

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  035268	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/15/2023
NAME OF PROVIDER OR SUPPLIER  Advance Health Care of Scottsdale		STREET ADDRESS, CITY, STATE, ZIP CODE  9846 North 95th Street Scottsdale, AZ 85258	
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 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47911</b></p> <p>Based on closed clinical record review, staff interviews, and facility policy review, the facility failed to inform residents #32, #195, #4, and #146, in advance, of the risks and benefits of proposed care for opioid medications via informed consent. The deficient practice can result in the resident and/or the resident representative not being aware of the benefits and the potential adverse side effects of taking opioid medications.</p> <p>Findings include:</p> <p>Resident #146 was admitted on [DATE] with diagnosis including a wedge compression fracture of T11-T12 vertebra, urinary tract infection, morbid obesity, anemia, lymphedema, atrial fibrillation, anxiety disorder, depression, and muscle spasms.</p> <p>A review of the physician orders revealed that the resident was prescribed 5mg of oxycodone every 4 hours as needed for pain, ranging from a scale of 6 to 10. Pain scale and side effects monitoring were observed to be present in the medical record; however, there was no evidence of a signed consent for opioid medications in the record.</p> <p>An interview was conducted on December 14, 2023 at 10:25 AM with the Director of Nursing (DON) staff #62, who stated that she was unaware that opioid consents were required and therefore the facility did not have them in the medical record.</p> <p>An interview was conducted on December 14, 2023 at 11:07 AM with the clinical nurse manager (RN staff #24). Staff #24 stated, we do not do consent for pain for controlled medication. It is not part of our protocol. We do have a block box warning that nurses sign off for. The black box is in the orders and in the MAR for pain medication controlled substances that are tracked. She stated that no pain medication consents are obtained from residents.</p> <p>The policy and procedure document titled, Resident Rights -version A0717 (updated 28 September 2022) was reviewed and revealed, that the resident has the right to be informed of, and participate in, his/her treatment, including: the right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers.</p> <p>48814</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 035268
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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Findings include:</p> <p>Resident #195 was admitted on [DATE] with a diagnosis of Wedge compression fracture of T11-T12 vertebra, Chronic atrial fibrillation, Depression, Long term (current) use of anticoagulants, and Chest pain.</p> <p>A review of the current active physician orders revealed the following orders for: Oxycodone - Schedule II tablet, 5 mg; oral: Pain of 6-10 on a pain scale of 0-10, Every 6 Hours - PRN (order date of December 02, 2023)</p> <p>These orders were transcribed onto the MAR (Medication Administration Record) and the TAR (Treatment Administration Record) for December 2023.</p> <p>Review of the MAR and TAR for December 2023 revealed that Oxycodone - Schedule II tablet, 5 mg was given on December 3, 4 and 5, 2023 after monitoring the pain level.</p> <p>The Admission Minimum Data Set (MDS) assessment at the time of admission revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was alert and oriented.</p> <p>An interview with the Director of Nursing (DON/Staff #62) was conducted on December 14, 2023 at 10:25 AM who stated opioid consents are not present in the medical records and having consents for opioid medications was new to her.</p> <p>The policy and procedure document titled, Resident Rights -version A0717 (updated 28 September 2022) was reviewed and revealed, that the resident has the right to be informed of, and participate in, his/her treatment, including: the right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers.</p> <p>49325</p> <p>Findings include:</p> <p>Resident #32 was first admitted into the facility on [DATE] with diagnoses that included fracture of right femur, dementia, and constipation.</p> <p>The Admission Minimum Data Set (MDS) assessment at the time of admission revealed a Brief Interview for Mental Status (BIMS) score of 12 which indicated the resident was moderately cognitively impaired.</p> <p>Care plan-initiated November 7, 2023 revealed, the patient has advance directives on record with the goal that patient's wishes and directions will be carried out in accordance with their advance directives on an ongoing basis throughout the next 90 days.</p> <p>An interview with Licensed Practical Nurse (staff #32) conducted on December 14, 2023 at 10:59 AM revealed that staff #32 monitors whether medications are effective through observation of behaviors. In regards to pain medications, if you remove the pain it helps resident #32 relax. Staff #32 confirmed that the following opioid order was part of active medications:</p> <p>(continued on next page)</p>		

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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Tramadol tablet- amount to administer: 25 milligrams; oral; special instructions: diagnosis pain 6-10 on a pain scale 0-10; every 6 hours prn (as needed).</p> <p>An interview with the Director of Nursing (DON/Staff #62) was conducted on December 14, 2023 at 10:25 AM who stated opioid consents are not present in the medical records and having consents for opioid medications was new to her.</p> <p>The policy and procedure document titled, Resident Rights -version A0717 (updated 28 September 2022) was reviewed and revealed, that the resident has the right to be informed of, and participate in, his/her treatment, including: the right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers.</p> <p>49399</p> <p>Findings include:</p> <p>Resident #4 was admitted on [DATE] with diagnoses of acute respiratory failure with hypoxia, rheumatoid arthritis, and polyneuropathy.</p> <p>The admission Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 11, which indicated the resident has moderate cognitive impairment. The assessment also included the resident is taking opioid medication.</p> <p>Review of the clinical records for the month of November and December 2023 revealed the following physician's orders: OPIOID medication use-Observe patient closely for: Tolerance (meaning more medication may be needed to achieve the same level of pain relief). Physical dependence which causes symptoms of withdrawal when opioid medication is stopped, or a dose is held or missed. Increased sensitivity to pain. Constipation, Nausea, Vomiting, Dry mouth, Sleepiness, Dizziness, Confusion, Depression, Itching, Sweating. Special instructions: Document +/- results. Explain + results in NN every shift, date of order November 29, 2023; Tramadol- Schedule IV tablet 50 mg orally every 12 hours as needed for diagnosis of Pain 4-6/10 * Pain Scale 0-10/10. This medication had a start date of November 29, 2023 and discontinued date of December 9, 2023; Gabapentin capsule; 300mg; oral Special Instructions: DX. Neuropathy every 8 hours. Start date November 29, 2023 and discontinued date of December 13, 2023; Cyclobenzaprine tablet; 5mg; amount to administer: 5 mg; oral three times a day - PRN for muscle spasms as needed. Start date December 3, 2023 and discontinued date December 4, 2023; Cyclobenzaprine tablet; 5mg; amount to administer: 5 mg; oral three times a day for muscle spasms. Start date December 3, 2023 and discontinued date December 3, 2023; Cyclobenzaprine tablet; 5mg; amount to administer: 5 mg; oral every 8 hours - PRN Dx. Muscle spasms. Start date December 4, 2023 and discontinued date December 10, 2023; Trazadone tablet; 50 mg; amount: 50 mg; oral Special Instructions: DX: Insomnia AEB inability to fall/stay asleep at bedtime; oxycodone - Schedule II tablet; 5mg; amount: 5mg; oral Special Instructions: DX. Pain 4-10/10 * Pain Scale 0-10/10 every 6 hours -PRN ordered on December 9, 2023; Tramadol- Schedule IV tablet 50 mg orally once a day for diagnosis of chronic pain on December 9, 2023; Tramadol- Schedule IV tablet 50 mg orally every 12 hours as needed for diagnosis of Pain 4-6/10 * Pain Scale 0-10/10. This medication had a start date of December 9, 2023 and discontinued date of December 11, 2023; Gabapentin capsule; 300mg; oral Special Instructions: DX. Neuropathy twice a day. Start date December 13, 2023;</p> <p>(continued on next page)</p>		

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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During clinical record review, record revealed on November 30, 2023, a care plan for alteration in comfort; Patient has acute pain related to neuropathy generalized pain s/d to deconditioning was initiated. The goal was patient will express relief or reduction in pain within 30-40 minutes of administration of medication throughout stay. Patient will demonstrate decrease in discomfort within 30-40 minutes of administration of medication throughout stay. Patient will state satisfaction with pain management regimen throughout stay. The interventions included to administer medication per MD order; assess for signs and/or symptoms of pain with each encounter; offer treatment and/or Rx per MD order; educate patient on pain control measures and managing acute pain; encourage patient to express concerns or fears regarding pain management; if current regimen is ineffective in managing pain, notify MD; observe for relief within 30-40 minutes of administration of medication; and offer alternative pain relief methods, i.e., heat/cold applications, deep breathing, diversion, repositioning, etc.</p> <p>Review of Medication Administration Record (MAR) for the month of December 2023 revealed the resident was administered the following opioid medications: Tramadol- Schedule IV tablet 50 mg orally every 12 hours as needed for diagnosis of Pain 4-6/10 * Pain Scale 0-10/10 on December 1, 2, 6, and 8. Tramadol- Schedule IV tablet 50 mg orally once a day for diagnosis of chronic pain on December 10 and 11. Oxycodone - Schedule II tablet; 5 mg orally for Diagnosis of Pain 7-10/10 *Pain Scale 0-10/10 every 6 hours - PRN on December 3, 4, 5, 7, and 8; Oxycodone - Schedule II tablet; 5mg; amount: 5mg; oral Special Instructions: DX. Pain 4-10/10 * Pain Scale 0-10/10 every 6 hours -PRN on December 9, 12, 13 and 14.</p> <p>A review of the physician progress notes visit dates for December 2023 revealed on: December 9, 2023, states she is having pain from RA all over body pain. She has Pain Mgt at home who has prescribed oxy and tramadol. She would like to trial tramadol 50 mg every morning as she is aching after PT, continue oxy for BTP. December 10, 2023 indicates pain has improved with scheduled am dose of tramadol. December 11 patient states she is too drowsy on tramadol so will dc it and continue (home dose) oxy 5 mg q6hr prn for pain. December 12 adjusting meds secondary to drowsiness.</p> <p>A review of the nursing progress notes dated December 12, 2023 at 11:55 AM revealed Resident continues to experience Fatigue. This writer did communicate information to doctor and he saw her on December 12, 2023. New order received for a BMP and Magnesium Level in am. Resident informed she will be having labs drawn in am to monitor the chronic Fatigue.</p> <p>Further review of the clinical records revealed no evidence was found in the clinical record that the resident and/or representative was informed of the risk and benefits of this medication.</p> <p>An interview was conducted with a Registered Nurse (RN/staff # 23) on December 14, 2023 at 11:00 AM. Staff #23 stated that she assesses residents for pain, let them know to tell the certified nursing assistant (CNA) if they have pain, or give pain med before therapy, or during dressing changes. She further stated that still need consent for pain medications when resident is coming with for instance oxy medication. Staff #23 was unable to see or locate a pain consent from the electronic medical record of this resident. She stated that she will check with the charge nurse, Staff #24.</p> <p>An interview was conducted with clinical nurse manager (RN staff #24) on December 14, 2023 at 11:07 AM. Staff #24 stated, we do not do consent for pain for controlled medication. It is not part of our protocol. We do have a block box warning that nurses sign off for. The black box is in the orders and in the MAR. For pain medication controlled substances, controlled medications we track. No pain medication consent from residents.</p> <p>(continued on next page)</p>		

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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On December 14, 2023 at 11:12 AM, a follow up interview with Resident #4 was conducted. Resident #4 stated they did a test and has nothing to do with the medication. Resident #4 sitting in her wheelchair and stated going to have lunch.</p> <p>On December 14, 2023, at 1:23 PM, the Director of Nursing (DON/Staff #62) stated she does not have a resident consent policy for opioids. She stated that this is the first time she has heard of it and not aware of the consent. Staff #62 was made aware of Arizona Department of Health Services and Arizona Administrative Code R9-10-120.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47911</p> <p>Based on observations, review of records, maintenance log, policy review, as well as staff and resident interviews, the facility failed to provide a safe, clean, comfortable, home like environment for 3 out of 35 residents sampled and ensure that all areas in the facility are in good repair. The deficient practice could result in accidents and or impact resident health.</p> <p>Findings include:</p> <p>Resident #32 was admitted on [DATE] with diagnosis including a closed fracture with routine healing, osteoarthritis of the hip, spinal stenosis, unspecified dementia, peripheral vascular disease, type 2 diabetes, age related osteoporosis, fall and hairy cell leukemia in remission. A review of the 5-day MDS (minimum data set) dated November 3, 2023 revealed a BIMS (brief interview of mental status) score of 12, suggesting moderate cognitive impairment.</p> <p>An observation was conducted on December 12, 2023 at 10:42 AM. The resident was observed to be walking to the bathroom and reminded by the caregiver to use his wheelchair and to be careful. The hot water temperature was measured in the bathroom and revealed no significant findings; however, the hot water temperature in the resident's kitchenette area revealed a temperature of 124.3 degrees Fahrenheit. The caregiver stated that the resident has dementia but that there is a private caregiver with the resident 24 hours a day, 7 days a week.</p> <p>-----</p> <p>Resident #25 was admitted on [DATE] with diagnosis including joint replacement, generalized arthritis, acute kidney failure, protein-calorie malnutrition, atrial fibrillation, and long-term use of anticoagulants. A review of the 5-day MDS (minimum data set) dated November 30, 2023 revealed a BIMS (brief interview of mental status) score of 15, suggesting the resident is cognitively intact.</p> <p>An observation was conducted on December 12, 2023 at 10:50 AM. The hot water temperature in the resident's kitchenette area measured 125.2 degrees Fahrenheit.</p> <p>-----</p> <p>Resident #344 was admitted on [DATE] with diagnosis including encephalopathy, urinary tract infection, sepsis, acute kidney failure, unspecified dementia, hypertensive heart disease, atherosclerotic heart disease and muscle weakness. A record review revealed no current completed MDS (minimum data set) was available.</p> <p>An observation was conducted on December 12, 2023 at 10:34 AM. The hot water temperature in the resident's kitchenette sink measured 122 degrees Fahrenheit.</p> <p>-----</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An observation was conducted on December 12, 2023 at 10:34 AM. This room (rm 202) was designated as a vacant room at the time and measured 121 degrees Fahrenheit for the in the kitchenette sink.</p> <p>-----</p> <p>An interview was conducted with the administrator, staff #115 and the DON (director of nursing) staff #62 on December 12, 2023 at 12:12 PM, informing them of the kitchenette hot water observations in the resident rooms. The administrator stated that she was surprised as they have a mixer and stated that the hot water temperatures are checked daily. She stated that she would immediately call the maintenance person to address the issues and would then report back.</p> <p>A follow-up interview was conducted with the administrator, staff #115 on December 12, 2023 at 12:45 PM. The administrator stated that the maintenance manager did identify water temperatures in the resident rooms above 120 degrees Fahrenheit on the wing identified by the survey team. She stated that the maintenance director is adjusting the mixer and will recheck every single room temperature and will provide the temperature log.</p> <p>An additional interview was conducted with the DON (director of nursing), staff #62 on December 12, 2023 at 2:02 PM, who stated that she was reporting back that the maintenance manager had drained all of the hot water tanks and has let the hot water temperatures reset.</p> <p>An interview was conducted on December 12, 2023 at 2:53 PM, with the maintenance director, staff #114. Staff #114 stated that on December 8, 2023 the facility had a plumber come out to make some repairs which may have impacted the mixer. He stated that he would provide copies of the corresponding work order and receipts.</p> <p>A review of the plumbing receipt from Umbrella Plumbing revealed that an after-hours annual maintenance request of the commercial water heaters had taken place on Friday, December 8, 2023, which involved turning off the hot water supply and draining both tanks to eliminate the calcium build-up inside. It was noted that these were cleaned and debris was removed, and subsequently the water tanks were refilled and hot water temperatures were stated to have been adjusted to the requested range of 100 to 120 degrees Fahrenheit.</p> <p>A review of the facility submitted temperature recheck on December 12, 2023 post adjustments revealed that all temperatures on the 200 unit were in compliance ranging from 112 to 117 degrees Fahrenheit for the resident kitchenette sinks. This was confirmed by the survey team.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A follow-up interview was conducted with the maintenance director, staff #114 on December 13, 2023 at 7:34 AM. The maintenance director stated that he checks the water temperatures for both the bathrooms and kitchenette areas in each resident room weekly. He stated that in the past occasionally things may break down but that there have been no recent occurrences impacting water temperature. He further stated that when he was advised yesterday that the temperatures were outside of parameters, he only checked one room [ROOM NUMBER], which he stated measured 124 degrees Fahrenheit. He stated that when the plumbers came in last week and turned everything off after hours, when they turned the system back on there may have been some temperature fluctuations. He stated that these fluctuations could last 2-3 hours. He stated that to mitigate potential issues going forward, a different bypass would be utilized. The new bypass would not allow the water temperatures to exceed 120 degrees Fahrenheit. He stated that the new bypass would be installed today. Staff #114 stated that if temperatures exceed 120 degrees Fahrenheit, it does not meet his expectations and the risk to the residents could include burns.</p> <p>An interview was conducted on December 13, 2023 at 9:14 A.M. with the administrator, staff #115. Staff #115 stated that the maintenance director checks the temperatures every week and that they meet 'sporadically' to review the logs, but least quarterly and as needed. She stated that her expectation is that that temperatures are checked weekly and that the hot water is maintained between 100 and 120 degrees Fahrenheit. She stated if the temperatures exceeds 120 degrees Fahrenheit, it would not meet her expectations. She stated that the risk to the resident would be that they could burn their hands.</p> <p>A final interview was conducted with the maintenance director, staff #114 on December 13, 2023 at 9:53 AM. Staff #114 provided the actual T-valve taken from the unit for review and stated that the observed build-up in the valve could have caused narrowing of the pipes and improper mixing of water temperatures. He further stated that the facility had done everything they can to ensure the proper operation of the pipes and mixer.</p> <p>A review of the water temperature policy dated July 25, 2023 revealed that hot water temperature in resident areas will be between 110-120 degrees Fahrenheit; however, per observation, several kitchenette sinks in the resident rooms exceeded the hot water temperature of 120 degrees Fahrenheit during the survey.</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>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** 48814</b></p> <p>Based on closed clinical record review, staff interviews, and facility policy review, the facility failed to ensure medications were administer as ordered by the physician for one resident (#195). The deficient practice could result in adverse effects to the residents.</p> <p>Findings include:</p> <p>Resident #195 was admitted on [DATE] with a diagnosis of Wedge compression fracture of T11-T12 vertebra, Chronic atrial fibrillation, Depression, Long term (current) use of anticoagulants, and Chest pain.</p> <p>A review of the current active physician orders revealed the following orders for: Duloxetine capsule, 20mg; oral for Depression (order date of [DATE] Twice A Day 07:00 -09:00, 19:00 -21:00); Eliquis (apixaban) tablet, 5mg; oral for Anticoagulant (order date of [DATE] Twice A Day 07:00 - 09:00, 19:00 -21:00); Escitalopram oxalate tablet, 10mg; oral for Depression (order date of [DATE] Once A Day 07:00 - 09:00); Pantoprazole tablet, 40mg; oral for GERD (order date of [DATE] At Bedtime, 19:00 -21:00).</p> <p>These orders were transcribed onto the MAR (Medication Administration Record) and the TAR (Treatment Administration Record) for [DATE].</p> <p>Review of the MAR and TAR for [DATE] revealed that Duloxetine capsule, Eliquis (apixaban) tablet, Escitalopram oxalate tablet, and Pantoprazole tablet were administered late from half an hour to an hour on [DATE] and 10 ,2023.</p> <p>Further review of the clinical record revealed no documentation of reason why these medications were not administered as ordered.</p> <p>An interview was conducted with resident (#195) on [DATE] at 9:49 AM. The resident stated that her medications were delayed by an hour to two hours at night and when she notified to Licensed Practical Nurse (LPN, staff #75), staff #75 stated that she got lots of patient and it takes her longer.</p> <p>An interview was conducted with resident (#195) again on [DATE] at 9:25 AM. The resident stated that LPN (staff #75), missed pills of Eliquis (apixaban) tablet and when she notified staff #75 then it was remedied .</p> <p>A phone interview was conducted with LPN (staff #75) on [DATE] at 9:46 AM. The staff (#75) stated about late medication administration that she is new to facility and tries to do things quickly but wants to be safe and sometime resident has emergency. She further stated about risk associated with late medication administration that it is unavoidable and she is not aware of whether any medications are of high risk.</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>An interview was conducted with Director of Nursing (DON, staff #62) on [DATE] at 10:19 AM. The staff (#62) stated about late medication administration that it is appropriate to give medication late, depend on situation. She further stated about risk associated with late medication that you need to be specific and not general. When pulled the resident (#195) clinical record of MAR and TAR and asked DON about whether it is acceptable to administer medication late and risks associated with it then DON stated that nurse prioritize medication and prioritize patients.</p> <p>Review of the facility policies and procedure regarding Administration of Medication revealed 6 medication administration rights: right patient, right drug, right dose, right dosage form, right route and right time.</p>		