STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035114	A. Building B. Wing	08/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Manor	1045 Sandretto Drive Prescott, AZ 86305

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22366 Based on clinical record reviews, staff interviews, facility documentation and policies and procedures, the facility failed to ensure that one resident (#38) was free from physical abuse by two residents (#7 and #24) and that one resident (#18) was free from abuse by resident (#38). The facility census was 50. The deficient practice could result in further incidents of resident-to-resident physicial abuse. Findings include: -Resident #7 was admitted to the facility on [DATE], with diagnoses that included other mental disorders due to known physiological condition and Alzheimer's disease. Review of a care plan dated November 20, 2018 revealed the resident has a history of anxiety, Alzheimer's and dementia with at times poor comprehension of directives secondary to advancing disease process, feeling of owning space within the facility related to length of stay and becoming upset with others use of said space. The resident fails to verbally communicate her feelings and will show them externally by shaking her walker. Risk for decline secondary to advancing disease process. A goal included that the resident will be able to express her ideas or wants. Approaches were to allow the resident plenty of time to respond as needed, provide a quiet environment when discussing important issues and the resident understands simple, direct communication best. A quarterly MDS assessment dated [DATE] revealed the resident had short and long term memory problems and was severely impaired with cognitive skills for daily decision making. -Resident #38 was admitted to the facility on [DATE], with diagnoses that included unspecified dementia without behavioral disturbance and chronic kidney disease. A care plan dated April 26, 2019 documented the resident has a history of wandering throughout the facility and placing herself in unsafe situations. Diagnosis of dementia with short and long term memory loss, poor safety awareness. A goal was I will not wander into unsafe situations. Approaches included Place me in area where frequent observation is possible. Alert staff to my wandering behavior. Provide diversional activities for me. Approach me positively and in calm, accepting manner. Record and report changes to MD (medical doctor) and family as needed. (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the quarterly MDS (Minimum Data Set) assessment dated [DATE], revealed the resident had short and long term memory problems and was severely impaired with cognitive skills for daily decision making. Review of the nurse's notes for resident #38 dated April 19, 2019 at 9:00 a.m. revealed the following: Heard patient (resident #38) state 'she hit me she hit me hard.' Ran to see another peer (resident #7) with her hands in the air . Resident #7 was immediately removed. No injuries were noted. The resident had two levels of long sleeves on. An Incident/Accident Report dated April 19, 2019 included that resident #38 was heard saying She hit me she hit me hard. A CNA observed (resident #7) attempting to hit her again and they were immediately separated. A facility Reportable Event Record/Report revealed that on April 19, 2019, resident (#7) hit resident (#38) while they were sitting in the 100/200 hall common area watching TV. Apparently resident #38 was too close to the recliner that resident #7 was sitting in and she hit resident #38. No injury was noted. Interventions implemented after the incident included the two residents were immediately separated and resident #7 was placed on 30 minute checks for 72 hours without further incident. As the resident's shared a room, resident #38 was moved to a room on a separate hall to maintain distance between them. A second recliner was placed approximately a foot and a half from the recliner that resident #7usually sits in, so that a permanent chair is a safe distance from her recliner, and no one in a wheelchair will be placed too close to her recliner to avoid any further potential incident. Further review of the nurses notes for resident #38 dated June 9, 2019 at 9:30 a.m. revealed Patient (#38) observed to hit a female resident (#18) open handed on the forehead. No injury . Review of an Incident/Accident Report dated June 9, 2019 revealed CNA's reported this client (#38) struck another female (#18) with her open hand in the forehead. Patients immediately separated. Core staff informed. Keep space between them. -Resident #18 was admitted to the facility on [DATE], with diagnoses that included cerebrovascular disease and aphasia. A review of the quarterly MDS assessment dated [DATE], revealed a Brief Interview for Mental Status score of 12, which indicated the resident had moderate cognitive impairment. Review of a care plan dated May 31, 2019 documented the resident exhibits social isolation as evidenced by spending most of her day in her room. Another care plan dated May 31, 2019 included the resident has potential for communication difficulty related to expressive aphasia and dysarthria. -Resident #24 was admitted to the facility on [DATE], with diagnoses that included unspecified dementia without behavioral disturbance and sleep disorder. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a care plan dated April 25, 2019 revealed the resident has a potential to wander into unsafe situations related to history of dementia with short and long term memory loss and fails to realize her safety need as evidenced by elopement. A goal was I will not wander into unsafe situations. Approaches were place in area where frequent observation is possible, provide diversional activities for me as needed, approach me positively and in a calm, accepting manner, nurses/CNA (certified nursing assistant) to account for my whereabouts throughout the day, 30 minute visual checks and to monitor and document my behavior and wandering and record and report changes to MD. A quarterly MDS assessment dated [DATE] revealed the resident had short and long term memory problems and was severely impaired with cognitive skills for daily decision making. Review of the nurse's notes for resident #24 dated July 28, 2019 at 12:00 p.m. revealed Patient (#24) wandering halls per usual. Walked past 100/200 TV area. Hit a female (resident #38) of 200 hall in the head/shoulder. Did make some contact. No injury noted. Patient (#38) kept in observation area. Other female (resident #24) returned to her side of the building. Her nurse informed. An Incident/Accident Report dated July 28, 2019 included a resident (#24) was walking by resident #38 and reached out and hit resident #38 in the head and shoulder. No injury occurred. An interview was conducted with a CNA (staff #24) on August 7, 2019 at 8:12 a.m. Staff #24 stated that resident #24 was on 15 minute checks by staff to monitor where she is so that she does not bother the other residents. An interview was conducted with a licensed practical nurse (LPN/staff #52) on August 7, 2019 at 8:58 a.m. Staff #52 stated that resident #38 talks a lot because of her dementia and says I love you, I love you frequently. Staff #52 stated that probably bothered resident #7 and that's why she hit resident #38. Staff #52 stated that resident #7 is very territorial and they try to keep other residents at least 18 inches away from her. Staff #52 further stated that the TV room was monitored very closely to prevent resident to resident altercations. An interview was conducted with a CNA (staff #44) on August 7, 2019 at 9:13 a.m. Staff #44 stated that resident #7 was very territorial and did not like others in her space. Staff #44 stated they try not to have anyone in arm's reach of resident #7. Staff #44 further stated that resident #7 gets mad when someone is in her space and will shake her walker or swat out at them. An interview was conducted with the Director of Nursing (DON/staff #28) on August 7, 2019 at 11:00 a.m. Staff #28 stated the residents with behaviors were monitored closely by staff. Staff #28 stated that staff get to know the residents and how close they can be to other residents. Staff #28 further stated that residents are involved in activities to prevent resident to resident altercations. Review of the Abuse Prevention Program policy dated April 2019 revealed the facility had zero tolerance of physical, verbal and mental .abuse by .other residents. The facility will assure that all residents and staff understand that there is zero tolerance of abuse by any person known or unknown to the resident. An objective included to develop and implement a system for preventing, identifying, reporting and investigating any incident or suspected incident of abuse, neglect or misappropriation of resident property. The policy further included The facility will have a system in place to prevent abuse.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22366 Based on clinical record reviews, staff interviews, facility documentation and policies and procedures, the facility failed to implement their abuse policy, by failing to thoroughly investigate two incidents of resident-to-resident physical abuse involving three resident's (#'s 18, 24 and 38), and by failing to report these incidents to the State Survey Agency. The deficient practice could result in further incidents of resident-to resident abuse. Findings include: -Resident #18 was admitted to the facility on [DATE], with diagnoses that included cerebrovascular disease and aphasia. A review of the quarterly MDS assessment dated [DATE], revealed a Brief Interview for Mental Status score of 12, which indicated the resident had moderate cognitive impairment. Review of a care plan dated May 31, 2019 documented the resident exhibits social isolation as evidenced by spending most of her day in her room. Another care plan dated May 31, 2019 included the resident has potential for communication difficulty related to expressive aphasia and dysarthria. -Resident #38 was admitted to the facility on [DATE], with diagnoses that included unspecified dementia without behavioral disturbance and chronic kidney disease. A care plan dated April 26, 2019 documented the resident has a history of wandering throughout the facility and placing herself in unsafe situations. Diagnosis of dementia with short and long term memory loss, poor safety awareness. A goal was I will not wander into unsafe situations. Approaches included Place me in area where frequent observation is possible. Alert staff to my wandering behavior. Provide diversional activities for me. Approach me positively and in calm, accepting manner. Record and report changes to MD (medical doctor) and family as needed. Review of the quarterly MDS (Minimum Data Set) assessment dated [DATE], revealed the resident had short and long term memory problems and was severely impaired with cognitive skills for daily decision making. Review of the nurses notes for resident #38 dated June 9, 2019 at 9:30 a.m. revealed Patient (#38) observed to hit a female resident (#18) open handed on the forehead. No injury . Review of an Incident/Accident Report dated June 9, 2019 revealed CNA's reported this client (#38) struck another female (#18) with her open hand in the forehead. Patients immediately separated. Core staff informed. Keep space between them. Further review of the facility's documentation revealed no evidence that this incident of resident-to-resident abuse was reported to the State Survey Agency, or that the incident was thoroughly investigated. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident #24 was admitted to the facility on [DATE], with diagnoses that included unspecified dementia without behavioral disturbance and sleep disorder. Review of a care plan dated April 25, 2019 revealed the resident has a potential to wander into unsafe situations related to history of dementia with short and long term memory loss and fails to realize her safety need as evidenced by elopement. A goal was I will not wander into unsafe situations. Approaches were place in area where frequent observation is possible, provide diversional activities for me as needed, approach me positively and in a calm, accepting manner, nurses/CNA (certified nursing assistant) to account for my whereabouts throughout the day, 30 minute visual checks and to monitor and document my behavior and wandering and record and report changes to MD. A quarterly MDS assessment dated [DATE] revealed the resident had short and long term memory problems and was severely impaired with cognitive skills for daily decision making. Review of the nurse's notes for resident #24 dated July 28, 2019 at 12:00 p.m. revealed Patient (#24) wandering halls per usual. Walked past 100/200 TV area. Hit a female (resident #38) of 200 hall in the head/shoulder. Did make some contact. No injury noted. Patient (#38) kept in observation area. Other female (resident #24) returned to her side of the building. Her nurse informed. An Incident/Accident Report dated July 28, 2019 included a resident (#24) was walking by resident #38 and reached out and hit resident #38 in the head and shoulder. No injury occurred. Further review of the facility's documentation revealed no evidence that this incident of resident-to-resident abuse was reported to the State Survey Agency, or that the incident was thoroughly investigated. An interview was conducted with the Director of Nursing (DON/staff #28) on August 6, 2019 at 11:25 a.m. Staff #28 stated that the incidents that occurred on June 9, 2019 and July 28, 2019 were not reported to the State Survey Agency, because she had just been to a training and thought that if no injury or red marks occurred, the resident-to-resident incidents of physical abuse were not reportable to the State Survey Agency. An interview was conducted with the Administrator (staff #14) on August 7, 2019 at 11:00 a.m. Staff #14 stated the two incidents were not reported and investigated, because they were considered a behavioral incident and not an abuse situation. Review of the Abuse Prevention Program policy dated April 2019 revealed to develop and implement a system for preventing, identifying, reporting and investigating any incident or suspected incident of abuse, neglect or misappropriation of resident property. The policy included that events such as slapping, hitting, pinching, yelling at, cursing, threatening . should be reported to the State Survey Agency. The Administrator or Director of Nursing Services shall report allegations to the State Survey Agency immediately, but not later than 2 hours after the allegation is made. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regarding the investigation of possible abuse, neglect, mistreatment or misappropriation of property, the policy included the following: .If an incident occurs, or there is any allegation that an incident might have occurred, of abuse, neglect, mistreatment, exploitation or misappropriation of resident property, the Administrator, or designee, will investigate . The person doing the investigation will complete an initial report with the State Survey Agency. The Administrator will maintain all completed abuse/neglect investigation reports and investigation materials, and that the findings shall be reported to the State Survey Agency, within 5 days of the initial report.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22366 Based on clinical record reviews, staff interviews, facility documentation and review of policies and procedures, the facility failed to report two incidents of resident-to-resident physical abuse involving three resident's (#'s 18, 24 and 38) to the State Survey Agency. The deficient practice could result in further incidents of resident-to-resident abuse not being reported to the State Survey Agency. Findings include: -Resident #18 was admitted to the facility on [DATE], with diagnoses that included cerebrovascular disease and aphasia. A review of the quarterly MDS assessment dated [DATE], revealed a Brief Interview for Mental Status score of 12, which indicated the resident had moderate cognitive impairment. Review of a care plan dated May 31, 2019 documented the resident exhibits social isolation as evidenced by spending most of her day in her room. Another care plan dated May 31, 2019 included the resident has potential for communication difficulty related to expressive aphasia and dysarthria. -Resident #38 was admitted to the facility on [DATE], with diagnoses that included unspecified dementia without behavioral disturbance and chronic kidney disease. A care plan dated April 26, 2019 documented the resident has a history of wandering throughout the facility and placing herself in unsafe situations. Diagnosis of dementia with short and long term memory loss, poor safety awareness. A goal was I will not wander into unsafe situations. Approaches included Place me in area where frequent observation is possible. Alert staff to my wandering behavior. Provide diversional activities for me. Approach me positively and in calm, accepting manner. Record and report changes to MD (medical doctor) and family as needed. Review of the quarterly MDS (Minimum Data Set) assessment dated [DATE], revealed the resident had short and long term memory problems and was severely impaired with cognitive skills for daily decision making. Review of the nurses notes for resident #38 dated June 9, 2019 at 9:30 a.m. revealed Patient (#38) observed to hit a female resident (#18) open handed on the forehead. No injury . Review of an Incident/Accident Report dated June 9, 2019 revealed CNA's reported this client (#38) struck another female (#18) with her open hand in the forehead. Patients immediately separated. Core staff informed. Keep space between them. Further review of the facility's documentation revealed no evidence that this incident of resident-to-resident abuse was reported to the State Survey Agency. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident #24 was admitted to the facility on [DATE], with diagnoses that included unspecified dementia without behavioral disturbance and sleep disorder. Review of a care plan dated April 25, 2019 revealed the resident has a potential to wander into unsafe situations related to history of dementia with short and long term memory loss and fails to realize her safety need as evidenced by elopement. A goal was I will not wander into unsafe situations. Approaches were place in area where frequent observation is possible, provide diversional activities for me as needed, approach me positively and in a calm, accepting manner, nurses/CNA (certified nursing assistant) to account for my whereabouts throughout the day, 30 minute visual checks and to monitor and document my behavior and wandering and record and report changes to MD. A quarterly MDS assessment dated [DATE] revealed the resident had short and long term memory problems and was severely impaired with cognitive skills for daily decision making. Review of the nurse's notes for resident #24 dated July 28, 2019 at 12:00 p.m. revealed Patient (#24) wandering halls per usual. Walked past 100/200 TV area. Hit a female (resident #38) of 200 hall in the head/shoulder. Did make some contact. No injury noted. Patient (#38) kept in observation area. Other female (resident #24) returned to her side of the building. Her nurse informed. An Incident/Accident Report dated July 28, 2019 included a resident (#24) was walking by resident #38 and reached out and hit resident #38 in the head and shoulder. No injury occurred. Further review of the facility's documentation revealed no evidence that this incident of resident-to-resident abuse was reported to the State Survey Agency. An interview was conducted with a licensed practical nurse (LPN/staff #52) on August 6, 2019 at 8:47 a.m. Staff #52 stated that if resident-to-resident abuse should occur, she always notifies the Director of Nursing (DON) and Administrator (staff #14) immediately. An interview was conducted with a registered nurse (RN/staff #37) on August 6, 2019 at 10:03 a.m. Staff #37 stated that she reports resident-to-resident abuse to the DON and Administrator immediately. Staff #37 further stated the DON and the Administrator then report the incidents to the State Survey Agency as required. An interview was conducted with the DON (staff #28) on August 6, 2019 at 10:06 a.m. Staff #28 stated that staff are informed that they need to report resident-to-resident abuse incidents to her or the Administrator immediately, because of the 2 hour window for reporting the incident to the State Survey Agency. Another interview was conducted with the DON (staff #28) on August 6, 2019 at 11:25 a.m. Staff #28 stated the incidents which occurred on June 9, 2019 and July 28, 2019 were not reported to the State Survey Agency, because she had just been to a training and she thought that if no injury or red marks occurred, then resident-to-resident incidents of physical abuse were not reportable to the State Survey Agency. An interview was conducted with the Administrator on August 7, 2019 at 11:00 a.m. Staff #14 stated that incidents of resident-to-resident abuse are reported to him immediately, so he can report the incidents to the State Survey agency within the required time frame of two hours. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Abuse Prevention Program policy dated April 2019 revealed to develop and implement a system for preventing, identifying, reporting and investigating any incident or suspected incident of abuse, neglect or misappropriation of resident property. The policy included that events such as slapping, hitting, pinching, yelling at, cursing, threatening . should be reported to the State Survey Agency. The Administrator or Director of Nursing Services shall report allegations to the State Survey Agency immediately, but not later than 2 hours after the allegation is made.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35111 Based on clinical record review, staff interviews, and the RAI (Resident Assessment Instrument) manual, the facility failed to ensure a Death in the Facility Tracking Record was encoded and transmitted within the required timeframe for one sampled resident (#1). The deficient practice could result in resident specific information for payment and quality measure purposes not being provided. Findings include: Resident #1 was admitted on [DATE], with diagnoses of chronic ischemic heart disease and unspecified atrial fibrillation. Review of the clinical record revealed a nursing progress note dated March 5, 2019 that the resident had passed away. The note included hospice and the family were notified. Further review of the clinical record did not reveal a Death in the Facility Tracking Record had been encoded and transmitted. An interview was conducted with the MDS (Minimum Data Set) Coordinator (staff #29) on August 7, 2019 at 2:29 p.m. The MDS Coordinator stated that the death tracking record is completed within 24 hours of a resident's death but that she has 7 days to complete the tracking record. She stated the transmission of MDS assessments including death tracking records are once a week but that she has 14 after completion of assessments and tracking records to transmit. After reviewing resident #1 clinical record, the MDS Coordinator stated that there was no death tracking record for resident #1. She stated that the death tracking record was missed. Review of the RAI manual revealed the Death in Facility Tracking Record must be completed within 7 calendar days after the resident's death and transmitted no later than 14 calendar days after the death date.

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22366 Based on personnel record reviews and staff interviews, the facility failed to ensure that four (#'s 13, 27, 32, and 37) of six sampled nursing staff had evidence of CPR (Cardiopulmonary Resuscitation) training, and failed to develop a policy regarding CPR to include CPR training for nursing staff. The deficient practice could result in untrained staff in CPR. Findings include: -Review of the personnel record for a Certified Nursing Assistant (CNA/staff #13), revealed a hire date of [DATE]. Further review of staff #13's personnel record revealed no evidence of CPR training. -Review of the personnel record for a Registered Nurse (RN/staff #27), revealed a hire date of [DATE]. Further review of staff #27's personnel file revealed no evidence of CPR training. -Review of the personnel record for a Licensed Practical Nurse (LPN/staff #32), revealed a hire date of [DATE]. Further review of staff #32's personnel record revealed no evidence of CPR training. -Review of the personnel record for a RN (staff #37), revealed a hire date of [DATE]. Further review of staff #37's personnel record revealed no evidence of CPR training. An interview was conducted with the Human Resources Director (staff #49) on [DATE] at 12:30 p.m. Staff #49 stated that she would have to check to see which staff are required by the facility to have CPR training. An interview was conducted with the Administrator (staff #14) on [DATE] at 12:50 p.m. Staff #14 stated that the facility did not have a requirement as to which staff were required to be trained in CPR. Staff #14 stated that next week the facility was providing certified CPR training for all RNs, LPNs, and CNAs. The Administrator further stated that the facility did not have a policy regarding CPR training for staff.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35111 Based on clinical record review, staff interviews and policy and procedures, the facility failed to ensure that care and services were provided to prevent the worsening of pressure sores for one resident (#17). The deficient practices resulted in pressure ulcers not being thoroughly assessed and monitored, delays in treatment and worsening of pressure ulcers. Findings include: Resident #17 was admitted to the facility on [DATE], with diagnoses of pressure ulcers of the sacral region and pressure ulcers to the right and left heel, with an unspecified stage. Review of the clinical record revealed the resident was receiving hospice services. Regarding the pressure ulcer to the right heel: According to an untitled and undated transfer note, the resident had blisters on the right heel, which was protected with an ace bandage. The admission nursing evaluation dated May 15, 2019 included the resident was admitted on hospice services. The evaluation included the resident had stage 2 pressure ulcers to both heels and that treatment orders were received. The evaluation did not include any further description of the right heel. A hospice nurse start of care visit note May 15, 2019 included the resident was alert and oriented to place and was forgetful. It also included a Braden Risk Assessment, which identified that the resident was at moderate risk for pressure ulcer development. The note did not include any documentation regarding a right heel stage 2 pressure ulcer. Review of the admission physician orders revealed for weekly skin checks and for heel protectors while in bed. The orders did not include for any treatment for the right heel. Hospice physician orders dated May 15, 2019 included for heel protectors while in bed. The orders did not include any treatment for the right heel. According to an initial Individual Resident Care Plan dated May 19, 2019, the resident had actual alteration in skin integrity. The documentation included the resident had wounds to both heels. The goal was that the resident would show improvement in skin areas. Interventions included for skin assessments every week and as needed, assist to reposition resident when in bed and chair, treat per physician's order, measure open area weekly and document, and refer to wound consultant as needed. Review of the May 2019 TAR (treatment administration record) revealed the orders for heel protectors to be on while in bed. However, there was no documentation this was done from May 16 through 20, on the 6:00 a. m. to 2:00 p.m. shift. (continued on next page)

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	035114	A. Building B. Wing	08/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Manor	1045 Sandretto Drive Prescott, AZ 86305

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F 0686 Level of Harm - Actual harm Residents Affected - Few	An admission MDS (Minimum Data Set) assessment dated [DATE] included the resident had short and long term memory problems, had moderate cognitive impairment with daily decision making skills and required extensive assistance with Activities of Daily Living. Per the MDS, the resident was also assessed to have three unhealed pressure ulcers, which included a pressure ulcer to the right heel, unspecified stage. A hospice nurse supervisory visit note dated May 25, 2019 revealed under integumentary assessment that the resident had wounds. However, the documentation did not include the type of wounds, location, number and a description of the wounds. There was no mention that the resident had a pressure ulcer to the right heel. An initial dietary review dated May 27, 2019 included the resident had stage 2 pressure injuries to bilateral heels. Further review of the hospice visit notes dated May 16, 17, 21, 23, 24, 25, 27, 28 and 29, 2019, revealed documentation that the resident had wounds. However, the notes did not include any documentation regarding a right heel pressure ulcer. Review of the Daily Skilled Nurse's notes from May 16 through 31, 2019 included the resident had pressure ulcer on the heels. However, the documentation did not include a description of the heel wounds, staging or any measurements. Despite documentation upon admission that the resident had blisters/stage 2 pressure ulcer to the right heel, there were no physician orders for any treatment, and there was no evidence that a thorough assessment of the right heel pressure ulcer was done upon admission through May 31, 2019, which included a description of the wound bed and surrounding skin, measurements and if any drainage was present. Daily skilled nurse's notes from June 1 through June 5, 2019 included documentation that the resident had pressure ulcers on the heels. However, the documentation did not reflect a description of the right heel wound, staging or any measurements. A hospice nurse visit note dated June 5, 2019 included the resident had wounds. However, the documentation did not include the resident had a pressure ulcer to the right heel. A pressure ulcer care plan dated June 5, 2019 revealed the resident had multiple stage 2 pressure injuries, including a stage 2 pressure ulcer to the right heel. Interventions included floating the heels, use of heel protectors, reposition every 2 hours, pressure reducing mattress, wound care as directed and as needed and report changes to doctor as needed. Continue review of the clinical record revealed no physician orders for any treatment to the right heel pressure ulcer, nor was there documentation that a thorough assessment of the pressure ulcer was completed from June 1 through 5, which included a description of the wound bed and surrounding skin, measurements and if any drainage was present. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Hospice physician orders dated June 7, 2019 now included to cleanse the right heel wound with wound cleanser, pat dry, leave open to air and to float heels. The orders also included for the hospice nurse to assess the wound every nurse visit, and for the facility nurse to do daily checks and notify hospice for wound changes, increase in size, pain, swelling, redness, bleeding, drainage or foul odor. The diagnosis was an unstageable SDTI (suspected deep tissue injury) to the right heel. Despite wound care orders for a SDTI to the right heel, there was no documentation that a thorough assessment of the right heel had been done from June 7 through 10, 2019, which included a description of the wound bed and surrounding skin and any measurements. A hospice visit note dated June 11, 2019 now included the resident had an unstageable deep tissue injury (DTI) to the right mid-heel with an onset date of June 7, 2019. The pressure ulcer measured 2.4 cm (centimeters) x 2.3 cm, with intact granulation tissue, 100% epithelialization and 0-25% necrotic tissue with slough/eschar, with indistinct edges and no odor or exudate was present. The note included that wound care was provided. A hospice visit note dated June 13, 2019 included an unstageable DTI to the right mid-heel, with intact granulation tissue, indistinct edges, 100% epithelialization, and 0-25% necrotic tissue slough/eschar, with no odor or exudate. The note also included that wound care was provided. A hospice visit note dated June 14, 2019 included the fluid filled blister to the right heel had subsided, with a black discoloration on the edge. The right heel was described as an unstageable DTI with 0-25% necrotic tissue/slough/eschar and 100% epithelialization. No measurements were documented. The note further included that the order for the right heel was not on the treatment record. Review of a hospice visit note dated June 18, 2019 revealed documentation that the right heel unstageable SDTI was assessed, however, there were no measurements or any description of the wound bed. Review of the June 2019 TAR revealed the physician ordered wound treatment to the right heel from June 7, was not initiated until June 20. There was no documentation that wound care was provided to the right heal from June 7 through 19. Additional hospice visits notes dated June 20, 21, 24, 26 and 28, 2019 did not include any documentation regarding the right heel unstageable pressure ulcer. Review of the physician order recapitulation for July 2019 revealed the following treatment orders: cleanse the wound on the right heel with wound cleanser, pat dry, leave open to air and to float heels. The orders also included for the hospice nurse to assess the wound every nurse visit, and for the facility nurse to do daily checks and notify hospice for wound changes, increase in size, pain, swelling, redness, bleeding, drainage or foul odor. The diagnosis was an unstageable SDTI to the right heel. According to the July 2019 TAR, the above orders were included. However, on July 25, 29 and 30, there was no documentation that the treatment was provided. Review of the hospice notes for July 1, 3, 5, 8, 11, 16, 19, 23 and 30, 2019 revealed no documentation regarding the right heel pressure ulcer. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Further review of the clinical record revealed there was no documentation that a thorough assessment of the right heel pressure ulcer had been completed at least weekly, which included a description of the wound bed and surrounding skin, any measurements and if any drainage was present, since June 11 and 13, 2019, when the pressure ulcer was described as having 0-25% necrotic tissue slough/eschar. During a wound observation conducted with a registered nurse (staff #37) on August 6, 2019 at 12:55 p.m., the resident's right heel was observed and no open areas were noted. Staff #37 stated the resident has no open wounds. She said the hospice nurse does the treatments, but the facility nurse can do dressing changes on an as needed basis. She described the wound to the right heel as closed, with blanchable areas. Regarding the pressure ulcer to the right posterior ear: A physician's order dated May 15, 2019 included for oxygen 2-5 liters per minute continuously via nasal cannula. A nursing note dated June 11, 2019 included that a message was left with hospice related to a report made by a CNA (certified nursing assistant) that there was an odor present during resident care. The location of the odor was not documented. The hospice visit note dated June 11, 2019 revealed that a new abrasion was noted above the resident's right ear and that the oxygen tubing cannot sit above the ear, as it causes pain. The note included that foam was ordered for the oxygen tubing. The note did not incude a description of the wound or any measurements. Despite documentation that foam was ordered for the oxygen tubing, there was no physician's order for this and there were no orders for any treatment to the right ear on June 11, 2019. The hospice visit notes dated June 13, 14 and 18, 2019 did not include the resident had a wound to the right ear. A nurse's note dated June 19, 2019 included that a CNA reported finding 2 new wounds on the resident's ear. Per the documentation, treatment was provided and hospice was notified. The note did not include a description of the 2 wounds, nor were there any measurements. Further review of the physician orders revealed there were no treatment orders for the right ear pressure ulcers from June 11-18, 2019. A physician's order dated June 19, 2019 now included to cleanse the right posterior ear wound with normal saline or wound cleanser, apply antibiotic ointment twice daily and as needed for two weeks and then re-evaluate. A care plan dated June 19, 2019 included the resident had impaired skin integrity, with two pressure ulcers to the right posterior ear. The goal was for the wounds to heal within 2 weeks. Interventions included treatment as ordered and to measure and record weekly. The hospice visit note dated June 20, 2019 revealed no documentation regarding the right ear wound. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the June 2019 TAR revealed the wound care order for the right posterior ear. However, there was no documentation that the wound treatment was provided on June 22, 26, 27, 29 and 30, on the second shift. The July 2019 TAR also included the orders for the right ear wound, however, it was not marked as administered on July 1. Review of the hospice notes dated July 1, 3, 5, 8, 11, 16, 19, 23 and 30, 2019, revealed no documentation regarding the right ear pressure ulcer. Continued review of the clinical record revealed no evidence that the pressure ulcers to the right posterior ear were thoroughly assessed from June 11 through July 31, 2019., which included a description of the wound beds and surrounding skin, staging of the wounds and if any drainage was present. During a wound observation conducted with a registered nurse (staff #37) on August 6, 2019 at 12:55 p.m., the resident had a scabbed area, which reached behind the ear and under the right ear lobe, and was approximately 2 cm in length. Regarding the sacral/coccyx area: Review of the untitled and undated transfer note revealed the resident had a healing stage 2 pressure ulcer to the coccyx. The hospice physician orders dated May 15, 2019 included for the application of zinc to the stage 2 pressure ulcer to the coccyx with each brief change. The admission nursing evaluation dated May 15, 2019 included the resident was admitted on hospice and had a stage 2 pressure ulcer to the coccyx. The evaluation did not include a description of the wound bed and surrounding skin, any measurements, if any tunneling/undermining were present and if there was any drainage. It also included that treatment orders were received. A hospice nurse start of care visit note May 15, 2019 included the resident was alert and oriented to place and was forgetful. The note included that a Braden Risk assessment indicated the resident was at moderate risk for developing pressure ulcers. Under the integumentary assessment, the resident was noted to be bedbound, but was able to adjust slightly in bed. It also included the resident had a stage 2 pressure injury to the coccyx and that zinc ointment was applied. However, the documentation did not include a description of the wound bed and surrounding skin, any measurements or if any drainage was present. Review of the physician order recapitulation for May 2019 included to apply zinc with each brief change to the stage 2 pressure ulcer on the coccyx and for weekly skin checks. This order was transcribed onto the May 2019 TAR and showed that the treatment was not marked as administered on May 16 and 19, on the 6:00 a.m. to 2:00 p.m. shift. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The Individual Resident Care Plan dated May 19, 2019 included the resident had actual alteration in skin integrity, as the resident had a wound to the coccyx, which was present prior to admission. Interventions included treatment per physician's order, skin assessment every week and as needed and measuring/documenting open area weekly. The admission MDS assessment dated [DATE] included the resident had a pressure ulcer to the sacral region, unspecified stage. Review of the hospice visit notes dated May 21 and 23, 2019 revealed documentation that the resident's skin was assessed, however, there was no assessment documentation regarding the coccyx pressure ulcer, which included measurements, a description of the wound bed and surrounding skin and if any drainage was present. The daily skilled nurse's notes from May 16 through May 24, 2019 also documented the resident had a pressure ulcer to the coccyx. However, the documentation did not include a thorough assessment of the wound. A hospice visit note dated May 25, 2019 revealed the resident was lethargic, bedbound and had wounds. However, the assessment did not include any description of the coccyx pressure ulcer or any measurements. A hospice visit note dated May 26, 2019 revealed the resident was alert and oriented to person, forgetful, had pale skin with poor turgor and had wounds. The note included the resident had a stage 2 pressure ulcer to the coccyx, with an onset date of May 26, 2019. However, previous documentation showed that the coccyx pressure ulcer was identified on admission. Per the note, measurements were unable to be taken, but no explanation was given. The wound bed was described as having intact granulation tissue, distinct edges with 75-<100% epithelialization and had 0-25% total necrotic tissue slough/eschar present. This is the first assessment documentation of the coccyx wound bed, since it was identified upon admission. This hospice visit note also stated that wound care was ordered and included the following treatment: wound cleanser, pat dry with 4 x 4 and cover with foam dressing, which was to be removed every 3 days and as needed. The wound care was to be done by facility staff or the hospice nurse. Review of a hospice physician's order dated May 26, 2019 revealed to cleanse the coccyx area with soap and water or wound cleanser, pat dry with 4 x 4, cover with foam dressing every 3 days or as needed by facility or hospice nurse. The orders also included to monitor for increase in redness or drainage. According to the May 2019 TAR, this order was not transcribed onto the TAR. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A hospice visit note dated May 31, 2019 included a stage 2 pressure ulcer to the coccyx, which measured 8 cm x 6 cm. This is the first documentation of the measurements of the coccyx pressure ulcer. The note further included the coccyx wound bed had <75 and >25% of granulation tissue, 50-<75% epithelialization and had necrotic tissue slough/eschar of 0-25%, and the surrounding skin was dark red. Per the note, the resident's sacral pressure injury was worsening and that a sacral dressing to the resident's spine for pressure injury prevention was applied, because it was very red and facility was not keeping up with frequent repositioning. Further, the note stated that orders for turning the resident every 2 hours were written. Review of a hospice physician order dated May 31, 2019 included for wound care to be performed by hospice nurse weekly and as needed, and the facility nurse was to perform wound care as needed if dressing is soiled. The order further included to cleanse with soap and water or wound cleanser, pat dry, then apply 7 x 7 sacral foam dressing and to notify hospice if wound worsens or shows signs of infection. The order also included to turn resident every 2 hours for pressure relief. This order was transcribed onto the TAR for June 2019 and provided as ordered. Further review of the clinical record revealed documentation that the coccyx pressure ulcer was assessed at least weekly in June 2019 and healed by July 19, 2019. A wound observation was conducted on August 6, 2019 at 12:55 p.m., with a registered nurse (staff #37). At this time, staff #37 provided wound care to the sacral area. The sacral area appeared red, with no open areas. Staff #37 described the wound as a sacral, non-open, reddened, blanchable area, with no drainage and measured 12 cm x 9 cm. In an interview with a registered nurse (RN/staff #55) conducted on August 7, 2019 at 1:57 p.m., she stated when a resident is admitted with or develops a pressure ulcer, a skin assessment is conducted and the Weekly Pressure Ulcer Healing Assessment form is completed for each pressure ulcer identified. She stated the pressure ulcer assessment included staging, measurements and a description of the wound such as; presence/absence of eschar or drainage. She stated the wound should be monitored every shift for signs and symptoms of infection, and that weekly wound assessments should be done and documented. An interview with a licensed practical nurse (LPN/staff #32) was conducted on August 7, 2019 at 2:17 p.m. Staff #32 stated when a resident is admitted with or develops a pressure ulcer, she will conduct an assessment of the wound which includes measurements, staging and a description of the depth of the wound or presence/absence of drainage. She stated that treatment will then be initiated and administered based on the facility's standing orders for pressure ulcers. She said succeeding assessments of the pressure ulcer will be done weekly and as needed, and that findings will be documented in the pressure ulcer form, which is maintained in the resident's clinical record. Regarding resident's receiving hospice services and who have pressure ulcers/injuries, staff #32 stated that if hospice provides the treatment for the wound, the hospice nurse will conduct the assessment and document it in the clinical record. She stated the facility nurse will conduct an assessment of the resident's wound as needed, if the wound dressing gets loose. She further stated that if there is no documentation found in the resident's chart from the facility nurse regarding the pressure ulcer/wound, it means the facility nurse did not do the dressing change or assessment. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview with the assistant Director of Nursing (ADON/staff #29) conducted on August 7, 2019 at 2:29 p.m., she stated the floor nurses are expected to conduct an assessment and stage the pressure ulcer when they find it. She stated the floor nurses are expected to note the size, depth, description and measurement of the pressure ulcer, and that succeeding assessments of the wound should be done weekly or as needed when there are changes. She said if the resident is on hospice, the hospice nurse is expected to assess and document the wound on a weekly basis. An interview with the Director of Nursing (DON/staff #28) was conducted on August 7, 2019 at 3:47 p.m. Staff #28 stated that pressure ulcer wounds are assessed by the nurses, and that assessments are done on a weekly basis, which includes staging, measurements and a description of the wound. She stated if the hospice nurse is providing the treatment for the pressure ulcer, the hospice nurse is responsible for completing and documenting the weekly pressure ulcer assessment. She said the facility nurse will conduct an assessment on an as needed basis, when the facility nurse changes the dressing. She further stated that all assessments including pressure ulcers are maintained in the resident's clinical record. Review of the Wound and Skin Care Protocols and Procedures revealed the purpose was to promote a systematic approach and monitoring process for the care of the residents with existing wounds and for those who are at risk for skin breakdown; and to prevent pressure ulcer formation by identifying those residents who are at risk for pressure ulcers and to develop appropriate interventions. The objective was to maintain skin integrity and promote wound healing. The policy further included that a complete wound assessment and documentation will be done weekly on all pressure ulcers until healed. The criteria included site/location, stage, size, appearance of wound bed, undermining/tunneling, surrounding skin and drainage/exudate. The policy also stated to provide ongoing documentation by the charge/treatment nurses in the medical record to describe the effectiveness of interventions and resident's response to therapy.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19453 Based on clinical record reviews, staff interviews and policy review, the facility failed to ensure that additional interventions were implemented including adequate supervision for one resident (#24) with ongoing wandering behaviors, who was involved in an incident with resident #37. The deficient practice could result in a lack of interventions being implemented to address behaviors and possibly causing increased incidents and injuries to residents. Findings include: -Resident #37 was admitted on [DATE] with diagnoses that included end stage renal disease, chronic obstructive pulmonary disease and diabetes. Review of a care plan revealed the resident displays periods of anxiety and verbal abruptness. A goal was the resident would not display any anxiety through the next review. Interventions included to monitor and document behavior, discuss options for appropriate channeling of anxiety, administer medications as ordered, talk to resident in a calm voice when behaviors are disruptive, and assist in selection of appropriate coping mechanisms. A quarterly Minimum Data Set (MDS) assessment dated [DATE] included the resident was cognitively intact and required supervision with bed mobility and transfers, and was independent with ambulating in room. The MDS also noted that the resident did not have any physical or verbal aggressive behaviors. According to the October 2019 Medication Administration Record, the resident was receiving Buspar (Buspirone/anxiolytic) 5 mg one tablet twice a day from October 8-14, and Buspar 10 mg one tablet twice a day starting on October 15, for increased anxiety. A nurses note dated 10/16/19 at 6 a.m. included the nurse heard screams from down the hall and found another resident (#24) on the floor by the bed in the room of resident #37. Per the note, resident #24 had tried to climb in resident #37's bed, which startled him and he jumped up and pushed resident #24 away, which resulted in her landing on the floor. A nurses note written on 10/16/10 at 9:30 a.m. included that resident #37 was worked up and was reassured that they would keep closer observation on all roaming residents. Review of the October 2019 Behavior/Intervention Monthly Flow Record revealed the resident was being monitored for high anxiety and panic behaviors and did exhibit a few behaviors of each throughout the month. -Resident #24 was admitted on [DATE] with diagnoses that included dementia without behavioral disturbance, macular degeneration and sleep disorder. The resident was discharged on [DATE]. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A care plan dated 4/25/19 included the resident has the potential to wander into unsafe situations and fails to realize her safety needs as evidenced by elopement. A goal included the resident would not wander into unsafe situations. Interventions were to place resident in area where frequent observation is possible, provide diversional activities, approach resident in a calm and positive manner, nurses/CNA to account for resident's whereabouts throughout the day with 30 minute visual checks, monitor and document wandering behaviors and record and report changes to physician. Review of an Unsafe Wandering/Elopement Risk assessment dated [DATE] revealed the resident was at risk for possible unsafe wandering/elopement risk. Nurses notes in June 2019 included the resident continues to walk frequently in hallways. The notes also included that at times the resident was on 15 minute checks for wandering. The care plan for the potential to wander into unsafe situations was revised on 7/19/19 to reflect that the resident was getting into others occupied beds. An additional intervention included to monitor when out of bed. Nurses notes in July 2019 included the resident was wandering halls as usual. A note dated July 28, stated the resident was walking past the TV area on the 100/200 unit and hit a resident on the head/shoulder. Review of the nurses notes for August 2019 revealed the resident frequently was pacing the halls. A nurses note dated September 3, 2019 revealed that resident #24 smacked another resident in the back of the head. A nurses note dated September 5 included the resident's power of attorney was given a 30 day notice and that the facility will help find placement. An Unsafe Wandering/Elopement Risk assessment dated [DATE] included the resident was at risk for possible unsafe wandering/elopement risk. According to a quarterly MDS assessment dated [DATE], the resident was assessed to have severe cognitive impairment, required limited assistance with transfers, was independent with ambulation and had no mood or behavior problems, including no physical or verbal aggressive behaviors. The MDS also included the resident had no wandering behaviors, despite clinical record documentation that the resident had ongoing wandering behaviors. Further review of the care plan for the potential to wander into unsafe situations revealed it was reviewed on 9/26/19. However, despite the residents ongoing wandering behaviors, there were no additional interventions which were implemented, including providing any increased supervision. A note dated September 30, 2019 included the resident was found in an empty room sitting on the bed, and was taken to her own room and was changed. Further review of the September 2019 nurses notes revealed the resident was up and down the halls and would often walk for an hour, then sit in a chair. The notes also included that resident #24 would swipe at other residents, as she passes by. Per the notes, the resident was toileted, given food/fluids and at times was on 15 minute checks. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the Behavior/Intervention Monthly Flow Record dated September 2019, the resident was being monitored for wandering/exit seeking behaviors. Per the record, the resident had multiple daily episodes of wandering throughout the shifts, with interventions that included redirection, 1:1, activity, gave food and fluids and changed positions. Review of the 15 and 30 minute logs for August and September 2019 revealed multiple times when either 15 minute or 30 minute checks were done on resident #24. Review of the October 2019 physician orders revealed the resident was receiving Buspirone (anxiolytic) 5 mg, 1 tablet twice a day for dementia with anxiety and Divalproex Sodium (anticonvulsant) 125 mg, 2 capsules twice a day for dementia with aggression. A nursing note dated October 1, 2019 included the resident was walking the halls as usual and oncoming staff were notified to be on the lookout for her tiring out. A note dated October 6, stated the resident was walking the halls. Another note dated October 9, included the resident walks for 1 hour then sits, and that snacks were offered. A nurses note dated 10/11/19 included the resident was approved for placement in a behavioral health unit. Nurses notes dated 10/13/19 and 10/14/19 included the resident wanders the halls for an hour. Although there were interventions implemented at times when the resident exhibited wandering behaviors, (such as redirection, 1:1, activities, 15-30 minutes checks, offering food/fluids and toileting), there was no evidence that the resident was reevaluated for the effectiveness of these interventions and that additional interventions were implemented to address the resident's ongoing behaviors. Review of a nurses note dated 10/16/19 at 4:45 a.m. revealed the nurse heard yelling and screaming and went to the room of resident #37. Another resident (#24) was lying on the floor. The resident (#24) had tried to get into resident #37's bed, which startled him and he jumped up and pushed the resident (#24) off of him onto the floor. No injuries were noted. Review of the facility's investigative report revealed that on October 16, 2019 at 4 a.m., resident #24 wandered into resident #37's room and tried to get in bed with resident #37, which startled him and he jumped up pushing resident #24 off the bed resulting in her landing on the floor. No injuries were noted. The report included that resident #24 has the potential to wander into unsafe situations, due to a history of dementia. Review of the Behavior/Intervention Monthly Flow Record for October 2019 revealed that resident #24 was being monitored for wandering/exit seeking behaviors through October 18. Per the record, the resident had multiple daily episodes of wandering each day, with interventions that included redirection, 1:1, activity, gave food and fluids and changed positions. A nurses noted dated 10/18/19 included the resident was discharged from the facility to a closed behavioral wandering unit. (continued on next page)

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	035114	A. Building B. Wing	08/07/2019

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A phone interview was conducted on November 19, 2019 at 9:03 p.m., with a Certified Nursing Assistant (CNA/staff #3), who stated that she usually works nights and had taken care of resident #24 when she was in the facility. She said the resident would wander around the facility and go into other resident's rooms. Regarding interventions in place to address this behavior she said that she would redirect her, try and help her get back into bed and keep a close eye on her. A phone interview was conducted on November 19, 2019 at 9:18 p.m. with a registry CNA (staff #10). She said that she works nights and has taken care of resident #24. She said that the resident did go into other rooms with residents in them and would also go into empty rooms. Regarding the incident on 10/16/19, she said that she was working that night. She said when she and the nurse went into resident #37's room, resident #24 was on the floor. She said resident #37 told them that he had been asleep and resident #24 tried to get in his bed and it scared him and he pushed her. A phone interview was conducted on November 19, 2019 at 10:35 p.m. with a Registered Nurse (staff #4). Staff #4 stated that resident #24 wandered around the building and would go into other residents rooms, but some were empty. She said they would keep a close eye on her, do frequent checks during the night and that she was easily redirected. Regarding the incident on 10/16/19, she said that she was working that night. She said that she was charting around 4 a.m. when she heard screaming and went into resident #37's room. She said the room was dark and resident #24 was on the floor. She said resident #37 told her that resident #24 was trying to get in his bed and it startled him and he tried to get her off the bed. She said resident #37 is very anxious, so this really startled him. An interview was conducted on November 20, 2019 at 8:50 a.m. with a CNA (staff #5). She said that resident #24 wandered around the facility and would often go into rooms that were not occupied. She said the resident had to be monitored closely and they would redirect her, get her involved in activities including 1:1 activities, would offer her snacks and would try and keep her busy. In an interview with a CNA (staff #6) conducted on November 20, 2019 at 9:55 a.m., staff #6 stated that she knew resident #24. She said the resident wandered in the facility and went into other resident rooms, but some of the times the rooms were empty. Regarding interventions to address the wandering behavior, staff #6 stated that they tried activities, gave her snacks and redirected her. During an interview with the Director of Nursing (DON/staff #8) on November 20, 2019 at 2:30 p.m., the DON stated the resident (#24) wandered the halls and would go into resident rooms, but was not sure if she did it a lot. Regarding interventions in place to address the ongoing wandering behavior, she said that staff redirected her, involved her in activities and gave her snacks. In an interview with resident #37 on November 20, 2019 at 4 p.m., the resident stated that he remembered the incident. He said it happened in the middle of the night. He said his door was open and he was sound asleep. He said he felt someone touch him and get into his bed. He said it scared him and he reacted and kicked out his leg and the resident fell down. Another interview was conducted on November 20, 2019 at 4:25 p.m. with the DON. Regarding providing increased supervision for residents with behaviors, including wandering behaviors, she said behaviors are discussed in the morning meetings and if a resident needs increased supervision, they will do 15 or 30 minute checks. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a policy regarding Behavioral Assessment, Intervention and Monitoring revealed that residents will receive behavioral health services as needed to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and care plan. Behaviors will be identified using the behavioral tools and the comprehensive assessment. Residents will have minimal complications associated with the management of altered or impaired behaviors. The interdisciplinary team (IDT) will evaluate behavioral symptoms to determine the degree of severity, distress and potential safety risk to the resident and develop a plan of care accordingly. Safety strategies will be implemented immediately if necessary to protect the resident and others from harm. Interventions will be individualized and part of an overall environment that supports physical, functional and psychosocial needs, and strives to understand, prevent or relieve the resident's distress or loss of abilities. Interventions will be based on a detailed assessment of physical, psychological and behavioral symptoms and their underlying causes, as well as the potential situational and environment reasons for the behavior. The care plan will include the following: a description of the behavioral symptoms including frequency, intensity, duration, outcomes, location environment and precipitating factors or situations; targeted and individualized interventions for the behavioral symptoms; the rationale for the interventions; and how staff will monitor for effectiveness of the interventions. The policy further included that the DON or designee will evaluate whether the staffing needs have changed based on the acuity of the residents and their plans of care. Additional staff and/or staff training will be provided if determined that the needs of the residents cannot be met with the current level of staff or staff training. Under monitoring it included that IDT will monitor the progress of individuals with impaired cognition and behavior until stable. Interventions will be adjusted based on the impact on behavior and other symptoms.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35111 Based on clinical record reviews, facility documentation, staff interviews and policy review, the facility failed to ensure two of five sampled residents (#41 and #48) receiving psychotropic medications had GDR's (gradual dose reductions) attempted or that there was documentation that GDR's were clinically contraindicated, and failed to ensure that resident #41 was monitored for specific target behaviors related to the use of an antidepressant medication. The deficient practice could result in residents receiving psychotropic medications which are not necessary and could result in residents experiencing possible adverse consequences. Findings include: -Resident #41 was admitted to the facility on [DATE] with a diagnosis of major depressive disorder. A physician's order dated October 17, 2018 included for Zoloft (antidepressant) 100 mg (milligrams) 2 tablets by mouth every day for depression. The order did not include what target behaviors were to be monitored. Review of the Psychoactive Drug Use Authorization form dated October 17, 2018 revealed the resident was informed regarding the use of Zoloft. The form also included that all medications will be reviewed by a pharmacist and that a gradual dose reduction will be done to identify the lowest optimal dose. The form did not include what the specific target behaviors were related to the use of this medication. Review of the Medication Administration Records (MAR) from October 2018 through April 2019 revealed the resident was administered Zoloft daily. However, there was no evidence in the clinical record that the resident was being monitored for any specific target behaviors related to depression from October 2018 through April 2019. Review of the Pharmacy Consultation Reports for November 2018 through March 2019 revealed the resident's medication regimen was reviewed and contained no new irregularities. A Care plan with a revision date of April 12, 2019 revealed the resident was at risk for side effects related to the use of an antidepressant. The goal was that the resident would not have any injury related to medication usage and side effects. Interventions included to administer the medication as ordered, monitor and record the resident's target behaviors, observe for adverse side effects and document and report them to the physician, and monthly review of the medication by the pharmacy consultant. The care plan did not include what target behaviors were to be monitored. The Significant Change Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 13, indicating the resident was cognitively intact. The MDS included the resident had no depression and received an antidepressant during the 7 day look-back period. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Pharmacy Consultation Report for April 2019, revealed a pharmacy recommendation to the provider dated April 22, 2019 that certain antidepressants are associated with an increase in blood pressure in some individuals and to consider a dose reduction or discontinuation of Zoloft in these individuals. The report was signed by the Director of Nursing (DON/staff #28) on May 1, 2019. There was also a handwritten note checked on MAR from the provider. The documentation did not include whether Zoloft would be reduced or discontinued or that a gradual dose reduction (GDR) was contraindicated. According to the MARs for May 2019 through July 2019, the resident continued to receive Zoloft 100 mg 2 tablets by mouth daily. Review of the Pharmacy Consultation Reports for May 2019 through July 2019 revealed the resident's medication regimen was reviewed and contained no new irregularities. The reports did not include any recommendations regarding the Zoloft. Review of the Behavior/Intervention Monthly Flow Record sheets from May 2019 through July 2019, did not reveal any target behaviors related to depression which were being monitored. Further review of the clinical record revealed there was no documentation by the physician/provider for a GDR related to the use of Zoloft, or the rationale as to why a GDR was contraindicated. In an interview conducted with a Registered Nurse (RN/staff #55) on August 7, 2019 at 1:57 p.m., the RN stated that she reviews the order for a psychotropic medication to ensure the order includes the target behaviors that are to be monitored and it should be documented in the clinical record. An interview was conducted on August 7, 2019 at 2:17 p.m with a Licensed Practical Nurse (LPN/staff #32). The LPN stated that when the pharmacist makes a recommendation, the nurses are informed of the recommendation by the DON. She said the nurses will then notify the physician/provider who will either agree or disagree with the recommendation. The LPN stated that if the physician/provider agrees with the recommendation, an order to reflect the recommendation will be written. In an interview conducted with the DON (staff #28) on August 7, 2019 at 3:35 p.m., she stated that resident #41's medications were reviewed monthly by the pharmacist and that the review did not include GDR recommendations. The DON stated that when a pharmacist makes a recommendation for a GDR, she reviews it and it is sent to the physician/provider for review and signature. The DON stated the physician/provider has to agree or disagree with the pharmacist's recommendation. She also stated that they will ensure that GDR's are attempted for psychotropic medications. 40148 -Resident #48 was readmitted to the facility on [DATE], with diagnoses that included aphasia following cerebral infarction and unspecified dementia, without behavioral disturbance. Review of the physician's orders for August 2018 through December 2018, revealed for Mirtazapine (Remeron/antidepressant) 15 mg one tablet by mouth at bedtime for appetite/depression. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A care plan revised on January 23, 2019 identified that the resident was at risk for side effects related to an antidepressant medication. The goal was that the resident would not have an injury related to medication usage or side effects. Interventions included to discuss potential side effects of Remeron with resident/responsible party, administer medication as ordered, monitor and record target behaviors and keep Remeron at the lowest therapeutic dose possible. A quarterly MDS assessment dated [DATE] revealed the resident had severe cognitive impairment. The MDS also included the resident received an antidepressant medication during the 7 day look-back period. Review of a behavioral care plan revised on July 9, 2019 revealed the resident had the following behaviors: crying or talking very quickly in a non-sensical manner; increased signs/symptoms of anxiety behaviors focusing on hair, dental care, pain or family. The goals were that the resident would not have any behavior outbursts that put her or others at risk and the resident will take medications as ordered. An intervention included administering Remeron as ordered. Further review of the physician's orders revealed that Remeron 15 mg at bedtime continued to be ordered from January 2019 through August 2019. Review of the Medication Administration Records (MARs) for July and August 2019 revealed the resident was administered Remeron at bedtime. Further review of the clinical record revealed there was no documentation that a GDR was attempted related to the use of Remeron or documentation by the physician/provider of the rationale as to why a GDR was contraindicated. During an interview conducted with the pharmacist (staff #62) on August 7, 2019 at 3:21 p.m., staff #62 stated that he follows the Centers for Medicare/Medicaid Services (CMS) guidelines when recommending GDR's. The pharmacist stated that GDR's are recommended yearly for antidepressant medications, every 6 month for antianxiety medications, and every 3 month for antipsychotic and hypnotic medications. He also stated that if the physician/provider contraindicated his GDR recommendation, he would continue to recommend a GDR on his next review. In an interview conducted with the DON (staff #28) on August 7, 2019 at 3:30 p.m., the DON stated that the team meets monthly with the pharmacist and they review all residents receiving psychotropic medications and discuss the recommendations for GDR's. Review of the facility's policy on Behavioral Assessment, Intervention and Monitoring revealed the facility will comply with regulatory requirements related to the use of medications to manage behavioral changes. Behavioral symptoms will be identified using facility approved behavioral screening tools and the comprehensive assessment. The interdisciplinary team will thoroughly evaluate new or changing behavioral symptoms in order to identify underlying causes and address any modifiable factors that may have contributed to the resident's change in condition. When medications are prescribed for behavioral symptoms, documentation will include the rationale for its use, specific target behaviors and expected outcomes, monitoring for adverse consequences and plans (if applicable) for gradual dose reductions. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's pharmacy consultant agreement revealed the pharmacy shall provide Consultant Services to the facility in accordance with applicable law and the State Operations Manual, Appendix PP.