

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  035260	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/25/2024
NAME OF PROVIDER OR SUPPLIER  Fountain Hills Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  16300 East Keith McMahan Drive Fountain Hills, AZ 85268	

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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49325</b></p> <p>Based on review of clinical records and policy, observations, and staff interviews the facility failed to ensure a complete anti-seizure medication regimen was administered to Resident # 295 within accepted professional standards of practice. The deficient practice of incomplete medication administration does not align with accepted professional standards of practice and may result in undesirable quality of care.</p> <p>Findings Include:</p> <p>Resident # 295 was admitted on [DATE] with diagnoses of burn of unspecified degree of buttock, essential hypertension, and unspecified convulsions. The most recent Admission Minimum Data Set (MDS) assessment revealed a Brief Interview for Mental Status (BIMS) score of 13 which indicated the resident was cognitively intact.</p> <p>On admission, Resident # 295 had the following anti-seizure medication regimen: Vimpat (Lacosamide) oral tablet 200 milligrams, give 1 table by mouth two times a day for seizures, dated January 22, 2024 and Lamotrigine oral tablet 25 milligrams, give 2 tablets by mouth one time a day for seizure, dated January 19, 2024.</p> <p>Review of the Medication Administration Record with Staff #23 revealed that Lacosamide had initially been added the medication onto the facility's system on January 19, 2024. Lacosamide (Vimpat) oral tablets were entered on January 22, 2024 but no dispensed documentaton was provided for administration.</p> <p>Review of medication dispensing machine/emergency kit on January 24, 2024 at 11:02 AM revealed Lacosamide was not included in the list of available medications.</p> <p>During an interview conducted with Resident # 295, she stated she had not been receiving one of her two anti-seizure medications for 3 days. This prompted a review of the Medication Administration Records (MAR) on January 22, 2024 at 12:42 PM. The MAR revealed Lacosamide medication order had not been administered to her since her admission on January 19, 2024. Additionally, the MAR revealed 5 attempts of medication administrations had passed before a hold and discontinue was placed on the initial order of Lacosamide. MAR revealed Lacosamide medication was later re-ordered January 22, 2024 at 0927.</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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview conducted on January 24, 2024 at 10:05 AM with a Registered Nurse (RN/Staff # 48) who stated that nurses input medication orders onto the electronic records prior to admissions. Staff # 48 further stated this allows planning ahead so medications are on hand upon admission of new residents. However, electronic orders are always verified by the medical doctor prior to getting sent to pharmacy. She stated that medications have always gotten here when we needed them, pharmacy makes multiple runs in a day, and if we call they will make an extra run. Staff # 48 also reviewed the MAR and determined resident should be taking the medication based on her orders which listed Lacosamide was part of her anti-seizure regimen. Staff # 48 noted upon review of the MAR that Lacosamide should have been administered on admission day or by the next medication pass, and it did not meet expectations that the Lacosamide was unavailable to the resident since her admission.</p> <p>During an interview conducted on January 24, 2024 at 10:35 AM with the Medical Director (Staff # 82) he stated that when residents are sent to this facility, the discharging facility who is sending the resident over, is responsible for sending all electronic orders to pharmacy. Staff # 82 also stated since Resident #295 had not had seizures recently and felt comfortable waiting for the medication to arrive. Staff # 82 further stated if there was a chance of seizure, Ativan could always be given if needed. Staff # 82 stated he also contemplated the option of sending Resident #295 to the emergency department to obtain the medication, however he believed they would be sending her back immediately.</p> <p>During an interview conducted on January 24, 2024 at 1:37 PM with a Pharmacy Representative (Staff # 91) who stated that the first Lacosamide prescription sent to the Pharmacy was January 21, 2024 at 11:25 PM after the facility learned it could not be processed due to not having an electronic signature per auditing records. Staff #91 further stated that although the facility's records showed the Lacosamide was added onto the facility's system, the medication was never sent over to the Pharmacy because it required a signature.</p> <p>During an interview conducted on January 25, 2024 at 11:36 AM with Registered Nurse (RN/Staff # 23) in the presence of Director of Nursing (DON/Staff # 46), Staff # 23 stated we input all orders, however they have to be verified by the doctor. If a resident does not receive their order: we will call the doctor and pharmacy, and obtain the medication from the medication dispensing machine/emergency kit if available. Staff #23 revealed she had a secure communication with the Medical Director on January 21, 2024 when she noted that Lacosamide was unavailable to Resident # 295, Hi again. Pt was admitted on ,d+[DATE] and was sent with orders for Lacosamide 200 mg 1 tab BiD for seizures. We have not received any medication. I called Pharmacy and they do not have any prescriptions in their system. Could you escribe it over?. Staff # 23 stated she was unavailable to communicate with Medical Director prior to January 21, 2024 because she was not working in the facility prior to January 21, 2024.</p> <p>A second interview was conducted on January 25, 2024 at 12:00 PM with Staff #82 while he reviewed medical records. Staff #82 stated we do not get many residents from the county. Now I see county did not send the medications over to pharmacy they only listed them on her discharge documents. Staff # 82 stated normally there is a picture of signed scripts on the discharge documentation. Staff #82 stated it does not meet expectations, and that Resident #295 should have received medication next scheduled administration after her admission.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The policy and procedure document titled Nursing Clinical, Nursing Services - Physician Orders (reviewed Aug/2023) revealed that Admission orders are reviewed with the Physician upon admission based on the discharge instructions from the discharging facility and are transcribed accordingly.</p> <p>The policy and procedure document titled, Clinical - Medication Management (reviewed July/2023) revealed unless otherwise specified by the resident's attending physician, routing medications will be administered per the facility time ranges within 1 hour before and 1 hour after the ordered time frame. Should a drug be withheld, refused, or given other than the scheduled time, the staff administering must indicate the reason on the MAR. Medication that has not arrived from the pharmacy should be pulled from the Stat Safe if available. If not available in the Stat Safe, the provider should be notified to determine if alternative medication, that is available in Stat Safe, should be given and order written for temporary medication, if applicable. It is the policy of this facility, medication shall be administered as prescribed by the resident's physician, nurse practitioner, or physician's assistant.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49325</p> <p>Based on review of clinical records and policy, observations, and staff interviews the facility failed to ensure cautionary slippery-floor safety signs were present near a hazardous area for Resident #295. The deficient practice of reduced safety measures may result in a higher likelihood of accidental falls.</p> <p>Findings Include:</p> <p>Resident #295 was admitted on [DATE] with diagnoses of burn of unspecified degree of buttock, muscle weakness, abnormalities of gait and mobility, and unspecified convulsions. The most recent Admission Minimum Data Set (MDS) assessment revealed a Brief Interview for Mental Status (BIMS) score of 13 which indicated the resident was cognitively intact.</p> <p>Care plan initiated on January 19, 2024, revealed a goal for Resident #295 was not to sustain serious injury due to risk for falls related to impaired mobility.</p> <p>On January 22, 2024 at 9:34 AM, Resident #295 was observed walking in front of room [ROOM NUMBER] with Physical Therapist (PT/Staff #81).</p> <p>On January 22, 2024 at 9:34 AM, an observation of room [ROOM NUMBER] revealed pooling of liquid on the floor at the doorway and into the facility's hallway. The pooled liquid covered approximately 75% of the door's width and extended a distance outside of the door which was approximately 25-33% of the width of the hallway. This liquid appeared to be water due to its transparency, however it was the facility's cleaning solution that was being used to mop the floor inside room [ROOM NUMBER] by Housekeeping/Staff #67. No cautionary slippery-floor safety signs were present in this area. An interview was conducted with Staff #67 who stated caution signs are always required when cleaning the floor. Staff #67 stated that the cleaning cart she was using was her usual cart and did not have a caution sign.</p> <p>On January 22, 2024 at 9:52 AM, an interview was conducted with Physical Therapist (PT/Staff #81) who stated making the initial therapy evaluation of Resident #295. She stated while walking the hallway earlier she saw the water on the floor outside of room [ROOM NUMBER] and tried to keep Resident #295 on the other side of the wet area. She added that having water on the floor where the residents are walking did not meet her expectations.</p> <p>On January 24, 2024 at 9:01 AM, an interview was conducted with Maintenance Supervisor/Staff # 45 who stated rooms are mopped daily with a cleaner of prediluted bleach and water. Staff #45 stated the cleaning process includes mopping the solution slightly past the resident's room door into the hallway. Staff #45 stated that it is expected to have the sign, caution slippery when wet sign placed at all times while mopping. Staff #45 stated if there are no wet floor caution signs residents may slip.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On January 24, 2024 at 2:15 PM, an interview was conducted with Director of Nursing (DON/Staff # 46) who stated staff should have a caution sign when the floor is being mopped. The DON stated she would not want residents walking near a wet area. She further stated that the expectation is that a cone is out there whenever the floor is wet.</p> <p>The policy and procedure document titled Nursing, Resident Assessment - Fall Management System (reviewed Nov/2023) revealed that the facility is committed to promoting resident autonomy by providing an environment that remains free of accident hazards as possible. Furthermore, the policy of this facility to provide each resident with appropriate assessment and interventions to prevent falls and to minimize complications if a fall occurs.</p>