cognitive skills for daily decision making. The assessment included the resident had wandering behavior which significantly intruded on the privacy or activities of others and placed the resident at significant risk of getting to a potentially dangerous place. Review of the care plan initiated 8/28/19 revealed the resident wanders the hall and goes into other residents' room. The goal was that the resident would not display any inappropriate or disruptive behaviors. Interventions included monitoring and documenting resident #38's behavior, removing the resident from public area when behavior is disruptive and unacceptable and for activity staff to visit with the resident and provide diversional activities as needed. The care plan interventions were updated 9/21/19 to include redirecting the resident not to go into other residents' room and separating residents and redirecting resident #38 out of other residents' rooms. Review of nursing notes from 9/4/19 - 10/10/19 revealed multiple entries of the resident pacing, going into other residents' rooms, pulling blankets off of sleeping residents, pushing residents in wheelchairs down the hallway, and hitting one Certified Nursing Assistant (CNA) in the face causing the CNA's lip to bleed. Review of Behavioral Intervention Monthly Flow Records dated (MONTH) 2019 and (MONTH) 2019 revealed the resident was being monitored for continuously pacing and impulsiveness. Interventions included redirection. On 10/7/19 at 1:41 PM, resident #38 was observed pacing in the hallway, going through the unattended housekeeping cart and pushing it down the hallway. Approximately 5 minutes later, a staff member redirected the resident to the lobby of the dementia unit and encouraged the resident to sit in a chair. The resident started pacing the hallway again and took another resident's wheelchair and pushed it down the hallway. No staff members were observed to redirect resident #38. During an observation conducted on 10/09/19 at 10:33 AM, the resident was observed walking down the hallway going in and out of three rooms. No staff members were observed to redirect the resident. On 10/09/19 at 12:45 PM, resident #38 was observed pacing in the hallway with her clothing protector still on from lunch. A medication cart was observed at the far end of the hallway with cartons of supplement on the top of the cart. The resident was observed trying to open the cartons. No staff members were observed present to redirect the resident. An interview was conducted with the Director of Nursing (DON/staff #65) on 10/09/19 at 10:25 AM. The DON stated that she is aware resident #38 wanders into other residents' room. The DON stated that it is OK for residents to go into each other rooms because they reside on a dementia unit. During an interview conducted with social services (staff #22), staff # stated that they expect residents to go into each other's rooms on the dementia unit. She stated that they redirect the residents as soon as they can. Staff #22 also stated that they need to be more creative to prevent resident #38 from going into other residents' rooms. A review of the facility's policy regarding care plans, comprehensive person-centered revised (MONTH) (YEAR), revealed the care plan interventions are derived from a though analysis of the information gathered as part of the comprehensive assessment. Areas of concern that are identified during the resident assessment will be evaluated before interventions are added to the care plan. Identifying problem areas and their causes, and developing interventions that are targeted and meaningful to the resident, are the endpoint of an interdisciplinary process. The policy included care plan interventions are chosen only after careful data gathering, proper sequencing of events, and careful consideration of the relationship between the resident's problem areas and their causes, and relevant decision making. The facility's policy regarding unsafe resident wandering revised (MONTH) 2011 revealed the resident's care plan will indicate the resident is at risk for elopement or other safety issues. Interventions to try to maintain safety will be included in the resident's care plan.
F 0660 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Plan the resident's discharge to meet the resident's goals and needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policy review, the facility failed to ensure discharge planning included developing a discharge care plan, which is part of the comprehensive care plan for one sampled resident (#85). The deficient practice could result in the facility failing to develop discharge care plans that address all the needs for residents being discharged . Findings include: Resident #85 was readmitted on (MONTH) 11, 2019, with [DIAGNOSES REDACTED]. Review of the admission care plan and the 48-hour care plan dated (MONTH) 11, 2019, revealed no discharge care plan had been developed. Review of the PPS (Prospective Payment System) 5 day Minimum Data Set assessment dated (MONTH) 18, 2019 revealed there was an active discharge plan in place for the resident to return to the community. A care plan conference summary signed by the social service director dated (MONTH) 20, 2019, revealed the discharge potential location was home and that they discussed the resident returning home with possible outpatient IV's. A physician's orders [REDACTED]. A daily skilled nursing note dated (MONTH) 26, 2019, revealed the resident was discharged to home on (MONTH) 26, 2019. The note revealed the resident went home with a wheelchair, medication list, wound care directions and list of follow up appointments. A review of the social services progress note dated (MONTH) 26, 2019, revealed resident #85 was discharged home with home health and a wheelchair and cushion. However, review of the comprehensive care plan revealed no evidence a discharge care plan was developed. An interview was conducted with the social services director (SSD/staff #42) on (MONTH) 9, 2019 at 8:34 a.m. Staff #42 stated that discharge goals are discussed with a resident upon admission and that based on that discussion, the discharge care plan is developed. She stated the discharge care plan is initiated on the admission care plan or within 48 hours on the baseline care plan. The SSD also stated that a discharge care plan should be initially developed for a resident on the baseline care plan and then developed on the comprehensive care plan. After reviewing the clinical record, she stated the discharge care plan for resident #85 was not developed, that it must have been missed. An interview was conducted on (MONTH) 9, 2019 at 10:24 a.m. with the Director of Nursing (DON/staff #65). She stated there should have been a discharge care plan initiated within 48 hours of admission. The DON also stated that the discharge care plan that includes goals and interventions for discharge should be part of the comprehensive care plan. Review of the facility's policy titled care plans, comprehensive person-centered revised (MONTH) (YEAR), revealed 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. The interdisciplinary team in conjunction with the resident develops and implements a comprehensive person-centered care plan for each resident. The comprehensive care plan will include the resident's stated goals upon admission and desired outcomes. The policy also revealed the comprehensive care plan will include the resident's stated preference and potential for future discharge, including the resident's desire to return to the community and any referrals made to local agencies or other entities to support such desire.

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F 0660 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3)
F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, clinical record review, and policy review, the facility failed to provide adequate supervision for one sampled resident (#38) that wandered. The deficient practice could result in avoidable accidents. Findings include: Resident #38 was admitted [DATE], with [DIAGNOSES REDACTED]. The admission Minimum Data Set ((MDS) dated [DATE] revealed the resident was severely impaired regarding cognitive skills for daily decision making. The assessment included the resident had wandering behavior which significantly intruded on the privacy or activities of others and placed the resident at significant risk of getting to a potentially dangerous place. Review of the care plan initiated 8/28/19 revealed the resident wanders the hall and goes into other residents' room. The goal was that the resident would not display any inappropriate or disruptive behaviors. Interventions included monitoring and documenting resident#38's behavior, removing the resident from public area when behavior is disruptive and unacceptable and for activity staff to visit with the resident and provide diversional activities as needed. The care plan interventions were updated 9/21/19 to include redirecting the resident not to go into other residents' room and separating residents and redirecting resident #38 out of other residents' rooms. Review of nursing notes from 9/4/19 - 10/9/19 revealed multiple entries of the resident pacing, going into other residents' rooms, pulling blankets off of sleeping residents, pushing residents in wheelchairs down the hall, and hitting a Certified Nursing Assistant (CNA) in the face causing the CNA's lip to bleed. On 10/7/19 at 1:41 PM, resident #38 was observed pacing in the hallway, going through the unattended locked housekeeping cart that contained floor mop water and gloves on top pushing it down the hallway. Approximately 5 minutes later, a staff member redirected the resident to the lobby of the dementia unit and encouraged the resident to sit in a chair. The resident started pacing the hallway again and took another resident's wheelchair and pushed it down the hallway. No staff members were observed to redirect resident #38. During an observation conducted on 10/09/19 at 10:33 AM, the resident was observed walking down the hallway going in and out of three rooms. No staff members were observed to redirect the resident. On 10/09/19 at 12:45 PM, resident #38 was observed pacing in the hallway with her clothing protector still on from lunch. A medication cart was observed at the far end of the hallway with cartons of supplement on the top of the cart. The resident was observed trying to open the cartons. No staff members were observed present to redirect the resident. During an interview conducted with a Certified Nursing Assistant (CNA/staff #67), the CNA confirmed resident #38 wanders constantly. The CNA stated they try to redirect the resident and that at times the resident becomes aggressive. An interview was conducted with a Registered Nurse (RN/staff #6) on 10/7/19 at 2:00 PM. The RN stated that she was aware resident #38 goes in and out of other residents' rooms. The RN stated the resident is on a dementia unit and that is expected behavior. She stated that the other residents did not mind resident #38 going into their rooms. The RN was unable to say if the residents who are unable to communicate objected to resident #38 going into their rooms. During an interview conducted with another CNA (staff #18), the CNA stated that she knows at times resident #38 pushes residents in their wheel chair down the hallway. The CNA stated that it is very hard to redirect the resident because the resident gets very angry. An interview was conducted with the Director of Nursing (DON/staff #65) on 10/09/19 at 10:25 AM. The DON stated that she is aware resident #38 wanders into other residents' room. The DON stated that it is OK for residents to go into each other rooms because they reside on a dementia unit. The DON further stated that she was not aware resident #38 was in the housekeeping cart and the supplements on the medication cart. During an interview conducted with social services (staff #22), staff #22 stated that they expect residents to go into each other's rooms on the dementia unit. She stated that they redirect the residents as soon as they can. Staff #22 also stated that they need to be more creative to prevent resident #38 from going into other residents' rooms. A review of the facility's policy and procedure Wandering, Unsafe Resident revised (MONTH) 2011, revealed the facility will strive to prevent unsafe wandering while maintaining the least restrictive environment for residents who are at risk for elopement. The staff will identify residents who are at risk for harm because of unsafe wandering. The staff will assess at risk residents for potentially correctible risk factors related to unsafe wandering. The policy included nursing staff will document circumstances related to unsafe actions, including wandering, by a resident as needed.
F 0757 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews and policy review, the facility failed to ensure one resident (#64) had clinical indications regarding antibiotic medication use. The deficient practice could result in residents receiving unnecessary antibiotics, which could result in infectious microorganisms with increased drug resistance. Findings include: Resident #64 was readmitted to the facility on (MONTH) 4, 2019, with [DIAGNOSES REDACTED]. Review of the admission physician's orders [REDACTED]. Further review of the physician's orders [REDACTED]. Review of a pharmacy medication regimen review dated (MONTH) 5, 2019, revealed the question, Please clarify if patient is to be on both oral antibiotics. The review contained a handwritten note signed by a nurse on (MONTH) 9, 2019, that the physician was notified and to see the telephone order dated (MONTH) 9, 2019. The completed wound culture results dated (MONTH) 7, 2019, revealed no organisms were seen, with the comment, staph epidermidis rare. The final urine C & S results dated (MONTH) 8, 2019, revealed there was no growth for 2 days. Review of the physician's orders [REDACTED]. The handwritten comment on the order was, no infection. The Medication Administration Record [REDACTED]. Continued review of the clinical record revealed a hospice nursing assessment dated (MONTH) 30, 2019, that the resident had no redness to his penis; however smegma (a buildup of dead skin cells, oil, and other fluids affected by personal hygiene) was observed and cleansed. The assessment included staff was re-educated on perineal care. The assessment also contained no documentation under the section Renal/Urological signs and symptoms of infection. A hospice physician's orders [REDACTED]. Review of an infection report form dated (MONTH) 30, 2019, revealed the resident's signs and symptoms included increased confusion, drainage of the penis, and lethargy. The form revealed that a UA was not performed, and that no diagnostic tests were done. The form further revealed the resident had a history of [REDACTED]. Review of the Medication Administration Record [REDACTED]. An interview was conducted on (MONTH) 9, 2019 at 11:59 a.m., with the Director of Nursing (DON/staff #65). She stated that when a nurse receives a new order for antibiotics, the nurse completes an infection report form and gives it to her or the Assistant Director of Nursing (ADON). She said the form would be used to evaluate the order using McGeer criteria for infections. She said resident #64's signs and symptoms included increased confusion, yelling, fatigue, drowsiness, and [MEDICAL CONDITION], which would satisfy one of two components of the McGeer criteria for a UTI with an indwelling catheter. She said the second component of the McGeer criteria would be a positive urine culture. She stated both components must be present to satisfy the McGeer criteria for a UTI. She said for resident #64, a UA with C & S was not done, so she questioned the order for Bactrim. She said she spoke to the hospice nurse to find out why the order was initiated. She said the hospice nurse told her the physician ordered Bactrim because of the resident's increased confusion, yelling, and the presence of smegma. She said it was not normal to have an order for [REDACTED]. She said she was satisfied with what the hospice nurse had provided. An interview was conducted on (MONTH) 9, 2019 at 12:52 p.m., with a registered nurse (RN/staff #118). She said if a nurse suspected a resident had a UTI, the nurse would implement a 72 hour protocol which included monitoring the resident's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035152	A. BUILDING ______ B. WING _____	**10/10/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
YUMA NURSING CENTER	**1850 WEST 25TH STREET YUMA, AZ 85364**

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 0757 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 4) temperature, behavior, and urinary symptoms. She said if the resident continued to have signs or symptoms, the nurse would ask the provider for an order for [REDACTED]. She said that when the provider orders antibiotics; the nurse completes an infection report form and gives it to the DON or ADON. She said resident #64 was currently receiving antibiotics for a UTI. She said the order had been received via fax from hospice, and she had notified the DON of the order and that a UA had not been collected for the resident. She said the DON told her that she would follow up with hospice. Review of the facility's Antibiotic Stewardship policy revealed antibiotics will be prescribed and administered under the guidance of the facility's antibiotic stewardship program. The purpose of the Antibiotic Stewardship Program is to monitor the use of antibiotics in the residents. Staff will receive training and education that will emphasize the importance of antibiotic stewardship, including how inappropriate use of antibiotics affects individual residents and the overall community. Training will include the relationship between antibiotic use and gastrointestinal disorders, opportunistic infections, medication interactions, and the evolution of drug-resistant pathogens. When antibiotics are prescribed over the phone, the primary care practitioner will assess the resident within 72 hours of the telephone order. When a C & S is ordered lab results and the current clinical situation will be communicated to the prescriber as soon as available to determine if antibiotic therapy should be started, continued, modified, or discontinued.