| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 035262 | A. Building<br>B. Wing | 06/06/2024 |

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| The Lingenfelter Center | 1099 Sunrise Avenue<br>Kingman, AZ 86401 |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40581<br><br>Based on documentation, staff interviews, and the facility policy and procedures, the facility failed to ensure that resident (#69) to resident (#25) abuse did not occur with two residents. The deficient practice could result in residents being physically and emotionally injured.<br><br>Findings include:<br><br>Resident #69 was admitted to the facility on [DATE] with diagnoses that included dementia in other diseases classified elsewhere, severe, with behavioral, mood, and psychotic disturbance.<br><br>The minimum data set (MDS) dated [DATE] included a brief interview for mental status score of 7 indicating the resident had a severe cognitive impairment.<br><br>A progress note dated December 2, 2023 revealed that the resident wandered about the unit approaching others' personal space and attempted to push residents who were in their wheelchairs and Geri chairs around.<br><br>A progress note dated December 4, 2023 revealed that the resident was observed rapidly pacing around the unit. She was moving furniture and other residents. She appeared to be talking to people who weren't there.<br><br>The care plan dated December 20, 2023 revealed that the resident engages in unsafe wandering related to a decline in cognitive status, poor decisions, puts her at risk of falling during elopement attempts or upsetting other residents. Interventions included to monitor for any needed interventions such as alarms, etc. Monitor closely, and 30-minute safety checks as needed. Monitor the resident's patterns and redirect her to safe areas.<br><br>Progress notes dated December 21, 2023 revealed that the resident wanders aimlessly or non-goal directed. Wandering behavior is likely to affect the safety or well-being of self and others. Wandering behavior is likely to affect the privacy of others.<br><br>Progress note dated December 29, 2023 revealed that the resident entered another resident's room and the other resident started to yell at her to leave her room.<br><br>(continued on next page) |

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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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Progress note dated January 8, 2024 revealed that the resident was wandering in the dining room and talking out loud. Another resident pulled resident #69 down and the two residents began yelling loudly and grabbing each others arms. The two residents were separated. Resident #69 did not have any injuries.<br><br>A behavior care plan note dated January 8, 2024 revealed that the resident was a victim in a resident to resident altercation. Provide the resident with a psych consultation for increased behaviors.<br><br>-Resident #25 was admitted to the facility on [DATE] with diagnoses that included unspecified dementia with anxiety, major depressive disorder, and a delusional disorder.<br><br>The care plan dated November 8, 2022 revealed that the resident exhibits negative physical behavior manifested by: hitting, kicking, spitting, pinching or biting towards others. She strikes out, hits, pinches, and attempts to bite/scratch staff when they assist with activities of daily living (ADLs) or administer medications. Interventions included to provide a calm, non-rushed environment and to provide individualized attention and time with a goal to be free of physical altercations with injury involving other residents.<br><br>The minimum data set (MDS) dated [DATE] included a brief interview for mental status score of 1 indicating the resident had a severe cognitive impairment.<br><br>The behavioral care plan dated January 11, 2024 states that the resident requires frequent supervision and redirection from staff as she frequently enters other residents' space, makes loud inappropriate comments, and becomes physically aggressive with staff including hitting, punching, grabbing, kicking, and scratching during redirection and cares. I have frequent outbursts of unprovoked crying. I have also been involved in a resident altercation where I was the aggressor. She becomes physically aggressive when others enter her personal space. Interventions included to monitor the resident via 15-minute safety checks and will be redirected if noted to be entering others personal space or becoming verbally/physically aggressive.<br><br>Progress note dated December 25, 2023 reveals that the resident is observed to have increased behaviors during meal times. The resident yells loudly and constantly at staff and other residents, swearing and name calling.<br><br>Progress note dated December 29, 2023 revealed that the resident became combative with a certified nursing assistant (CNA) during care. She cussed and slapped at the CNA.<br><br>Progress note dated January 1, 2024 revealed that the resident was redirected from yelling at other residents three times.<br><br>Progress note dated January 6, 2024 revealed that the resident was grabbing and pinching staff while being provided care.<br><br>Review of the progress note dated January 8, 2024 revealed that while resident #25 was sitting in the dining room, she was showing signs of increased anxiety. Another resident was walking close to her and both residents began yelling loudly, while grabbing onto each other. The two residents were separated. Resident #25 had a 2.5 cm long superficial scratch to her upper left arm.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the 5-day written investigation dated January 12, 2024 per review of the camera system, resident #25 was sitting in her wheelchair when she was approached from behind by resident #69, who appeared to lean around the wheelchair. Resident #25 grabbed resident #69's arm and pulled her down towards herself. The staff intervened and skin checks were completed on both residents. Resident #25 had a small scratch to her upper left arm. There were three staff statements included in the investigation and all three staff stated that the two residents were grabbing and holding onto each other and yelling.<br><br>An interview was conducted on June 6, 2024 at 1:45 p.m. with the Administrator (staff #103), who stated that resident #69 was trying to push resident #25's wheelchair. Resident #69 bent down and resident #26 pulled resident #69 down. She stated that she watched the video of the incident and the staff intervened immediately and separated the residents. She agreed that this was resident to resident abuse, but thought that her staff interceded quickly.<br><br>The facility policy, Abuse Prohibition stated that it is the policy of this facility to screen and train employees to provide for the protection of residents and for the prevention, identification, investigation, and reporting of abuse, exploitation, neglect, mistreatment, and misappropriation of property. |

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| F 0622<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47911<br><br>Based on clinical record review, staff interviews, and review of facility policies and procedures, the facility failed to ensure one resident's (#70) clinical record included the required information for discharge. The deficient practice could result in residents not having a safe and effective transition of care.<br><br>Findings include:<br><br>Resident #70 was admitted on [DATE] with diagnosis including recurrent major depressive disorder, pneumonia, dementia with mood disturbance, agitation and psychotic disturbance, anemia, wandering, insomnia and hypertension.<br><br>A review of the electronic health record for resident #70 revealed two short-term unplanned hospital discharges, one on November 7, 2023 and the other on February 12, 2024.<br><br>A review of the quarterly MDS (minimum data set) dated March 15, 2024 revealed a BIMS (brief interview of mental status) score of 3, suggesting severe cognitive impairment.<br><br>A review of the progress notes revealed that notifications for both of the aforenoted hospital discharges transpired timely. A progress noted dated November 7, 2023 revealed a communication entry noting that the nurse had call the resident's doctor and notify him of what had happened, vital signs, and signs/ symptoms the resident was experiencing.<br><br>A review of the physician orders revealed an order on February 12, 2024 noting that the resident is to be sent to 'KRMC' ([NAME] Regional Medical Center). However, there was no evidence of a physician order evident for the hospitalization on [DATE].<br><br>An interview was conducted on May 5, 2024 at 12:15 P.M. with staff #1 , CNA (certified nursing assistants). Staff #1 stated that generally CNA's ready the resident for discharge and the nurses conduct the notifications, to include notifying the doctor and obtaining the necessary orders. Staff #1 stated that there is a guide available that breaks down the steps to make sure nothing is missed.<br><br>An interview was conducted on June 6, 2024 at 12:23 PM with staff #101, LPN (licensed practical nurse). Staff #101 stated that an order is required any time that a resident is transferred out of the facility and that this would include hospitalization s. Staff #101 further stated that notification of family, case manager and doctor also needed to transpire and that the notifications are generally done by the charge nurse. Staff #101 stated that the facility has a resource binder on each hall that contains a step by step process on what need to happen for a hospitalization to include who is responsible for what step of the process. She stated that if it's an emergent situation, that the order might not immediately be noted in the record but should within a few days of the transfer to the hospital.<br><br>(continued on next page) |

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| F 0622<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An interview was conducted on June 6, 2024 at 12:42 P.M. with staff #19, DON (director of nursing). Staff #19 stated that the facility was unable to find the physician order for the hospital transfer on November 7, 2023. She stated that the expectation would be that an order is in place for each hospital transfer. She stated that the nursing staff have a guide in place that tells the staff the steps that they have to take for a discharge to the emergency department or hospital. Staff #19 stated that the risk could include potential liability for the nurse and the facility.<br><br>A review for the facility policy entitled Transfer and discharge date d December 2, 2021 revealed that if a transfer is necessary for the resident's welfare or that their needs can't be met in the facility, or due to an improvement in the resident's health where they no longer need the services of the facility or the resident has failed to pay after reasonable and appropriate notice, then the physician will provide documentation in the clinical record. |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46606<br><br>Based on clinical record review, staff interviews and policy review, the facility failed to ensure that one resident's (#76) care planned interventions were reassessed for effectiveness and revised as needed. The deficient practice could result in a care plan that does not meet the resident's needs.<br><br>Findings include:<br><br>Resident #76 was admitted on [DATE] with diagnoses that included chronic obstructive pulmonary disease, malignant neoplasm of left bronchus, metabolic encephalopathy, dementia, major depressive disorder, and insomnia.<br><br>A care plan dated December 26, 2023 indicated that resident has an order for psychotropic medications and exhibits behavior of psychosis and difficulty sleeping related to depression. Interventions include to administer medication per physician orders, medication use to be evaluated every 4 months and tapered to the lowest effective dose, notify nurse if increase in lethargy or change in behaviors or cognitive function.<br><br>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status score of 00 indicating that resident had severe cognitive impairment. The MDS also indicated that resident exhibited physical behavioral symptoms directed towards others 4-6 days during the assessment period. Additionally, he exhibited verbal behavioral symptoms directed towards other 1-3 days during the assessment period. The resident also exhibited other behavioral symptoms not directed towards others 1-3 days during the assessment period. The assessment also indicated that resident exhibited rejection of care 4-6 days during the assessment period. The resident also exhibited behavior of wandering which occurred 4-6 days during the assessment period.<br><br>A behavior note dated May 15, 2024, timestamped 4:37 (a.m.) documented that resident was up wandering all throughout shift in and out of others rooms. The note indicated that resident was turning on lights and talking loudly, and waking others. Resident was redirected several times throughout shift.<br><br>Review of a communication note dated May 15, 2024 documented that provider was consulted regarding resident not sleeping, going in others' rooms, turning on lights, and talking loudly. The note stated that provider will come in to see resident.<br><br>A physician visit note dated May 16, 2024 documented that provider came in to see resident and that new orders were received.<br><br>A physician's order note dated May 16, 2024 documented that resident prescription was increased to Seroquel 50 mg at hour of sleep. The note indicated to keep the resident awake during day shift at much as possible.<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of a skilled evaluation note dated May 16, 2024 and May 18, 2024 through May 21, 2024 stated that resident sleeps intermittently and wanders at night. A behavior note dated May 22, 2024, timestamped 4:47 (a.m.) documented that resident was up wandering and rummaging about room. The note stated that when resident was approached he became physically and verbally aggressive. Review of a neurologic focused evaluation note dated May 23, 2024 and skilled evaluation note from May 26, 2024 through May 29, 2024 documented that resident sleeps intermittently and wanders at night. A skilled evaluation note dated May 31, 2024, a long-term care evaluation note dated June 2, 2024 and a neurologic focused evaluation note dated June 4, 2024 indicated that resident sleeps intermittently and resident wanders at night.<br><br>During dining observation of residents conducted on June 3, 2024 at 12:42 p.m., resident #76 was not observed in the dining room. Staff indicated to the administrator (staff #103) that resident did not want to leave the room since he was tired and did not want to eat.<br><br>Further review of the resident's clinical record did not indicate that the resident's intermittent sleep pattern was addressed despite numerous instances/documentation's that resident was sleeping intermittently. Additionally, there was no evidence that provider was notified of this continued behavior since resident's medication was adjusted and provider was last notified of behavior on May 15, 2024.<br><br>An interview with a Licensed Practical Nurse (LPN/staff #101) was conducted on June 6, 2024 at 9:30 a.m. Staff #101 stated that typically if they see residents are having sleep issues, they talk with the doctor. Normally, they refer to psych doctor and prescribed Melatonin or Ativan if they have increased anxiety. Staff #101 noted that it is a nursing job to recognize if a resident is experiencing insomnia and relay that information to the provider. The LPN stated that if a resident is uncomfortable due to lack of sleep, they can become agitated. This would be documented in PCC (Point Click Care) and that it was communicated to the doctor. Staff #101 noted that each specific behavior as it pertains to the resident is in the care plan. The LPN said that nursing staff can add or discontinue items on care plan. Staff #101 said that for insomnia, care plan would state if doctor had prescribed a medication. Staff #101 stated non-pharmacological approaches would be noted in behavior note in PCC, might include taking a walk, putting on music. Staff #101 stated that if there is an increased pattern a psych eval is initiated to determine if medications need to be changed or increased.<br><br>During an interview with the Director of Nursing (DON/staff #19) conducted on June 6, 2024 at 1:41 p.m., staff #19 noted that care planning for issues ensures that behaviors are monitored and that interventions are in place to help residents. The DON stated that care plans are important so that the different caregivers know how to care and meet the needs of the resident. Staff #19 said that the impact of not addressing issues is that it could cause discomfort to resident and caregivers will not know how to re-direct behavior or if there is an increase in behavior. Staff #19 stated that with regards to resident #76, she acknowledged that the care plan should have been more updated.<br><br>The facility policy titled Comprehensive Care Plan signed June 1, 2020 indicated that assessments of residents are ongoing and care plans are revised as information about the resident and resident's condition change. The policy noted that an individualized comprehensive care plan that includes measurable objectives and time tables to meet the resident's medical, nursing, mental, and psychological needs is developed for each resident.<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the facility policy titled Behavior Monitoring Policy and Procedure signed June 1, 2020 indicated that nurses will document behavior information, interventions, and resident responses as needed. Should behavior have a significant change the nurse will notify the attending physician for orders for psych consult as determined needed for assistance in assessing the resident, identifying causes, and developing a care plan for intervention and management. The policy further noted that the care plan will be updated to include known triggers to behavior and interventions. |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47911<br><br>Based on clinical record review, interviews, and facility policy, the facility failed to ensure that ordered fluid restrictions were followed for one resident (#21) on dialysis. The deficient practice could result in the potential for complications and fluid overload for residents.<br><br>Findings include:<br><br>Resident # 21 was admitted on [DATE] with diagnosis that included congestive heart failure and dependence on renal dialysis.<br><br>A review of the MDS (minimum data set) dated revealed a BIMS (brief interview of mental status) score of 5, suggesting severe cognitive impairment. The MDS further noted that the resident was noted to be on dialysis.<br><br>A review of the physician orders revealed that the resident was on 950 cc (cubic centimeter) fluid restriction every day and night for end stage renal disease.<br><br>A review of the progress notes, revealed no documentation that CNA's (certified nursing assistants) had notified nursing staff of fluid intake beyond the ordered amount.<br><br>A review of the facility POC (plan of care) revealed that the following daily fluid intake levels: May 8, 2024 revealed 1080 cc of fluids, May 10, 2024 revealed 1440 cc of fluids, May 12, 2024 revealed 1680 cc of fluids and May27, 2024 revealed 1560 cc of fluids. However, per physician orders, fluid intake should have been limited to 950 cc.<br><br>There was no evidence of physician notification in the electronic health record that the resident's fluid intake was outside of ordered parameters on the previous dates identified.<br><br>An interview was conducted on June 6, 2024 at 12:18 P.M. with staff #98 , CNA (certified nursing assistant). Staff #98 stated that if there is an order in place for fluid restrictions then it has to be followed, but further stated that she thought there was some flexibility if the resident is on comfort care. She stated that if the resident had reached the maximum fluid allowed, per physician order, and he wanted more, she would give him more but would notify the nurse.<br><br>An interview was conducted on June 6, 2024 at 12:23 P.M. with staff #101, LPN (licensed practical nurse-[NAME]). Staff #101 stated that if a resident is on fluid restrictions, even if they are on comfort care, fluid restrictions must be adhered to. Staff #101 reviewed the residents POC and stated that the fluid intake noted on several days on the POC did not meet expectations. She stated that the risk to the resident could include fluid overload or potentially heart failure.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An interview was conducted on June 6, 2024 at 12:42 P.M. with staff #19 , DON (director of nursing). Staff #19 stated that with a dialysis resident who is on ordered fluid restrictions that input and output are monitored and that fluid restrictions are adhered to as much as possible. Staff #19 reviewed the resident's electronic health record and stated that on several days the resident had gone over the prescribed fluid restrictions. Staff #19 further reviewed the record for physician notification, but stated she saw no evidence that the physician had been notified. Staff #19 stated that the risk to the resident could include fluid volume overload and heart.<br><br>A review of the physician policy entitled Following Physician Orders dated June 1, 2020 revealed that it is the policy of the facility that physician orders be carried out as ordered and if an order is not completely carried out as ordered then the facility will notify the prescribing physician. |

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| F 0680<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure the activities program is directed by a qualified professional.<br><br>40581<br><br>Based on documentation, staff interviews, and facility policy and procedures, the facility failed to designate a qualified individual to provide recreational activities. The deficient practice could result in appropriate activities not being identified and assessed for the residents.<br><br>Findings include:<br><br>Review of the employee record revealed that staff #95 was:<br><br>-employed by the facility on October 27, 2020 as an Activities Assistant.<br><br>-employed by the facility on May 5, 2021, as the Director of Activities.<br><br>-employed by the facility on May 15, 2023 as the Director of Life Enrichment.<br><br>The employee record did not reveal a certification as an activities professional , or two years of prior experience in recreational activities prior to staff #95 being employed as the Director of Activities on May 5, 2021.<br><br>Review of staff #95's resume revealed that staff #95:<br><br>-received a high school diploma.<br><br>-did not have prior experience in recreational activities.<br><br>-did not have certification as an activities professional.<br><br>An interview was conducted on June 5, 2024 at 8:30 a.m. with the Human Resource Director (HR/staff #130), who stated that the Director of Life Enrichment had not completed the certification for activities specialist.<br><br>During an interview conducted on June 6, 2024 at 1:45 p.m. with the Administrator (staff #103), she stated that the Director of Life Enrichment (staff #95) requires certification and she is very close to finishing the training. Staff #103 was aware that staff #95 should have been certified as an activities specialist.<br><br>The job description for the Director of Life Enrichment included the following education, experience, and training:<br><br>-a high school diploma or its equivalent.<br><br>-satisfactory completion of a training course for Life Enrichment Director approved by the Department of Health and Human Services or a qualified therapeutic recreation specialist or an activities professional certified by a recognized accrediting body or a qualified occupational therapist or occupational therapy assistant.<br><br>(continued on next page) |

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| F 0680<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -two years of experience in a social or recreational program approved by the Department of Health and Human Services within the last five years, one of which was full time in a resident activities program in a health care setting. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40581<br><br>Based on observations, staff interviews, and the facility policy and procedures, the facility failed to ensure provide respiratory care for one resident (#6) is in accordance with physician's order. The deficient practice could result in hypoxia.<br><br>Findings include:<br><br>Resident #6 was admitted to the facility on [DATE] with diagnoses that included Epilepsy, dementia in other diseases classified elsewhere, severe with psychotic disturbance, mood disturbance, and anxiety.<br><br>Review of the orders revealed an order dated March 24, 2022 to administer 2 liters of oxygen via (cannula/mask) continuously per original order every day and night shift<br><br>The minimum data set (MDS) dated [DATE] included a brief interview for mental status score of 3 indicating the resident had a severe cognitive impairment.<br><br>During the initial interview with resident #6 conducted on June 3, 2024 in the afternoon the resident was observed lying in bed with the cannula placed under the nostrils. The concentrator was set at 1.5 liters (L).<br><br>On June 6, 11:04 a.m., the resident was observed sitting in the dining room to the left of the nurse's station. The resident was wearing the cannula and the concentrator was set at 1.5L. A licensed practical nurse (LPN/staff #47) looked at the concentrator and stated that it was set just past 1.5L. and was supposed to be at 2L. She checked the order and changed it to the correct amount, which was 2L.<br><br>During an interview with the Director of Nursing (DON/staff #19), she stated that a physician's order is needed to administer oxygen and the order should specify the amount/liters needed. She also stated that the facility has a standing order for 2L of oxygen if a resident is having trouble breathing. She stated that there is a risk of under oxygenation if staff don't follow the order and resident #6 is incapable of changing her O2 level.<br><br>The facility policy, Oxygen Administration dated June 1, 2020 states that It is the policy of this facility that oxygen therapy is administered, as ordered by the physician or as an emergency measure until the order can be obtained. Reassess oxygen flowmeter for correct liter flow. |

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| F 0732<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Post nurse staffing information every day.<br><br>40581<br><br>Based on documentation, staff interviews, and the facility policy and procedures, the facility failed to ensure all of the correct information was on the daily staff posting.<br><br>Findings include:<br><br>Review of the daily staff posting dated April 14, 2024 revealed the date, census, total number of licensed staff, the total number of non-licensed staff, total hours for licensed staff and total hours for non-licensed staff, but did not reveal the actual hours worked for each category of licensed and non-licensed staff.<br><br>The daily staff posting dated January 1, 2024 was not provided by the facility.<br><br>An interview was conducted on June 6, 2024 at 8:28 a.m. with the Resident Care Coordinator (staff #4), who stated that she is responsible for updating the daily staff posting and posting it daily and requires the date, first and last name of staff scheduled to work. She stated that the purpose of the daily staff posting is to make staff aware of their schedule. She reviewed the daily staff posting dated April 14, 2024 and acknowledged that the postings did not include the actual hours worked for the licensed and unlicensed staff. She stated that she was not aware that actual hours needed to be on the daily staff posting and payroll is responsible for keeping track of actual hours worked. She also stated that she did not have the daily staff posting dated January 1, 2024.<br><br>During an interview conducted on June 6, 2024 at 1:45 p.m. with the Administrator (staff #103), she stated that the pathway for the daily staff posting has been reviewed with Resident Care Coordinator (staff #4), and the daily staff posting regulation will be reviewed with her as well. She stated that the purpose of the daily staff posting is so the residents and visitors are aware of the ratios of staff in the building.<br><br>The facility policy, Posting Nurse Staffing Information stated that the information recorded on the form shall include the actual time worked during that shift for each category and type of nursing staff. |

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident must receive and the facility must provide necessary behavioral health care and services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46606<br><br>Based on clinical record review, staff interviews, the facility assessment, and review of policy and procedure, the facility failed to ensure that the necessary behavioral health care and services were provided to one resident (#76). The deficient practice could result in residents not receiving the necessary behavioral health care and services.<br><br>Findings include:<br><br>Resident #76 was admitted on [DATE] with diagnoses that included chronic obstructive pulmonary disease, malignant neoplasm of left bronchus, metabolic encephalopathy, dementia, major depressive disorder, and insomnia.<br><br>A care plan dated December 26, 2023 indicated that resident has an order for psychotropic medications and exhibits behavior of psychosis and difficulty sleeping related to depression. Interventions include to administer medication per physician orders, medication use to be evaluated every 4 months and tapered to the lowest effective dose, notify nurse if increase in lethargy or change in behaviors or cognitive function.<br><br>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status score of 00 indicating that resident had severe cognitive impairment. The MDS also indicated that resident exhibited physical behavioral symptoms directed towards others 4-6 days during the assessment period. Additionally, he exhibited verbal behavioral symptoms directed towards other 1-3 days during the assessment period. The resident also exhibited other behavioral symptoms not directed towards others 1-3 days during the assessment period. The assessment also indicated that resident exhibited rejection of care 4-6 days during the assessment period. The resident also exhibited behavior of wandering which occurred 4-6 days during the assessment period.<br><br>A behavior note dated May 15, 2024, timestamped 4:37 (a.m.) documented that resident was up wandering all throughout shift in and out of others rooms. The note indicated that resident was turning on lights and talking loudly, and waking others. Resident was redirected several times throughout shift.<br><br>Review of a communication note dated May 15, 2024 documented that provider was consulted regarding resident not sleeping, going in others' rooms, turning on lights, and talking loudly. The note stated that provider will come in to see resident.<br><br>A physician visit note dated May 16, 2024 documented that provider came in to see resident and that new orders were received. Another physician's order note dated May 16, 2024 documented that resident prescription was increased to Seroquel 50 mg at hour of sleep. The note indicated to keep the resident awake during day shift at much as possible.<br><br>Review of a skilled evaluation note dated May 16, 2024 and May 18, 2024 through May 21, 2024 stated that resident sleeps intermittently and wanders at night.<br><br>(continued on next page) |

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A behavior note dated May 22, 2024, timestamped 4:47 (a.m.) documented that resident was up wandering and rummaging about room. The note stated that when resident was approached he became physically and verbally aggressive.<br><br>Review of a neurologic focused evaluation note dated May 23, 2024 and skilled evaluation note from May 26, 2024 through May 29, 2024 documented that resident sleeps intermittently and wanders at night.<br><br>A skilled evaluation note dated May 31, 2024, a long-term care evaluation note dated June 2, 2024 and a neurologic focused evaluation note dated June 4, 2024 indicated that resident sleeps intermittently and resident wanders at night.<br><br>During dining observation of residents conducted on June 3, 2024 at 12:42 p.m., it was observed that resident #76 was not in the dining room. Staff indicated to the administrator (staff #103) that resident did not want to leave the room since he was tired. Resident did not want to eat.<br><br>A neurologic focused evaluation note dated June 4, 2024 indicated that resident sleeps intermittently. Additionally, the note stated that resident wanders at night.<br><br>Further review of the resident's clinical record did not indicate that the resident's intermittent sleep pattern was addressed despite numerous instances/documentations that resident was sleeping intermittently. Additionally, there was no evidence that provider was notified of this continued behavior since resident's medication was adjusted and provider was last notified of behavior on May 15, 2024.<br><br>An interview with a Licensed Practical Nurse (LPN/staff #101) was conducted on June 6, 2024 at 9:30 a.m. Staff #101 stated that typically if they see residents are having sleep issues, they talk with the doctor. Normally, they refer to psych doctor and prescribed melatonin or Ativan if they have increased anxiety. Staff #101 noted that it is a nursing job to recognize if a resident is experiencing insomnia and relay that information to the provider. The LPN stated that if a resident is uncomfortable due to lack of sleep, they can become agitated. This would be documented in PCC (Point Click Care) and that it was communicated to the doctor. Staff #101 stated that non-pharmacological approaches would be noted in behavior note in PCC, that might include taking a walk, putting on music.<br><br>During an interview with the Director of Nursing (DON/staff #19) conducted on June 6, 2024 at 1:41 p.m., staff #19 noted that her expectation is that if staff identifies a resident has a known history of insomnia who is sleeping intermittently and wandering at night is that the staff would offer activities at night and redirect. Additionally, staff #19 stated that she expects staff to notify the provider and get a psych eval. The DON noted that is it important to address this issue since it can disrupt the resident's daily living, disrupt other residents, and impact the comfort of the resident and fell ow residents.<br><br>Review of the facility policy titled Behavior Monitoring Policy and Procedure signed June 1, 2020 indicated that nurses will document behavior information, interventions, and resident responses as needed. Should behavior have a significant change the nurse will notify the attending physician for orders for psych consult as determined needed for assistance in assessing the resident, identifying causes, and developing a care plan for intervention and management. The policy further noted that the care plan will be updated to include known triggers to behavior and interventions. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46606<br><br>Based on observation, staff interview, facility policy and procedure review, the facility failed to ensure that four medications were disposed of in accordance with professional standards of practice. The deficient practice could result in medications not being disposed properly. The sample was 25 medication administrations observed.<br><br>Findings include:<br><br>During the medication pass observation with a licensed practical nurse (LPN/staff #47) conducted on [DATE] at 7:10 a.m., the LPN attempted to administer 5 medications to a resident. The resident ended up spitting out the Aspirin and Docusate Sodium back into the medicine cup. The LPN then went back to the nurse's station and threw the medicine cup containing the two medicine in the trash can.<br><br>In another medication administration observation with staff #47 conducted on [DATE] at 7:17 a.m., the LPN dropped one of the two Depakote (anticonvulsant) 125 mg (milligram) capsule on to the top of the medication cart. She then picked up the dropped capsule off the top of the medication cart and disposed of it with the other capsule in the trash can in the nurse's station.<br><br>An interview was conducted with a LPN (staff #47) on [DATE] at 7:17 a.m., staff #47 stated that she had to waste the first set (blister pack) of Depakote since one of the capsule fell on the medication cart.<br><br>During an interview with a Licensed Practical Nurse (LPN/staff #93) conducted on [DATE] at 8:42 a.m., staff #93 stated that non-narcotic drugs are wasted by throwing in the trash or sharps container. If not, MedSafe is used at the end of the Med Pass (Medication Pass) to get rid of medications that was refused by resident or fell to the floor or medication cart counter.<br><br>An interview was conducted with a LPN (staff #101) on [DATE] at 9:30 a.m. Staff #101 stated that they have a gray box in the conference room and that is where they dispose of medication. The LPN said that typically mediation disposal is done by two nurses. Usually the DON and the QA (Quality Assurance) nurse will take the unused/expired meds and dispose of them. Staff #101 said that if during Med Pass, medication is observed that needs to be disposed of, they call supervisor and will call pharmacy to get updated meds. The LPN said that if a resident refused meds, try a second approach. If the resident does not take the meds on the re-approach, then dispose of it in the sharp container or sand stuff if the meds are crushed and then throw it in the garbage. If meds are intact, throw in sharps container only. Staff #101 said never throw full pills in the garbage since you never know who could take it.<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview with the Director of Nursing (DON/staff #19) conducted on [DATE] at 1:41 p.m., staff #19 stated that her expectation is that staff use MedSafe bin if they have expired meds or have to dispose medication. The DON said that if the medication needing to be disposed/destructed is a narcotic, then two nurses have to be present to put it in the MedSafe. Staff #19 stated that MedSafe is where medication have to be disposed/destructed. The DON indicated that the importance of following the process for medication disposal/destruction is to ensure medication is not diverted and residents do not inadvertently get medication not meant for them. MedSafe is the used since nobody can get disposed drugs inside. Staff #19 stated that the potential impact of not following the process for medication disposal/destruction is that residents can get the medication, expose residents/staff to allergen, and get medication into the water system.<br><br>Review of the facility policy titled Discarding and Destroying Medications signed [DATE], indicated that the facility utilizes Tridecon Healthcare Solutions which is a registered biohazardous medical waste transporter approved by the Arizona Department of Environmental Quality to operate Pharmaceutical Waste Management. Medication that cannot be returned to the dispensing pharmacy, excluding controlled substances, will be placed in the Tridecon bin. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>40581<br><br>Based on observations, staff interviews, and the facility policy and procedures, the facility failed to maintain a safe and sanitary kitchen. The deficient practice could result in residents becoming ill.<br><br>Findings include:<br><br>On June 3, 2024 at 11:25 a.m. the initial tour of the kitchen was conducted with the Director of Nutritional Services (staff #72). During the tour of the large walk-in refrigerator, a one-pound box of strawberries was observed to have one strawberry with a fuzzy white patch approximately 1 inch by .5 inch. Staff #72 stated that the patch was mold and removed the box of strawberries from the refrigerator. She stated that it is everyone's responsibility to monitor the food and remove old food as needed. There was also a one-pound bag of green grapes that contained one brown grape, and a box of twenty-six green peppers that appeared shriveled and wilted. She stated that the peppers were not good. During a demonstration of the high temperature dishwasher, two cockroaches were observed running on floor from the dishwasher under the sink. Staff #72 told a male staff to get the cockroaches and the male staff used a paper towel to pick the cockroaches up.<br><br>An interview was conducted on June 6, 2024 at 1:45 p.m. with the Administrator (staff #103), who stated that she supervises staff #72 and it is expectation that staff #72 ensures that quality checks are done daily to ensure that the food is fresh and maintains nutritive value. She also stated that staff #72 should be ensuring that her staff are a part of the process and removing rotten, spoiled, and food that is not fresh. She stated that there is a potential risk of food borne illness if spoiled and/or food that it not fresh is served to the residents.<br><br>The facility policy, Food Storage and Date Marking states that perishable food such as meat, poultry, fish, dairy products, fruits, vegetables, and frozen products must be frozen or stored in the refrigerator or freezer immediately after receipt to assure nutritive value and quality. Refrigerated foods should be stored upon delivery and careful rotation procedures should be followed. |

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| F 0814<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Dispose of garbage and refuse properly.<br><br>40581<br><br>Based on observation, staff interviews, and the facility policy and procedures, the facility failed to ensure that garbage/refuse was disposed of properly. The deficient practice could attracted rodents and pests.<br><br>Findings include:<br><br>On June 3, 2024 at 11:25 a.m. the initial tour of the kitchen was conducted with the Director of Nutritional Services (staff #72). During a demonstration of the high temperature dishwasher, two cockroaches were observed running on floor from the dishwasher to under the sink. Staff #72 told a male staff to get the cockroaches and the male staff used a paper towel to pick the cockroaches up. Then a tour of the garbage/refuse area was conducted and a large grease trap was observed to the right of the garbage dumpster. Grease was dripping on the ground and a large area of the ground was covered with grease. Small particles of food and grease could also be seen on the grease trap. Staff #72 stated that the the grease was dripping onto the ground and the small particles were food, which created a risk of attracting bugs.<br><br>An interview was conducted on June 6, 2024 at 1:45 p.m. with the - Interview with Administrator (staff #103), who stated that staff #72 showed her the grease trap and she got staff to clean the ground, grates and the round cylinder. She stated that it is her expectation that staff #72 keeps it clean by by having dietary clean the grease trap and the groundskeeper clean the ground. Staff #103 agreed that a dirty grease trap could attract bugs.<br><br>The facility policy, Garbage Disposal dated June 1, 2020 states that garbage containing food wastes will be stored in a manner that is inaccessible to pests. Storage areas will be kept clean at all times, and shall not constitute a nuisance. |

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| F 0908<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Keep all essential equipment working safely.<br><br>40581<br><br>Based on observation, staff interviews, and the facility policy and procedures, the facility failed to ensure that essential kitchen equipment was maintained and in safe operating condition. The deficient practice could result in residents becoming ill.<br><br>Findings include:<br><br>On June 3, 2024 at 11:25 a.m. the initial tour of the kitchen was conducted with the Director of Nutritional Services (staff #72). She stated that the high temperature dishwasher needed to rise to 150 degress during the wash cycle and 180 degrees during the rinse cycle in order for the dishware to be properly sanitized. Multiple demonstrations were conducted with the following results:<br><br>-wash cycle 150 degrees<br><br>-wash cycle 150 degrees<br><br>-wash cycle 150 degrees<br><br>-rinse cycle 145 degrees<br><br>-rinse cycle 145 degrees<br><br>-rinse cycle 145 degrees<br><br>-rinse cycle 150 degrees and dropped instantly back to 145 degrees<br><br>-rinse cycle 180 degrees<br><br>Staff #72 stated that there was no risk of the dishes not being sanitized if the rinse cycle runs below 180 degrees, but if the wash cycle doesn't rise to 150 degrees there is a risk of the bacteria not being killed. She stated that they have ordered a new dishwasher and when the dishwasher doesn't rise to the required temperatures, she has the dishwasher wash the dishes in the sink using the three sink method. After the first five demonstrations, the Maintenance Manager (staff #14) came and ran the dishwasher a sixth time and the rinse cycle rose to 150 degrees. He stated that he would need to make some adjustments to the dishwasher. The dishwasher/Nutrition Service Worker I (staff #57) was present during this time and he stated that he has never washed the dishes in the sink and he just keeps running the dishwasher until it rises to correct temperatures.<br><br>An interview was conducted on June 6, 2024 at 1:45 p.m. with the Administrator (staff #103), who stated that a new dishwasher was just delivered and they did have the current dishwasher working. She stated there is a potential risk of infection if the dishwasher is not rising to the appropriate temperatures because the dishes wouldn't be sanitized.<br><br>(continued on next page) |

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| F 0908<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the CMA Dishmachines Owner's Manual states that the high temperature dishwasher temperature for the wash cycle is 155 to 160 degrees and temperature for the rinse cycle is 180 to 195 degrees. |