STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035112	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apache Junction Health Center	2012 West Southern Ave Apache Junction, AZ 85120

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42319 Based on observation, staff interviews, clinical record review and facility documentation and policy review, the facility failed to ensure that a medication was administered as ordered for 3 sampled residents (#6, #32 and #25). This deficient practice could result in residents not receiving the necessary treatment to address their medical issues/problems. Findings include: -Resident #6 was admitted on [DATE] with diagnoses of urinary tract infection, dysphagia, and neurogenic bladder. A care plan dated [DATE] for altered skin integrity included and intervention to notify the Physician or Nurse Practitioner as needed. The admission notes dated [DATE] revealed the resident was readmitted with diagnosis of MDR (multi-drug resistant) UTI (urinary tract infection); and was at the facility for IV (intravenous antibiotic). A care plan dated [DATE] revealed the resident had fluid overload. Interventions include to administer medications as ordered. A physician order dated [DATE] included for Ertapenem Sodium (antibiotic) injection solution reconstituted 1 GM (gram) intravenously one time a day for UTI for 14 Days. The start date was [DATE] at 12:00 P.M. This order was transcribed onto the medication administration record (MAR) for [DATE]. The MAR revealed that the resident received one dose of ertapenem on [DATE]. Continued review of the MAR revealed that ertapenem was not documented as administered on [DATE] and [DATE]. An eMAR (electronic MAR) note dated [DATE] revealed that included that there was no IV medication. The clinical record revealed no evidence of a reason why ertapenem was not administered to the resident on [DATE] and [DATE]; and that, the physician was notified. The physician progress note dated [DATE] included that the resident was tolerating ertapenem sodium 1 gram. (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 5-day MDS (Minimum Data Set) assessment dated [DATE] revealed that the resident was not taking antibiotic during the last 7 days. -Resident #32 was admitted on [DATE] with diagnoses of rheumatoid arthritis, sepsis and metabolic encephalopathy. The physician progress note dated [DATE] revealed the resident was alert and oriented x3, had chronic pain, chronic bilateral hip pain and sciatica. Assessment included chronic bilateral hip pain; and that, hip x-rays showed severe degenerative changes. Plan included pain control. An admission MDS dated [DATE] included the resident was moderately cognitively impaired, and that the resident occasionally experienced pain and the worst pain in the last 5 days was a 4. A physician order dated [DATE] included for oxycodone (narcotic opioid) ER (extended release) tablet 12 Hour Abuse-Deterrent 10 mg (milligram), give 1 tablet by mouth two times a day for pain. This medication had a trade name of oxycontin. This order was transcribed onto the MAR (medication administration record) for [DATE]. The MAR revealed that oxycodone was documented as administered from [DATE] through [DATE]; and, the total number of tablets given from [DATE] through [DATE] was 6 tablets. The clinical record revealed documentation that oxycodone was discontinued on [DATE]. However, the controlled substance countdown sheet included that Oxycodone was continued to be administered 9 instances after [DATE]. A physician order dated [DATE] included for oxycodone 5 mg give one tablet every 4 hours as needed for pain. This order was transcribed onto the MAR for August and [DATE] and revealed that oxycodone was documented as administered ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE] and [DATE]. A physician order dated [DATE] revealed an order for oxycodone 5 mg by mouth every 4 hours as needed for pain ,d+[DATE] related to rheumatoid arthritis. However, a medication cart observation conducted on [DATE] revealed that the oxycontin medication card for resident #32 had twenty 10 mg tablets of oxycontin (trade name for oxycodone). An interview was conducted on [DATE] at 5:23 P.M. with the registered nurse (RN/staff #11) who said that she administered oxycontin to the resident; and, she was using the 10 mg oxycontin in the medication card that was found in the medication to administer to the resident. She said that there were narcotics that were no longer used, or, when a medication was completed, the nurse would take the paper out and sign it as completed with another nurse to witness. She said she had always had someone available to give the narcotic cards to; and that, she was not sure what to do if there was no one. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview conducted on [DATE] at 5:25 P.M with another RN (staff #99) who reviewed the resident clinical record, the RN said that the resident had an order for oxycodone HCL ER from [DATE] - [DATE]. The RN also said that the staff should have used 8 tabs; and that, there were more tablets missing in the medication card than what should have been used, considering the time prescribed. -Resident #25 was admitted on [DATE] with diagnoses of elevated white blood cell count, myocardial infarction (MI) and UTI. A care plan dated [DATE] revealed the resident was at risk for impaired cardiac function and complications related to history of myocardial infarction. Interventions included to administer medications as ordered and to observe, document and notify MD of adverse side effects. A physician progress note dated [DATE] included that urine culture report showed sensitivity to meropenem. It also included that PICC (peripherally inserted central catheter) line was ordered and to start IV meropenem soon after PICC line insertion. Assessment included UTI. A physician order dated [DATE] for meropenem IV solution reconstituted 1 gram intravenously every 8 hours for UTI for 7 Days. This order was transcribed onto the MAR for August and revealed that IV meropenem was not documented as administered on at the 10:00 p.m. schedule on [DATE] There was no evidence found in the clinical record of a reason why this medication was not administered as ordered; and that, the physician was notified. A physician progress note dated [DATE] revealed that the resident was receiving antibiotic as scheduled and was tolerating it well. An interview was conducted on [DATE] at 5:30 p.m. with the unit manager/licensed practical nurse (LPN/staff #21) who said that nurses take the medication cards out periodically; and that, when the medication cards were still in the narcotics drawer in the medication cart, they do not have a way of knowing if the medications were discontinued. The LPN said that the nurses were usually good on knowing what medications were discontinued for a resident. She said that if IV medication was not available, the nurse should the pharmacy, inform the provider, then get the medication from the pyxis system if possible and document in the progress note. A review of the clinical record for resident #6 was conducted with the LPN who stated that she did not see any notes or any new orders that say it was ok to hold ertapenem on the [DATE]. The LPN further stated that the unmarked boxes in the MAR meant that medication was not given; and that, if it was not charted, it did not happen. In an interview with another LPN (staff #117) conducted on [DATE] at 1:30 p.m., the LPN stated that when doing medication administration, she checks the time, route and the medication, and, would look at the electronic MAR. She stated that it was absolutely not ok to give an extended release instead of an immediate release medication. She said that she just leaves medications in a cart if it is expired until it can be removed. The LPN said that if she was out of a medication she needed, she would reorder the medication, would document in the nursing note that the medication was pending pharm delivery and would notify the provider. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Nursing (DON/staff #56) conducted on [DATE] at 3:09 p.m., the DON stated that the expectation was that the unit manager or herself would collect the narcotics that were not in use twice a week. The DON also said that if medication go out of use before time of collection, the expectation was for staff to let management know sooner than our scheduled days. She said disposing of expired/unusable narcotic medication was just their standard practice and not a policy. The DON said that giving a narcotic without an order does not meet the expectation. The DON also said that she expected that all nurses follow the 5 rights: right medication, route, dose, patient and frequency. Regarding antibiotic administration, the DON stated that the expectation was for staff to notify the pharmacy, try to pull the medication from the Pyxis system when the antibiotic was not available. The DON said that if the staff could not the medication from the Pyxis, staff were expected to document that the medication was not given; and that, staff would notify the physician of any missed doses. Further, the DON stated that any missed doses would be provided at the end and the stop date would be extended. She said that there was a standing order that staff may administer the medication when available from the pharmacy. She said that if 3 standard doses were missed, then we notify them and that the Medical Director was aware of this policy. An interview was conducted on [DATE] at 1:37 P.M. with the Medical Director (staff #100) who said that if residents miss a dose, he will extend the treatment if missed a dose was at the beginning of a treatment because of delayed/pending pharmacy delivery. He said that there cannot be a standing order for missing doses in the middle of the treatment. He said that he would definitely want to be informed of any missed dosed. A policy titled Charting and Documentation revised ,d+[DATE] included all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident ' s medical record. This document included that the medical record should facilitate communication between the interdisciplinary team regarding the resident ' s condition and response to care. This policy included documentation of procedures and treatments will include care-specific details, including notification of family, physician or other staff, if indicated. A policy titled Administering Medication dated ,d+[DATE] revealed that medications are administered in a safe and timely manner, and as prescribed. This policy included the individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.