

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035147	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER Villa Maria Post Acute and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 4310 East Grant Road Tucson, AZ 85712	

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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48932</p> <p>Based on clinical record review, interviews, and policy review, and the State Agency (SA) complaint tracking system, the facility failed to ensure that one resident (#1) received treatment and care in accordance with professional standards of practice by failing to call a provider and emergency services in a timely manner. The deficient practice has the potential of the resident suffering from a life-threatening medical event.</p> <p>Findings include:</p> <p>Resident #1 was admitted to the facility on [DATE] with diagnoses that include epilepsy, intractable, with status epilepticus, major depressive disorder, and hemiplegia and hemiparesis following cerebral infarction (stroke) affecting the left non-dominant side.</p> <p>A review of a Minimum Data Set (MDS) assessment dated [DATE], indicated that resident #1 was unable to complete a Brief Interview for Mental Status (BIMS). Staff assessment revealed resident #1's cognitive skills for daily decision making was severely impaired.</p> <p>Review of the physician orders revealed resident was prescribed Levetiracetam (anticonvulsant), Lacosamide (anticonvulsant), and Divalproex Sodium (anticonvulsant). There were no orders for as needed seizure medication.</p> <p>A review of a care plan for seizure disorder revealed interventions that included seizure precautions: do not leave resident alone during a seizure, protect from injury. Other interventions included post seizure treatment: turn on side with head back, hyper-extended to prevent aspiration, keep airway open, after seizure take vital signs and neuro checks.</p> <p>Review of the intake information submitted by the fire department to the SA complaint tracking system on July 18, 2024 revealed that the fire department arrived to the facility and saw resident #1 actively vomiting and unable to protect his own airway; however, the resident was left unattended. The information also included that nurse in charge of the resident (referring to staff #28) was sitting at a desk away from the patient and knew very little about the resident. Per documentation, the nurse (referring to staff #28) waited almost 2 hours to call 911 and did not have eyes on the patient when the fire department arrived. Further, the fire department alleged that the resident was never given any medications to stop the resident's active seizures.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>A review of progress note revealed that on July 18, 2024 at 6:02 AM, resident #1 was found laying on the ground next to the sliding door. The note indicated that staff initiated neurological checks and assessed the resident for injuries. The note did not give any indication of a seizure activity taking place.</p> <p>Further review of the progress note dated July 18, 2024 at 7:00 AM indicated it was a late entry and that the Nurse Practitioner (staff #102/NP) had ordered the resident to be sent to the emergency room for an evaluation related to the fall and due to the resident hitting his head.</p> <p>Review of the progress note dated July 18, 2024 at 7:43 AM stated that the physician and Director of Nursing (DON) were contacted at 6:15 AM with a request to call the facility back related to the resident's condition.</p> <p>The progress note dated July 18, 2024 at 9:37 AM indicated the resident had a seizure at 5:45 AM. It noted that the resident was taken to his room and the resident had intermittent seizure activity persisted with some emesis. It also stated that after receiving orders from the NP (staff #102) the resident was sent to the hospital at 8:02 AM.</p> <p>An telephone interview was conducted with Licensed Practical Nurse (staff #28/LPN) on July 23, 2024 at 10:37 AM. The LPN stated he was familiar with resident #1. The LPN indicated that sometime after 5:00 AM on July 18, 2024 another staff member had seen resident #1 on the floor. They had assessed the resident for injuries and implemented 15-minute neurological checks. The LPN also indicated that once the resident had been assessed, the resident wanted to remain in his wheelchair in the hallway. The LPN stated that at 5:45 AM resident #1 informed the LPN that he felt he was going to have a seizure and proceeded to have a seizure which lasted approximately 1 to 1 1/2 minutes long. The LPN indicated that resident #1 was brought back to the room and that seizure activity continued intermittently. The LPN indicated the LPN reached out to NP (staff #102) at 5:59 AM and then called 911 at 6:00 AM and the Emergency Medical Technicians (EMT) arrived at 7:00 AM. The LPN stated that when EMTs arrived at the facility the EMT staff stated that the LPN waited too long to call the EMT and that the LPN should have called sooner.</p> <p>An interview was conducted with LPN (staff #61) on July 24, 2024 at 10:43 AM. The LPN stated that a resident having intermittent seizure would be considered a medical emergency. The LPN indicated that a provider's order was required before sending someone to the hospital, even in the event of a medical emergency. The LPN indicated that it was possible to call 911 and to be on the phone with a provider getting the order simultaneously.</p> <p>An interview was conducted with LPN (staff #54) on July 24, 2024 at 10:54 AM. The LPN stated that when a resident was having intermittent seizures that it was considered a medical emergency but as long as the resident was breathing, laying on their side and their head was being supported, they would call the provider and then 911. The LPN also stated calling 911 would have to be done quickly when a resident was having an active seizures. The LPN stated that per their clinical training, it was not acceptable that it would take an hour to reach a provider to get an order. The LPN stated than an hour was too long and that they would call the provider right away using their own personal phone because the facility did not have a cell phone for staff to use. The LPN also stated they would call the provider, not text them.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>A telephone interview was conducted on July 23, 2024 at 1:29 PM with a NP (staff #102). The NP indicated she was familiar with resident #1. The NP stated that she had received a call from staff #28's private number at 6:20 AM on July 18, 2024 but she did not answer the phone because she did not know who it was. The NP also stated she received a call at 6:40 AM on July 18, 2024 from the Villa [NAME] phone number and at that time the order was given to send the resident to the hospital.</p> <p>A telephone interview was conducted with the complainant on July 23, 2024 at 1:34 PM. The complainant indicated that the call from the facility regarding a resident having a seizure came in on July 18, 2024 at 6:53 AM and the EMT responded at 6:54 AM.</p> <p>An interview was conducted with the Director of Nursing (staff #81/DON) on July 24, 2024 at 11:45 AM. The DON stated that when a situation was an emergency staff can call 911 first and then contact the provider after or direct another staff to call 911 while another staff was contacting the provider. The DON stated that a resident having intermittent seizures was considered a medical emergency if there was no medication in place. The DON stated the expectation was for staff to contact the provider immediately if a resident was having seizures and was in epileptic status, maybe a few minutes to ensure resident safety. The DON stated that staff #28 contacted the provider 15 minutes after resident #1 had a seizure. The DON stated that it was not an acceptable length of time between the seizure activity and calling a provider and the expectation was that staff call much sooner than 15 minutes. The DON indicated the risk of the delay in care could lead to the resident having brain damage, hypoxia, and the patient could suffer.</p> <p>A review of the facility policy titled Change of Condition Reporting last reviewed in June 2024 revealed, Licensed nurse will initiate appropriate first aid measures until emergency response personnel arrive on the scene.</p>		