QUALITY RATING CERTIFICATE

ARIZONA DEPARTMENT OF HEALTH SERVICES
NURSING CARE INSTITUTION

ADHS

Issued To:

Devon Gables Rehabilitation Center, Llc
Devon Gables Rehabilitation Center
6150 East Grant Road
Tucson, AZ 85712

The above named facility has met licensure requirements, has been licensed for one year or more and, therefore, has received the following quality rating as required by R9-10-919.

COMPONENTS	CRITERIA MET	
	Yes	No
I. Nursing Services	18	7
II. Resident Rights	25	0
III. Administration	23	2
IV. Environment and Infection Control	15	0
V. Food Services	10	0
TOTAL CRITERIA MET	91	9

QUALITY PERFORMANCE SCALE	
"A" Excellent	X
"B"	
"C"	
"D"	
"A" 90-100 Points "B" 80-29 Points "C" 70-79 Points "D" 69 or fewer Points	

License Effective

From: 11/01/2018 To: 10/31/2019

Issued: 12/03/2018

Number: NCI-2652

Recommended By: Diane Eckles

Issued By

Assistant Director

TO BE FRAMED AND DISPLAYED IN A CONSPICUOUS PLACE

ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

February 14, 2019

IMPORTANT NOTICE- PLEASE READ CAREFULLY

Heather Friebus, Administrator
Devon Gables Rehabilitation Center
6150 East Grant Road
Tucson, AZ 85712

Dear Ms. Friebus:

On February 13, 2019, an offsite revisit was conducted for your facility by the Arizona Department of Public Health, Licensing, and Certification Bureau, to determine if your facility was in compliance with the State participation requirements to operate a nursing home in the State of Arizona.

Enclosed is the **State Revisit Report form**, which indicates the licensee to be in substantial compliance. A copy of this form will become a part of the facility's public file. Please keep this current inspection report in the facility and available for review.

If we can be of further assistance, please contact the Bureau of Long Term Care at (602) 364-2690.

Sincerely,

Shoalynn Gilliland

Shoalynn Gilliland
Program Project Specialist II
Bureau of Long Term Care Licensing

Enclosure

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NCI-2652	A. BUILDING: _____ B. WING _____	R 02/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEVON GABLES REHABILITATION CENTER	6150 EAST GRANT ROAD TUCSON, AZ 85712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{Y 000}	Initial Comments The follow up State Annual and complaint investigation survey was conducted on 2/13/19, there were no deficiencies cited.	{Y 000}		

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

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
NCI-2652 Y1	A. Building B. Wing Y2	2/13/2019 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
DEVON GABLES REHABILITATION CENTER	6150 EAST GRANT ROAD TUCSON, AZ 85712

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Y0339	Correction	ID Prefix Y1019	Correction	ID Prefix Y1233	Correction
Reg. # R9-10-403.C.2.b.	Completed	Reg. # R9-10-410.B.3.a.	Completed	Reg. # R9-10-412.B.6.c.	Completed
LSC	01/23/2019	LSC	01/23/2019	LSC	01/23/2019
ID Prefix Y2109	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # R9-10-421.A.1.b.i.	Completed	Reg. #	Completed	Reg. #	Completed
LSC	01/23/2019	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	DA	2/13/19	Dale Colam	2/13/19
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
11/1/2018	☐ YES ☐ NO

ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

December 3, 2018

Receipt Of This Notice Is Presumed To Be 12/03/2018
Important Notice - Please Read Carefully

Heather Friebus, Administrator
6150 East Grant Road
Tucson, AZ 85712

RE: Devon Gables Rehabilitation Center

Dear Ms. Friebus:

The purpose of this letter is to inform you that during a recent inspection of the facility on November 01, 2018 by the Arizona Department of Health Services, Public Health Licensing Services ("Department"), the Department substantiated at least one or more violations of Department statutes or rules. Due to the seriousness of the violations, this case has been referred to the Department's Enforcement Team (Enforcement Team) for further review.

Enclosed is a copy of the Statement of Deficiencies (SOD), which describes the violations the Department found at the facility. Because the case has been referred to the Enforcement Team, the Department is **not** requesting or accepting a **written** plan of correction for the violations at this time. However, the Department requires that you make immediate corrections of violations that present a threat to the health or safety of a client, resident, patient or agency personnel. Additionally, the Department urges correction of all deficiencies at the earliest possible date. The Department will notify you when a written plan of correction is required.

You have an opportunity to dispute any deficiencies or language listed on the SOD through an Informal Dispute Resolution (IDR). To dispute a deficiency or language listed on the SOD, send a written request on a separate document **due 10 days from receipt of this letter, December 13, 2018**. The written request must include documentation that shows the licensee was in compliance at the time of the inspection. The Department will review the written request and documentation provided to the Department and notify you of the Department's decision. If you have any questions, please call: Diane Eckles, Bureau Chief, Bureau of Long Term Care 150 North 18th Avenue, #440, Phoenix, Arizona 85007at (602) 364-2675.

Sincerely,

Diane Eckles

Diane Eckles
Bureau Chief

DE\sg

ADHS LICENSING SERVICES

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Y 000	Initial Comments The State compliance survey was conducted on October 29 through November 1, 2018, in conjunction with the following Complaint investigations: AZ00144571, AZ00148231, AZ00149315, AZ00150091, and AZ00152452. The following deficiencies were cited.	Y 000		
Y 339	R9-10-403.C.2.b. Administration R9-10-403.C. An administrator shall ensure that: R9-10-403.C.2. Policies and procedures for physical health services and behavioral health services are established, documented, and implemented to protect the health and safety of a resident that: R9-10-403.C.2.b. Cover the provision of physical health services and behavioral health services; This RULE is not met as evidenced by: Based on clinical record review, staff interviews, facility documentation and policy and procedures, the facility failed to implement their policy to ensure services provided met professional standards of quality, by failing to ensure that one resident (#370) received anticoagulant medication per the admission orders. Findings include: Resident #370 was admitted to the facility on 10/16/2017 and readmitted on 11/29/17, with	Y 339	Y339 **Correct to the individual:** Resident #370 was discharged from the facility on 12/6/2017. **Correct to all others:** Had the potential to affect all residents that have medication orders. A performance improvement plan was developed as outlined in the statement of deficiencies on 11/28/2017 with the root cause, tasks, and reporting process for findings.	

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

Heather Duchis — Administrator — 1/31/19

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Y 339	Continued From page 1 diagnoses that included chronic systolic congestive heart failure, prosthetic aortic heart valve, chronic obstructive pulmonary disease, prior myocardial infarction (MI), chronic kidney disease and pacemaker. Review of the Admission Orders received from the referring hospital dated 10/16/17 revealed for Warfarin (anticoagulant) 3 mg (milligram) tablet orally every Monday, Tuesday, Thursday, Friday and Sunday and Warfarin 5 mg tablet orally every Wednesday and Saturday. On the Admission Orders, these two medication orders were crossed through and it was handwritten in for Warfarin 3.5 mg daily and for INR (International Normalized Ratio) lab tests on Mondays and Thursdays. However, the recapitulation of physician orders (recap) for October 2017 did not include an order for Warfarin or for the INR lab tests to be done. Review of the Medication Administration Record (MAR) for October 2017 did not reveal any documentation that the resident was administered Warfarin. The MAR for October 2017 revealed documentation that a 24 hour chart check was completed for accuracy of daily new orders on 10/16/17, however, there was no documentation that the Warfarin and INR orders were identified as being missed from the recap and the MAR. Review of the Nurse Practitioner (NP) Initial Comprehensive Evaluation (H&P) dated 10/17/17, revealed the resident had HCVD (hypertensive cardiovascular disease) with CHF/CAD/AVR (congestive heart failure/coronary artery disease/aortic valve replacement).	Y 339	**System Correction:** Audits of medication reconciliation were completed thru 2/28/2018 and there were no discrepancies noted. These audits are ongoing. Education was provided to all Nursing staff, Medical Director, Providers and Pharmacists regarding our medication reconciliation process. Policy revision was completed to the Admission Orders policy, Anticoagulation, and 24-hour Chart Checks. **Monitoring of the System:** The analysis of the audits are taken to QAPI meeting for review and follow up as needed. **Correction Date:** The corrections were made and sustained since February of 2018 **Responsible Person:** DON or Designee	12/16/18

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Y 339	Continued From page 2 A baseline cardiovascular care plan dated 10/17/17 included under Cardio-output that the resident had a history of MI and Aortic Valve. The section to include the potential for bleeding related to anticoagulants was not selected and there were no interventions related to the use of anticoagulants. An Interim Medication Regimen Review was conducted on 10/18/17, which included documentation that no medication related issues were found. An admission Minimum Data Set (MDS) assessment dated 10/23/17 included the resident had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident was cognitively intact. Additional physician and NP notes dated 10/25/17, 10/27/17, 10/31/17, 11/01/17 contained documentation that the resident had a history of MI and AVR, however, there was no mention of any anticoagulant therapy. Review of recap for 10/16/17 through 11/16/17 revealed no orders for Warfarin or INR lab tests, however the orders were signed by a staff member and a Registered Nurse (RN) who noted the orders on 10/17/17. The recap was also signed by the physician. A review of the MARs from 10/16/17 through 11/20/17 revealed the resident's chart was checked on the night shift every 24 hours for accuracy of daily new orders. A physician's order was obtained on 11/20/16 for Warfarin 5 mg orally once each day and for INR's	Y 339		

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Y 339	Continued From page 3 to be done on Tuesday and Friday, for a diagnosis of prosthetic aortic heart valve. An INR lab test was completed on 11/21/17 and the lab result was 1.2 which was a sub-therapeutic level. (Therapeutic INR levels for secondary prevention after a myocardial infarction or for patients with high-risk mechanical prosthetic heart valves is 2.5 to 3.5. There was no clinical record documentation that the physician was notified of the sub-therapeutic INR result. A nurse progress note dated 11/22/17 revealed that around 7:30 p.m., the resident appeared to be confused. The resident's vital signs were stable, but her blood sugar was elevated at 447 and was administered insulin. The note also included that a family member requested the resident be sent to the hospital, so 911 was called and the resident was transported to the hospital at 9:00 p.m. Review of the emergency department physician note dated 11/22/17 revealed the resident presented with altered mental status. Diagnoses included confusion, delirium, cerebral vascular accident, hypoglycemia, intracranial hemorrhage and metabolic encephalopathy. The resident was admitted to the Telemetry Unit in stable condition. A hospital physician's note dated 11/27/17 revealed the chief complaint of the patient was "new CVA (cerebral vascular accident) with dysarthria (difficulty speaking)." The History of Present Illness included, "she has now suffered a CVA after being sub-therapeutic on her Warfarin." Review of the hospital course summary dated	Y 339		

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Y 339	Continued From page 4 11/29/17 revealed the resident was on chronic anticoagulation, due to mechanical aortic valve replacement. The resident presented to the emergency department due to progressive worsening of altered mental status, lethargy, and recent somnolence. In addition to confusion, the patient was having difficulty talking. The summary included the resident's INR level was 1.6, "which is sub-therapeutic and given the patient's mechanical aortic valve, the resident should have a goal INR of 3." The documentation further included the patient was found, on repeat Computerized Tomography (CT) imaging to have an "acute stroke, and this is thought to be embolic given her subacute therapeutic INR. Per neurology recommendations, we will continue Warfarin with up-titration still as to get her INR back in to range..at a goal of 3.0." In an interview conducted on 10/31/18 at 1:48 p.m. with a Licensed Practical Nurse (LPN/staff #214), who stated that the medication orders are supplied by the hospital and signed by the hospital physician or NP. Staff #214 said that on admission, the orders are reviewed with the physician, usually by reading them over the phone, and then the orders are entered into the electronic chart. He stated that after the orders are entered, the order recap is printed, reviewed and signed by the physician at the facility. He said they also have a chart check process which is completed every 24 hours by the night nurse and includes a check of the new orders and verification that the order recap is correct. Staff #214 stated if there are medications that were on the hospital orders and not on the order recap, the nurse should look for a note as to why or call the physician. Staff #214 stated he would expect a resident with clinical indications for long term anticoagulants would continue on that medication	Y 339		

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Y 339	Continued From page 5 while at the facility. He also stated that if the medications were missed when adding them to the electronic record, he would expect them to be caught during the chart check process. He said if a resident is on long term anticoagulants and they were suddenly stopped, it could result in coagulation of the blood leading to clots, pulmonary embolism, deep vein thrombosis and stroke. An interview was conducted on 11/01/18 at 9:15 a.m. with the Director of Nursing (DON/staff #241), who stated that the admitting department works on getting the resident information and orders from the hospital. The DON stated when she became aware of the missed Warfarin and labs for resident #370, she started a Performance Improvement Plan (PIP) for our Quality Assurance Process Improvement (QAPI) committee, which was designed to identify how this occurred and ensure there is a process in place so it does not happen again. The DON stated there was some confusion on the new admission orders regarding which list would be used to reconcile the orders and transcribe them into the electronic record. The DON said that now staff make a note as to which order list was used for reconciliation and they continue to do random audits on orders and 100% audits on all admission charts. The DON stated all staff were re-educated on the process. She said in the case of resident #370, all of the hospital orders had Warfarin on them, and that it just got missed, and fell through all of their safety checks. She said the 24-hour chart checks missed it, the physician did a History and Physical the next day and missed it, and the pharmacy review did a review 2 days later and it was missed. The DON stated the Unit Manager brought it to her attention that the Warfarin was missed since admission and the	Y 339		

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Y 339	Continued From page 6 physician was contacted and orders were obtained for the medication and lab tests on 11/20/18. The DON stated the INR was drawn on 11/21/17 and the result was 1.2, and the physician should have been notified, because it was at a sub-therapeutic level. The DON stated that as part of the PIP, a section was added to the MAR where the nurses document the result and that the provider was notified. An interview was conducted on 11/01/18 at 9:41 a.m. with the Administrator (staff #87), who stated the facility has initiated the following measures: -The nurse managers and weekend supervisors are completing chart audits and notify the Administrator if any discrepancies are identified -Staff education was initiated when this event was identified -Chart audits were completed on 100% of new admissions and randomly on other charts and no medication reconciliation issues were identified -Physicians are now asked to review the hospital orders for medications and the facility transcribed orders when they come in to see a new resident -The facility sends the hospital orders and the facility transcribed orders to the pharmacy for review -The pharmacy consultant reviews all medications errors and assists with identifying any process concerns and remedies -The medical director and the pharmacy consultant sign off on all medication errors. -The PIP was completed in February 2018 and the issue was then turned to ongoing QAPI quality audits. Review of the facility PIP and ongoing QAPI documentation revealed the following:	Y 339		

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Y 339	Continued From page 7 QAPI Action Plan was initiated on 11/28/17 with the root cause identified as multiple medication lists received from the hospital, causing confusion and changes to physician verified orders, which caused confusion with the chart checks. The tasks included education for licensed nurses on admission order transcription and 24-hour chart check process, updates to the admission audit process to ensure hospital orders and facility orders are reconciled and noted by the admission nurse, DON and Unit Managers will review all admission audits. All reports on activity for QAPI Action Plan will be reviewed every 2 weeks. The QAPI Action Plan also included the following: -Notes of ongoing review identified no new concerns on 12/15/17, 12/29/17, 1/11/18, 1/25/18, 2/8/18 and 2/22/18 -Action Plan did not note any concerns since staff education and the plan then transitioned to monthly updates at the QAPI Committee meeting -Staff education materials included 24-hour chart check steps and responsibilities, how to check orders for all admissions, and the procedure for admission order transcription and verification -Sign in sheets for 65 staff members between 11/28/17 and 1/9/18 -Admission audit sheets -Audits completed since beginning of PIP with no identified concerns Review of the facility's investigation and actions in response to the event included: -QAPI plan -Medication error report for the nurse that admitted resident #370 and reconciled the initial orders which were signed by the staff member,	Y 339		

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Y 339	Continued From page 8 supervisor, DON, Medical Director, Administrator and Pharmacy Consultant. -Components of the clinical record that included the admission order sheet with handwritten notes, the transcribed orders appearing on the order recap, Interim Medication Regimen Review, H&P, and all documents from the QAPI plan -Chronological summary of events that included how the medication was missed at multiple check points during the first few days of admission to the facility, the description of events on the 11/20/17 when it was discovered that the medication was not administered, the events on 11/22/17 when the resident's condition changed and was transported to the hospital, and the resident's return to the facility following a stroke on 11/29/17. Review of the facility's policy titled, Admission Orders: Reconciliation Procedures revealed the facility will take measures to obtain accurate admission orders. The policy included that the nurse receiving the resident shall review the orders and make recommendations to the provider after observation of the resident. All admitting orders are to be reviewed by a licensed nurse. The nurse will document that the admission orders were reconciled for accuracy and will notify the provider of any discrepancies. The nurse will then fax the admission orders and transcribed orders to the pharmacy. The policy also included the 24-hour chart check nurse will review transfer orders against admission orders and against the MAR for accuracy. Review of the facility's policy titled, Anticoagulation - Clinical Protocol revealed that as part of the initial assessment, the physician will help identify individuals who are currently anticoagulated and assess for any signs or	Y 339		

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Y 339	Continued From page 9 symptoms of adverse drug reactions and evidence of effects related to the sub-therapeutic or greater than therapeutic drug level. The policy included the nurse shall assess and document/report current drug and dosage of anticoagulation therapy, lab results and monitoring, active diagnoses, and other current medications. The physician will verify underlying causes of conditions requiring anticoagulation therapy and will prescribe the therapy in accordance with recognized guidelines and will order appropriate lab testing to monitor the therapy. The facility's policy titled, 24-Hour Chart Checks stated that the 24-hour chart checks will be completed by the night shift. The policy included that each chart is checked for new orders and if any error is noted it is reported to the unit manager and corrected immediately. If clarification of orders are needed, it must be followed-up promptly and reported. Staff will initial on the 24-hour chart check sheet located in the front of the physician's orders in the clinical record, after the chart check is completed.	Y 339		
Y1019	R9-10-410.B.3.a. Resident Rights R9-10-410.B. An administrator shall ensure that: R9-10-410.B.3. A resident is not subjected to: R9-10-410.B.3.a. Abuse; This RULE is not met as evidenced by: Based on clinical record reviews, staff and resident interviews, facility documentation, and review of policies and procedures, the facility	Y1019		

ADHS LICENSING SERVICES

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	NCI-2652	A. BUILDING: _____ B. WING _____	11/01/2018

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Y1019	Continued From page 10 failed to ensure resident #35 was not subjected to abuse by resident #91, and failed to ensure that resident #47 was not subjected to abuse by resident #152. Findings include: -Resident #35 was admitted to the facility on August 1, 2018 with diagnoses that included vascular dementia with behavioral disturbance, major depressive disorder, aphasia, cerebral infarction, and post-traumatic stress disorder. Review of a nursing note dated August 7, 2018 revealed "Admission MDS (Minimum Data Set) interview attempted. (Name of resident) has clear speech with aphasia, fluctuating inattention and was unable to answer BIMS (Brief Interview for Mental Status) assessment questions appropriately. He said multiple times that he wants to go home..." A behavioral symptoms care plan dated August 14, 2018 revealed "(Name of resident) has socially/inappropriate/disruptive behaviors related to dementia. He has target behavior for monitoring for physical aggression, verbal aggression, and restlessness/agitation..." An approach included was "...Avoid over-stimulation with noise, crowding, and other verbally/physically aggressive residents..." -Resident #91 was admitted to the facility on August 17, 2018 with a diagnosis of unspecified dementia with behavioral disturbance. A nursing note dated August 17, 2018 revealed "...Resident has a history of homicidal ideation, combative with family..."	Y1019	**Y1019** **Correct to the individual:** Immediately following the incident on 10/29/2018, Resident #91 was placed on 1:1 monitoring and the Physician ordered to send resident to emergency room for stabilization. Resident #91 has been discharged from the facility. Resident #152 was immediately separated from resident #47 and upon evaluation of resident #47 there were no identified injuries and she felt safe. There were no adverse outcomes to the residents involved in either of the events cited. **Correct to all others:** All residents have the potential to be affected. Direct Care staff will receive re-education on de-escalating techniques and ways to help prevent resident to resident altercations from occurring. **System Correction:** Visual audits of resident to resident interactions will be made weekly to help ensure that residents are safe.	

ADHS LICENSING SERVICES

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Y1019	Continued From page 11 An admission MDS assessment dated August 24, 2018 revealed a BIMS (Brief Interview for Mental Status) score of 3 which indicated the resident had severely impaired cognition. A behavioral symptoms care plan dated August 29, 2018 revealed "(Name of resident) has undesirable behaviors related to dementia..." An approach included was "...Assess whether (name of resident) behaviors endanger himself or others. Intervene as needed..." A nursing note dated September 25, 2018 revealed "BHT (behavioral health team) Review: Resident presented for new psychiatric consult for mental health managements. Resident has been pacing up and down the hall, non-redirectable. Target Behaviors monitored: hallucinations, wandering in unit..." A nursing note dated October 14, 2018 revealed "Resident in and out of other resident room. Yelling he needs to go pick up his wife. This nurse notified NP (nurse practitioner) and order obtained to reinstate IM (intramuscular) and PO (by mouth) Ativan." Another nursing note dated October 27, 2018 revealed "Resident observed on the floor with another resident. Appears to have wandered into another resident's room. This resident escorted him out, during this they both fell to the floor...no apparent injury..." A nursing note dated October 29, 2018 at 6:25 a.m. revealed "...resident medicated during the night with Ativan for increased behaviors. Resident trying to go out back door and in and out of residents room. Resident not easily redirected. Will continue to provide calm quiet environment."	Y1019	**Monitoring of System:** The analysis of the audits will be taken to QAPI meeting for review and follow-up as needed. **Correction Date:** **Responsible Person:** DON or Designee	12/16/18

ADHS LICENSING SERVICES

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Y1019	Continued From page 12 Another nursing note dated October 29, 2018 at 11:42 a.m. revealed "Resident involved in resident to resident altercation. Resident agitated and combative this morning. Multiple attempts at redirection unsuccessful. Resident medicated with PRN (as needed) Ativan with no helpful results. Resident wandered into peer's (resident #35) room, when approached by male peer, resident became aggressive striking peer with rolled up magazine to the face. Staff immediately intervened and redirected away from each other. Resident placed on 1:1. Provider contacted and new order received to send resident to emergency room for stabilization. Family notified..." The resident's clinical record revealed the resident (#91) was transferred to the emergency room at 12:27 p.m. on October 29, 2018. Review of resident #35's clinical record revealed the resident sustained slight redness to the right side of his cheek. A Witness Statement Form dated October 29, 2018 revealed "I was on the hallway by my cart and I heard yelling so I looked over to my left and I saw (resident #91) had a rolled up magazine in his hand and hit (resident #35) in the face. And then (resident #35) grabbed (resident #91) by the arms and I told him not to do anything to him as a CNA (certified nursing assistant) came to separate them since she was closer. (Resident #91) looked very upset even after being separated." An interview was conducted with a CNA (staff #272) on October 31, 2018 at 11:00 a.m. Staff #272 stated that she heard in report that resident	Y1019		

ADHS LICENSING SERVICES

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Y1019	Continued From page 13 #91 hit resident #35 with a magazine. Staff #272 further stated resident #91 is very busy and is everywhere. An interview was conducted with resident #35 on October 31, 2018 at 11:20 a.m. The resident had difficulty expressing himself. When asked about the incident which occurred on October 29, 2018 with resident #91, resident #35 clearly stated "I don't like that guy, he is an a--hole." Resident #35 further stated "I was sitting right here (as he pointed to his chair by his bed) and Bam (made a gesture that resident #91 hit him on the side of the face)." When asked what resident #91 hit him with, resident #35 stated "He is an a--hole." When asked if resident #91 use a magazine to hit him in the face, resident #35 stated "yes." During an interview conducted with an environmental services assistant (staff #300) on October 31, 2018 at 1:54 p.m. Staff #300 stated that she was cleaning the bathroom when she heard a noise and that it was a fight. Staff #300 stated that she did not see resident #91 hit resident #35. An interview was conducted with an LPN (licensed practical nurse/staff #29) on October 31, 2018 at 3:03 p.m. Staff #29 stated a CNA had attempted to redirect resident #91 closer to activities but that the resident would not follow along. Staff #29 stated that resident #91 "was on a roll" that day in and out of rooms so she ended up administering Ativan prior to the incident. Staff #29 further stated that she did not witness the incident but heard that resident #91 was "messing" with resident #35's wet floor sign in his room and that he (resident #91) "whacked" resident #35 with a rolled up magazine.	Y1019		

ADHS LICENSING SERVICES

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Y1019	Continued From page 14 During an interview conducted with the administrator (staff #87) on October 31, 2018 at 3:16 p.m. Staff #87 stated that staff receive training in CPI (crisis prevention intervention) and de-escalation of behaviors. An interview was conducted with a housekeeper (staff #45) on November 1, 2018 at 9:15 a.m. Staff #45 stated that she was in another resident's room when she heard residents #'s 35 and 91 talking loudly. Staff #45 stated that she turned around and saw resident #91 hit resident #35's face with a magazine. Staff #45 stated that resident #35 did not hit resident #91 back but tried to get him out of his room. -Resident #47 was admitted to the facility on February 6, 2009, with diagnoses that included obstructive hydrocephalus, diabetes type II, and Schizophrenia. A quarterly MDS assessment dated May 17, 2018, revealed a BIMS score of 4, which indicated the resident had severely impaired cognition. -Resident #152 was admitted to the facility on April 4, 2016 with diagnoses that included cellulitis, major depressive disorder, pain, and schizoaffective disorder. Review of the annual MDS assessment dated June 21, 2018, revealed a BIMS score of 15, which indicated the resident was cognitively intact. Review of the facility's investigation report revealed a resident to resident altercation occurred on June 23, 2018 between roommates	Y1019		

ADHS LICENSING SERVICES

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Y1019	Continued From page 15 resident #152 and resident #47. Staff overheard resident #152 yell at resident #47. When staff started walking toward the room a slapping sound was heard. Resident #152 verbalized that resident #47 was in the way and was repeatedly asking her questions. The report included resident #152 admitted she slapped her roommate and that no injuries were noted. The facility's investigation report included a written witness statement from a CNA (staff #205). Staff #205 stated that while on break in the dining room, she heard resident #152 yell at resident #47 and that before she could find out what was going, she heard a slap. The CNA stated that resident #47 was asking why did resident #152 hurt her. The CNA stated that she told resident #152 that she cannot do that, but that resident #152 said that she can slap resident #47. Another CNA (#273) written witness statement was included in the report. CNA #273 stated that she heard resident #152 yell at resident #47 because she was exiting the room while resident #152 was trying to enter. She stated as she was leaving the room that she was in, she heard resident #152 slap resident #47. The CNA stated that CNA #205 ran from the break area and asked resident #152 if she had slapped resident #47 and that resident #152 admitted she that hit resident #47. During an interview conducted with CNA #205 on October 31, 2018 at 8:47 a.m., she stated that she remembered the incident between the residents. The CNA stated that she heard a slapping sound coming from the doorway of the residents' room. She stated that she asked resident #152 if she had hit resident #47 and that	Y1019		

ADHS LICENSING SERVICES

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Y1019	Continued From page 16 resident #152 stated that she did hit resident #47. An interview was conducted with CNA #273 on October 31, 2018 10:34 a.m. She stated that she heard a loud slapping coming from the residents' room. The CNA stated that the residents were separated and another staff member asked resident #152 if she had slapped resident #47 and that the resident stated that she did slap resident #47. During an interview conducted on November 1, 2018 at 12:42 p.m. with the Director of Nursing (DON #241), she stated that she was familiar with the resident to resident altercation and that neither resident was injured. The facility's policy regarding Behavior Changes/Combative/Aggressive Behavior (Resident) revealed "...Every effort is made to have all staff trained in CPI (nonviolent crisis intervention program). The program educates and trains staff in identification of escalating behaviors and strategies in deceleration using supportive and/or directive approaches..." Review of another facility's policy regarding Preventing, Reporting and Investigating Abuse included "Our residents have the right to be free from abuse..."	Y1019		
Y1233	R9-10-412.B.6.c. Nursing Services R9-10-412.B. A director of nursing shall ensure that: R9-10-412.B.6. As soon as possible but not more than 24 hours after one of the following events occur, a nurse notifies a resident's	Y1233		

ADHS LICENSING SERVICES

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Y1233	Continued From page 17 attending physician and, if applicable, the resident's representative, if the resident: R9-10-412.B.6.c. Has a significant change in condition; and This RULE is not met as evidenced by: Based on clinical record review, staff and resident interviews, and policies and procedures, review, the facility failed to promptly notify the provider of abnormal laboratory results for one resident (#61) and failed to ensure the physician was notified of changes in the condition of two wounds for one resident (#470). Findings include: -Resident #61 was admitted to the facility on May 21, 2018, with diagnoses that included congestive heart failure, repeated falls, and urinary tract infection. Review of a quarterly Minimum Data Set (MDS) assessment dated August 23, 2018, revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. The assessment also included the resident had a urinary tract infection (UTI) within the last 30 days. A nursing progress note dated October 22, 2018, revealed the resident complained of pain when voiding and had a history of frequent UTIs. The note included the provider was notified and that an order was obtained for a urinalysis (UA) with a culture and sensitivity (c&s). The note also included that the sample was collected and sent to the laboratory (lab).	Y1233	**Y1233** **Correct to the individual:** Resident #61's Provider was notified of the results of her UA C&S and it was documented in the Medical Record. **Correct to all others:** Has the potential to affect all Residents that have lab orders. Licensed Nurses will receive re- education on procedure for notifying the Provider of abnormal lab results and document the results in the medical record accordingly. **System Correction:** Audits of abnormal lab results reported to the Provider and documented in the medical record will be completed 2 times weekly for 90 days and then weekly thereafter. **Monitoring System:** The analysis of the audits will be taken to QAPI meeting for review and follow-up as needed. **Correction Date:** **Responsible Person:** DON or	12/16/18

ADHS LICENSING SERVICES

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Y1233	Continued From page 18 Review of the physician's order dated October 22, 2018, revealed an order for a urinalysis with culture and sensitivity if indicated. The results of the UA, c&s dated October 24, 2018 revealed the following abnormal results: -nitrite positive -3+ leukocyte esterase -slight cloudy -white blood cell >50 -White blood cell clumps -many bacteria -squamous epithelial -mucous threads However, no documentation was found that the results of this abnormal lab test were communicated to the provider. The final report of the urine lab dated October 27, 2018 revealed: ->100,000 gram negative rods/ escheria coli Again, no documentation was found that this final report of the urine lab was communicated to the provider. A nursing progress note dated November 1, 2018 at 2:37 p.m. revealed the UA results read positive for an UTI and that the provider was notified. Review of the physician's orders dated November 1, 2018, revealed an order for Keflex (antibiotic) 500 milligrams capsule by mouth every 12 hours for an UTI. An interview was conducted with the resident (#61) on October 29, 2018 at 11:16 a.m. She stated that she thinks she has an UTI and stated that her urine was sent to the lab "last week". She stated that she does not think the results are back yet because no one has told her the results	Y1233	**Correct to individual:** Resident #470 was discharged from the facility on 9/28/17. **Correct to all others:** Has the potential to affect any residents with existing alterations in skin integrity. Licensed Nurses will be re- educated on the requirement to document that a Provider is notified of a decline in wound status. **System Correction:** Audits will be completed for any wounds weekly to ensure that the Provider is notified of a declining wound. **Monitoring of System:** The analysis of the audits will be taken to QAPI for review monthly and follow up as needed. **Correction Date:** **Responsible Person:** DON or designee	12/16/18

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Y1233	Continued From page 19 or started her on a treatment. The resident stated that she has severe pressure and pain when she urinates and that it has made her cry. She also stated that she has a spastic urethra. An interview was conducted with a Licensed Practical Nurse (LPN/staff #44) on November 1, 2018 at 1:35 p.m. She stated that it is the nurse's responsibility to be on the lookout the laboratory results. She stated that she had not seen the laboratory report. The LPN stated that as soon as she reviews a lab report, she will call the provider if the laboratory results were abnormal or ordered STAT. She stated that a delayed notification of an abnormal UA to the provider could put the resident at risk of discomfort or sepsis. The LPN stated that their procedure was not followed in this instance because the provider was not notified of the lab results when the facility received the report. During an interview conducted with the unit manager (LPN/staff #187) on November 1, 2018 at 1:38 p.m., she stated that the lab results are faxed to the fax machine on "south" and that they are sorted and put in the individual folder for each unit. She stated that as far as she knows, her unit did not receive the lab report of the urine results for resident #61. An interview was conducted with the Family Nurse Practitioner (FNP/#326) for this resident on November 1, 2018 at 1:39 p.m. She stated that normally the provider is notified of laboratory reports as soon as the facility receives them. The FNP stated that she would review the resident's symptoms and the culture results and then decide on what interventions to implement. She stated that she was not notified of the UA or c&s results for resident #61. She also stated that if the	Y1233		

ADHS LICENSING SERVICES

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Y1233	Continued From page 20 physician had been notified of the results; the physician would have asked her to follow up. The FNP stated that it was concerning to her that it was over 48 hours before the provider was notified. She further stated that this delay in notification and treatment puts the resident at risk for sepsis or a kidney infection. During an interview conducted with a laboratory customer service representative (#325) on November 1, 2018 at 2:00 p.m., she stated that the initial report of the UA was faxed to the facility on October 24, 2018 at 2:30 p.m. and that the final c&s was faxed to the facility on October 27, 2018 at 9:30 a.m. During an interview conducted with the receptionist (staff #130) on November 1, 2018 at 2:10 p.m., she confirmed that the fax number the lab customer service representative stated was used to fax the lab reports was the correct fax number. An interview was conducted with the Director of Nursing (DON/staff #241) on November 1, 2018 at 2:13 p.m. She stated that when an order is received for a lab, a slip is filled out and sent to the laboratory. She stated that the laboratory will fax the results to the facility and that if the labs results are abnormal, the provider is notified on the shift that the lab results were received. She stated that if the provider gives an order, it will be reflected in the orders and a progress note. After reviewing the UA and c&s results for resident #61, the DON stated that the provider should have been notified of the results within the receiving nurse's shift. She stated that delaying to notify the provider of the lab results puts the resident at risk for sepsis.	Y1233		

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Y1233	Continued From page 21 The facility's policy regarding laboratory ordering and monitoring revealed that each day the carbon copy of the previous day's lab log will be retrieved from each unit, the results obtained, and returned to the nursing staff. The policy included that the provider will be notified of results as needed, and that when the provider is notified verbally, the nurse is to date and sign/initial the lab slip, and include the name of the provider contacted. -Resident #470 was admitted on May 11, 2017, with diagnoses that included encounter for other orthopedic aftercare, muscle weakness, incomplete quadriplegia, and spinal stenosis of the cervical region. The care plan initiated June 1, 2017, revealed the resident was at risk for pressure ulcers. Interventions included reporting any signs of skin breakdown. Review of a significant change in status Minimum Data Assessment (MDS) assessment dated August 17, 2017, revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact. The MDS assessment further included the resident had no pressure ulcers. A nursing progress note dated September 19, 2017, revealed that the resident was assessed during a shower and was observed to have open areas to the right ischium and coccyx that were pink/red in color. A skin integrity event form dated September 19, 2017 revealed that the injury to the right ischium measured 6.5 centimeters (cm) x 7.6 cm x 0.2 cm and that the skin impairment to the coccyx measured 1 cm x 0.5 cm x 0.1 cm. and that they	Y1233		

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	NCI-2652	A. BUILDING: _____ B. WING _____	11/01/2018

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Y1233	Continued From page 22 were open, pink/red, and blanchable. The documentation also included that the physician was notified on September 19, 2017 at 2:00 p.m. Review of the care plan initiated September 19, 2017, revealed the resident had open areas to the right ischium and coccyx related to moisture associated skin damage. Review of a nursing progress note dated September 26, 2017, revealed the area to the right ischium had darkened in color to a dark purple and was no longer blanchable and measured 4.5 cm x 5.5 cm x 0.1 cm. and that there a small amount of drainage. The note also revealed the peri wound was intact and blanched well and that the treatment continued as ordered. The note further included the wound bed to the coccyx region was pink/red in color and had increased in size to 1.4 cm x 3.7 cm x 0.1 and now consisted of three small areas with attached edges with a scant amount of drainage. The note also included that the areas and the peri wound continued to blanche and that the treatment continued as ordered. However, further review of the clinical record did not reveal documentation that the physician was notified of the changes in the wounds' condition. The resident was discharged on September 28, 2017. During an interview conducted with a Licensed Practical Nurse (LPN/staff #44) on November 1, 2018 at 9:35 a.m., she stated that the floor nurse, the wound team, the Director of Nursing (DON), and the unit manager follow a resident with an existing wound. The LPN stated that if a wound worsens, the nurse would notify the physician and	Y1233		

ADHS LICENSING SERVICES

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Y1233	Continued From page 23 the wound team and document the notification in the nursing progress notes. An interview was conducted with the Wound Care Certified (WCC) Registered Nurse (RN/staff #253) on November 1, 2018 at 9:58 a.m. She stated that the wound care team, sometimes with the Nurse Practitioner, rounds on existing wounds once a week. The RN stated that if there was a change in the wound she would notify the provider and document the provider notification in her notes, progress notes, or by presence of a new physician order. She stated that if the floor nurse observed a change in the wound while providing the treatment, then the floor nurse would notify the provider that day and document the notification and any order obtained. She stated that the floor nurse would also notify her of the wound decline. The RN stated that on September 19, 2017, resident #470 wounds were assessed to be a mixture of moisture associated dermatitis with a fungal component. She stated that at the time of her observation on September 26, 2017, she classified the right ischium wound as a pressure related deep tissue injury and that the wound had declined. She also stated that the sacral coccyx area wounds were difficult to measure and that now there were three open areas, so she documented the overall size. The wound nurse stated that she notified the physician of the wound decline but she was unable to find any documentation of the notification. An interview was conducted with the DON (staff #241), who is wound care certified, on November 1, 2018 at 11:47 a.m. She stated that her expectation is that when a resident has a decline in skin integrity, the provider is notified of the decline and that staff document the provider	Y1233		

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Y1233	Continued From page 24 notification by some means i.e. progress notes, obtaining an new order, treatment records, etc. She stated that a wound that changed from blanchable to non-blanchable to dark purple with a change in classification from moisture associated skin damage to a deep tissue injury and any new open areas would be considered a decline in the skin integrity. The DON stated that the facility policy of notifying the physician of a change in a resident's condition was not followed for this resident. Review of the facility's wound identification guidelines policy revealed that routine rounds are done by staff and with any new area of concern staff will follow the procedure for a change of condition to include notifications to the provider. The facility's policy regarding a change in a resident's condition or status revealed that the facility shall promptly notify the attending physician of changes in the resident's medical condition.	Y1233		
Y2109	R9-10-421.A.1.b.i. Medication Services R9-10-421.A. An administrator shall ensure that policies and procedures for medication services: R9-10-421.A.1. Include: R9-10-421.A.1.b. Procedures for preventing, responding to, and reporting: R9-10-421.A.1.b.i. A medication error, This RULE is not met as evidenced by:	Y2109	**Y2109** **Correct to individual:** Resident #370 was discharged from the facility on 12/6/2017. **Correct to all others:** Had the potential to affect all residents that have medication orders. A performance improvement plan was developed as outlined in the statement of deficiencies on 11/28/2017 with the root cause, tasks, and reporting process for findings.	

ADHS LICENSING SERVICES

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Y2109	Continued From page 25 Based on clinical record review, staff interviews, facility documentation and policies and procedures, the facility failed to implement their policy to ensure one resident (#370) was free from a significant medication error, by failing to administer an anticoaglulant medication per the admission orders. Findings include: Resident #370 was admitted from a hospital to the facility on 10/16/2017, with diagnoses that included chronic systolic congestive heart failure, prosthetic aortic heart valve, chronic obstructive pulmonary disease, prior myocardial infarction, chronic kidney disease and pacemaker. Review of the Admission Orders dated 10/16/17 from the hospital included for Warfarin (anticoagulant) 3 mg (milligram) tablet orally every Monday, Tuesday, Thursday, Friday and Sunday and Warfarin 5 mg tablet orally every Wednesday and Sunday. On the Admission Orders these two medication orders were crossed through and it was handwritten in for Warfarin 3.5 mg daily and for INR (International Normalized Ratio) lab tests on Mondays and Thursdays. However, the recapitulation of physician orders for October 2017 did not include an order for Warfarin or for the INR lab tests to be done. Review of the Medication Administration Record (MAR) for October 2017 did not reveal any documentation that the resident was administered Warfarin. The MAR further showed that 24-hour chart checks were conducted daily, without recognition	Y2109	**System Correction:** Audits of medication reconciliation were completed thru 2/28/2018 and there were no discrepancies noted. Education was provided to all Nursing staff, Medical Director, Providers and Pharmacists regarding our medication reconciliation process. Policy revision was completed to the Admission Orders policy, Anticoagulation, and 24-hour Chart Checks. **Monitoring System:** The analysis of the audits are taken to QAPI meeting for review and follow up as needed. **Correction Date:** The corrections were made and sustained since February of 2018. **Responsible Party:** DON or Designee	12/16/18

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Y2109	Continued From page 26 of the missed medication. As a result the resident did not receive the anticoagulant medication from the time of admission on 10/16/17 to the time of the discovered missed medication on 11/20/17 (for a total of 34 days). In addition, no INR lab tests were obtained. A physician's order dated 11/20/17 now included for Warfarin 5 mg orally daily and for INR lab tests on Tuesday and Friday for a diagnosis of prosthetic heart valve. Review of the MAR for November 2017 revealed the resident was administered Warfarin on 11/20/17, 11/21/17 and 11/22/17. According to the INR lab test dated 11/21/17, the INR result was 1.2 (sub-therapeutic level). Further review of the clinical record revealed there was no documentation that the physician was notified of the sub-therapeutic level for the INR. A nurse progress note dated 11/22/17 revealed that around 7:30 p.m., the resident appeared to be confused. The note included the resident's vital signs were stable, but her blood sugar was elevated at 447 and was administered insulin. The note also included that a family member requested the resident be sent to the hospital, so 911 was called and the resident was transported to the hospital at 9:00 p.m. Review of the emergency department physician note dated 11/22/17 revealed the resident presented with altered mental status. Diagnoses included confusion, delirium, cerebral vascular accident, hypoglycemia, intracranial hemorrhage and metabolic encephalopathy. The resident was	Y2109		

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Y2109	Continued From page 27 admitted to the Telemetry Unit in stable condition. A hospital physician's note dated 11/27/17 revealed the chief complaint of the patient was "new CVA (cerebral vascular accident) with dysarthria (difficulty speaking)." The History of Present Illness included, "she has now suffered a CVA after being sub-therapeutic on her Warfarin." Review of the hospital course summary dated 11/29/17 revealed the resident was on chronic anticoagulation, due to mechanical aortic valve replacement. The resident presented to the emergency department due to progressive worsening of altered mental status, lethargy, and recent somnolence. In addition to confusion, the patient was having difficulty talking. The summary included the resident's INR level was 1.6, "which is sub-therapeutic and given the patient's mechanical aortic valve, the resident should have a goal INR of 3." The documentation further included the patient was found, on repeat Computerized Tomography (CT) imaging to have an "acute stroke, and this is thought to be embolic given her subacute therapeutic INR. Per neurology recommendations, we will continue Warfarin with up-titration still as to get her INR back in to range..at a goal of 3.0." An interview was conducted on 10/31/18 at 1:48 p.m., with a Licensed Practical Nurse (LPN/staff #214). Staff #214 stated that when a resident is admitted from the hospital, the hospital sends admissions orders, which are reviewed with the facility's physician, usually by reading them over the phone, and then entering them into the electronic chart. Staff #214 stated that after the orders are entered, the order recap is printed and the physician will review and sign the order recap. He stated that a chart check process is also	Y2109		

ADHS LICENSING SERVICES

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Y2109	Continued From page 28 completed every 24 hours by the night nurse which includes checking for new orders and verifying that the order recap is correct. Staff #214 stated that if there are medications that were on the hospital admission orders that were not on the order recap, the nurse should review the clinical record for documentation as to why the medications are not on the orders or call the physician to find out why. He stated that if the medications were missed when adding them to the electronic record, it should have been caught by the 24 hour chart check process. The LPN said that he would expect a resident on long term anticoagulants would continue on the medication while at the facility. He further stated that if a resident is on long term anticoagulants that were suddenly stopped it could result in coagulation of the blood leading to clots, pulmonary embolism, deep vein thrombosis and stroke. During an interview conducted on 11/01/18 at 9:15 a.m. with the Director of Nursing (DON/staff #241), the DON stated the admitting department obtains the resident information and orders from the hospital. She stated that when she became aware of the missed Warfarin and labs for resident #370, she started a Performance Improvement Plan (PIP) for their Quality Assurance Process Improvement (QAPI) committee. She said the PIP was designed to identify how this occurred and to ensure there is a process in place so that it does not happen again. The DON stated that in the case of resident #370, the hospital admission orders had Warfarin on them, it just got missed and fell through all of the safety checks. The DON stated that the 24-hour chart check missed it, the physician did a History and Physical the next day and missed it, and the pharmacy review conducted their review 2 days later and missed it.	Y2109		

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Y2109	Continued From page 29 An interview was conducted on 11/01/18 at 9:41 a.m. with the Administrator (staff #87). The Administrator stated that the facility has initiated the following measures: -Chart audits were conducted on 100% of new admissions and randomly on other charts and any discrepancies are reported to the Administrator and none were identified -Staff education was initiated and completed -Physicians and the Pharmacy now review the hospital orders for medications and the facility orders when they come in to see a new resident -All facility physicians and NPs were alerted to what occurred and their role in reviewing new admission orders. -The medical director and the pharmacy consultant review and sign off on all medication errors. -The PIP was completed in February 2018 and the issue was then turned to ongoing QAPI quality audits. Review of the facility's PIP and ongoing QAPI audits revealed the following: -QAPI Action Plan initiated on 11/28/17 with the root cause, tasks, and reporting process for findings -Notes of ongoing review identified no new concerns on 12/15/17, 12/29/17, 1/11/18, 1/25/18, 2/8/18, and 2/22/18 -Action Plan did not note any concerns since the staff education and the plan then transitioned to monthly updates at the QAPI Committee meeting -Staff education materials and education sign-in sheets -Admission audit sheet results	Y2109		

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Y2109	Continued From page 30 Review of the facility's policy titled, Admission Orders: Reconciliation Procedures revealed the facility will take measures to obtain accurate admission orders. The policy included that the nurse receiving the resident shall review the orders and make recommendations to the provider after observation of the resident. All admitting orders are to be reviewed by a licensed nurse. The nurse will document that the admission orders were reconciled for accuracy and will notify the provider of any discrepancies. The nurse will then fax the admission orders and transcribed orders to the pharmacy. The policy also included the 24-hour chart check nurse will review transfer orders against admission orders and against the MAR for accuracy. Review of the facility's policy titled, Anticoagulation - Clinical Protocol revealed that as part of the initial assessment, the physician will help identify individuals who are currently anticoagulated and assess for any signs or symptoms of adverse drug reactions and evidence of effects related to the sub-therapeutic or greater than therapeutic drug level. The policy included the nurse shall assess and document/report current drug and dosage of anticoagulation therapy, lab results and monitoring, active diagnoses, and other current medications. The physician will verify underlying causes of conditions requiring anticoagulation therapy and will prescribe the therapy in accordance with recognized guidelines and will order appropriate lab testing to monitor the therapy. The facility's policy titled, 24-Hour Chart Checks stated that the 24-hour chart checks will be completed by the night shift. The policy included that each chart is checked for new orders and if	Y2109		

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Y2109	Continued From page 31 any error is noted it is reported to the unit manager and corrected immediately. The policy included that if clarification of orders are needed, it must be followed-up promptly and reported. Staff will initial on the 24-hour chart check sheet located in the front of the physician's orders in the clinical record, after the chart check is completed.	Y2109		

ADHS
LICENSING

Notice of Inspection Rights

Facility/Agency Name: Devon Gables Rehabilitation Center

Address: 6150 East Grant Road		City: Tucson	Zip: 85712
Facility I.D.#: LTC0031	License #: NCI-2652	Medicare #: 035145	Date of Inspection: October 29, 2018

Survey Event ID: AKMC11

Inspector/Team Coordinator: Chris Benson

Accompanied By: Monica Mecham, Johnna High, Teresa Gallego, Brian Wachtendonk, Brenda Robinson, Kim Yedowitz

BUREAU OF LONG TERM CARE LICENSING

This inspection is conducted under the authority of:

1. Arizona Revised Statutes (A.R.S.) Title 36, Chapters 1 and 4, and Arizona Administrative Code (A.A.C.), Title 9, Chapter 10. Some of the activities during the inspection may include, but are not limited to, a facility premise inspection, review and/or copying of records, including personnel records, interviews with residents/patients/clients, family and staff, and review of services offered.
2. The purpose of this inspection is to:
   - x Determine compliance with health care institution requirements pursuant to the above A.R.S. and A.A.C.
   - x Conduct a complaint investigation.
3. No fees are charged for this inspection.
4. An authorized representative of this facility may accompany the inspector(s) during the inspection conducted on these premises, except during any confidential interview.
5. You have the right to receive copies of any original documents taken by the inspector(s) during the inspection in those cases where the agency has authority to take original documents.
6. You and your staff have the opportunity to provide any information that would clarify an issue. Additionally, interviews with staff, family or residents/patients/clients may be conducted privately. Each person interviewed will be informed that statements made by the person may be included in the inspection report and each person whose conversations are tape or video recorded will be informed that the conversation is being tape or video recorded.
7. Upon completion of the inspection the inspector(s) will conduct an exit interview and informally disclose their findings. A Statement of Deficiencies (SOD) formally notifying you of the findings will be provided within 30 working days. You will be afforded an opportunity to submit a Plan of Correction (POC) unless the Department is considering enforcement against the license.
8. You have an opportunity to dispute any findings of non-compliance through an Informal Dispute Resolution (IDR). Details of the IDR process will be provided when the SOD is mailed to you.
9. If you have questions regarding this inspection, you may contact: Diane Eckles, Bureau Chief, at 150 N. 18th Ave., Suite 440, Phoenix, Arizona 85007-3242, Phone: (602) 364-2675, FAX: (602) 324-0993, E-Mail: Diane.Eckles@azdhs.gov. If you have an issue that you cannot resolve with the Bureau or the Division, you may contact the Office of Ombudsman-Citizens' Aide, 3737 N. 7th St., Suite 209, Phoenix, AZ 85014 (602) 277-7292.
10. Your administrative hearing rights are found at A.R.S. § 41-1092 et seq., and rights relating to appeal of a final agency decision can be found in A.R.S. §12-901 et seq.

Upon entry to the premises for this inspection, the inspector(s) presented photo identification indicating that they are Arizona Department of Health Services (ADHS) employees and reviewed with me the above Notice of Inspection Rights. I have read the disclosures and am notified of my inspection and due process rights as listed. I understand that while I have the right to decline to sign this form, the ADHS representative(s) may proceed with the inspection.

Heather Luehrs — 10/29/18.

Administrator/Director/Agency Representative Signature — Date:

☐ Administrator/Director/Agency Representative refused to sign this form.
☐ Administrator/Director/Agency Representative or authorized on-site representative is not present.

Inspector/Team Coordinator Signature: — Date: 10/29/18

☒ Copy left with Administrator/Director/Agency Representative

RECEIVED
NOV 5 2018
By

QUALITY RATING CERTIFICATE

Arizona Department of Health Services

ARIZONA DEPARTMENT OF HEALTH SERVICES
NURSING CARE INSTITUTION

Issued To: Devon Gables Rehab Center

The above named facility has met licensure requirements, has been licensed for one year or more and, therefore, has received the following quality rating as required by R9-10-919.

COMPONENTS	CRITERIA MET	
	Yes	No
I. Nursing Services	18	7
II. Resident Rights	25	0
III. Administration	23	2
IV. Environment and Infection Control	15	0
V. Food Services	10	0
TOTAL CRITERIA MET	91	9

QUALITY PERFORMANCE SCALE	
"A"	X
"B"	
"C"	
"D"	
"A": 90 to 100 points	
"B": 80 to 89 points	
"C": 70 to 79 points	
"D": 69 or fewer points	

License Effective:

From: 11-1-18 To: 10-31-19

Issued: 12-3-18

Number: NCI- 26052

Recommended By

Issued By Assistant Director

Quality Rating Evaluation

Facility: Devon Gables Rehab Center Phone:

Address:

Survey Date: Contact Person:

Nursing Services:

Criteria:	Pts.	Criteria Met? YES	NO
The nursing care institution is implementing a system that ensures residents are provided nursing services to maintain the resident's highest practicable physical, mental, and psychosocial well-being according to the resident's comprehensive assessment and care plan.	15	15	Ø
The nursing care institution ensures that each resident is free from medication errors that resulted in actual harm.	5	Ø	5
The nursing care institution ensures the resident's representative is notified and the resident's attending physician is consulted if a resident has a significant change in condition or if the resident is in an incident that requires medical services.	5	3	2

Points Yes 18

Points No 7

Comments:

Resident Rights:

Criteria:	Pts.	Criteria Met? YES	NO
The nursing care institution is implementing a system that ensures a resident's privacy needs are met.	10	10	Ø
The nursing care institution ensures that a resident is free from physical and chemical restraints for purposes other than to treat the resident's medical condition.	10	10	Ø
The nursing care institution ensures that a resident or the resident's representative is allowed to participate in the planning of, or decisions concerning treatment including the right to refuse treatment and to formulate a health care directive.	5	5	Ø

Points Yes 25

Points No Ø

Comments:

Administration:

Criteria:	Pts.	Criteria Met? YES	NO
The nursing care institution has no repeat deficiencies that resulted in actual harm or immediate jeopardy to residents that were cited during the last survey or other survey or complaint investigation conducted between the last survey and the current survey.	10	10	Ø
The nursing care institution is implementing a system to prevent abuse of a resident and misappropriation of resident property, investigate each allegation of abuse of a resident and misappropriation of resident's property, and report each allegation of abuse of a resident and misappropriation of resident's property to the Office of Long Term Care Licensure and as required by A.R.S. § 46-454.	5	3	2
The nursing care institution is implementing a quality management program that addresses nursing care institution services provided to residents, resident complaints, and resident concerns, and documents actions taken for response, resolution, or correction of issues about nursing care institution services provided to residents, resident complaints, and resident concerns.	5	5	Ø
The nursing care institution is implementing a system to provide social services and a program of ongoing recreational activities to meet the resident's needs based on the resident's comprehensive assessment.	1	1	Ø
The nursing care institution is implementing a system to ensure that records documenting freedom from infectious pulmonary tuberculosis are maintained for each personnel member, volunteer, and resident.	1	1	Ø
The nursing care institution is implementing a system to ensure that a resident is free from unnecessary drugs.	2	2	Ø
The nursing care institution is implementing a system to ensure a personnel member attends in-service education according to policies and procedures.	1	1	Ø

Points Yes 23

Points No 2

Comments:

Environment and Infection Control:

Criteria:	Pts.	Criteria Met? YES	NO
The nursing care institution environment is free from a condition or situation within the nursing care institution's control that may cause a resident injury.	5	5	
The nursing care institution establishes and maintains a pest control program.	1	1	
The nursing care institution develops a written disaster plan that includes procedures for protecting the health and safety of residents.	1	1	
The nursing care institution ensures orientation to the disaster plan for each staff member is completed within the first scheduled week of employment.	1	1	
The nursing care institution maintains a clean and sanitary environment.	1	1	
The nursing care institution is implementing a system to prevent and control infection.	5	5	
An employee washes hands after each direct resident contact or where hand washing is indicated to prevent the spread of infection.	1	1	

Points Yes 15

Points No 0

Comments:

Food Services:

Criteria:	Pts.	Criteria Met? YES	NO
The nursing care institution complies with 9 A.A.C. 8, Article 1, for food preparation, storage and handling as evidenced by a current food establishment license	1	1	Ø
The nursing care institution provides each resident with food that meets the resident's needs as specified in the resident's comprehensive assessment and care plan.	3	3	Ø
The nursing care institution obtains input from each resident or the resident's representative and implements recommendations for meal planning and food choices consistent with the resident's dietary needs	2	2	Ø
The nursing care institution provides assistance to a resident who needs help in eating so that the individual's nutritional, physical, and social needs are met.	2	2	Ø
The nursing care institution prepares menus at least one week in advance, conspicuously posts each menu, and adheres to each planned menu unless an uncontrollable situation such as food spoilage or non-delivery of a specified food requires substitution.	1	1	Ø
The nursing care institution provides food substitution of similar nutritive value for residents who refuse the food served or who request a substitution.	1	1	Ø

Points Yes 10

Points No Ø

Comments:

DEVON GABLES
REHABILITATION CENTER

Dear Shoalynn Gilliland,

Attached is our plan of correction for the state tags.
Please let me know if you need anything further.

Sincerely,

Heather Friebus R.D., LNHA
Administrator
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(520) 296-6181 x 5011
(520) 298-0997 fax
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