STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035255	A. BUILDING _____ B. WING _____	06/30/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PALM VALLEY REHAB & CARE CTR	13575 WEST MCDOWELL ROAD GOODYEAR, AZ 85338

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 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation, interviews, and facility policy, the facility failed to ensure that one resident's (#1) provider was notified after a change in condition. The sample size was one resident. The deficient practice could result in delayed medical care. Findings include: Resident #1 was readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A physician's progress note dated [DATE] at 2:13 p.m. included that the resident had a medical history that included [MEDICAL CONDITION] with septic shock. The note included that the resident was alert, oriented, sitting up in bed, weak appearing, on oxygen support via trach, and the resident's lung sounds were clear. An admission MDS (Minimum Data Set) assessment dated [DATE] revealed that the resident scored a 10 on the Brief Interview for Mental Status (BIMS) indicating that he had moderately impaired cognition. The resident was coded as being totally dependent on staff for care and was to receive nothing by mouth. The assessment also included that the resident received oxygen therapy, suctioning,[MEDICAL CONDITION], and tube feeding. The resident's cognitive function care plan revealed that he had impaired cognitive function related to cerebral infarction and his [MEDICAL CONDITION]. An intervention included to monitor any changes in his cognitive function and to report these to the provider. Review of progress notes dated [DATE] included the following entries: -At 10:15 p.m. a note entered by a Respiratory Therapist (RT/staff #203) revealed that resident self induced a large amount of brownish vomit in front of a Certified Nursing Assistant (CNA/staff #79). The CNA cleaned the resident up and the RT suctioned the resident after the resident had small brownish secretions. The resident's heart rate was 136 beats per minute (bpm), his respiratory rate was 20 breaths per minute, and the resident's oxygen saturation was 91% on room air. The resident was noted to be in no distress and the nurse was notified of the situation. The note indicated [MEDICAL CONDITION] was done and the inner cannula was changed. -At 11:01 p.m. a late entry note for 10:15 p.m. entered by a RT revealed the resident may have aspirated small amounts when he self induced vomiting. -At 10:42 p.m. a note entered by a Licensed Practical Nurse (LPN/staff #40) documented that the resident was alert and oriented, able to make needs known, and was in no respiratory distress. The note indicated the resident had vomited once during the evening when he self induced vomiting in front of a CNA (staff #79) who reported that the resident placed his entire fingers in his mouth to the back of his throat, gagged, and then vomited. The resident's heart rate on a continuous pulse oximeter was at 141 bpm but when taken manually it was 112 bpm. The note indicated that the LPN would continue to monitor for acute changes. There was no documentation to show that the resident's provider was notified of the vomiting. Review of the progress notes dated [DATE] included the following entries: -At 07:46 a.m. a note entered by a LPN (staff #202) noted a decrease in the resident's oxygen concentration as it was reading 85% on 5 liters of oxygen, and the resident's heart rate was 49 bpm at 2:30 a.m. The LPN notified the Nurse Practitioner (NP/staff #197). The NP ordered to increase the resident's oxygen until saturations are at 90% or higher and to monitor the resident's vital signs. The note indicated that at 3:00 a.m., there were no positive results. The NP was notified again and the resident was to be sent to the hospital. The LPN also notified the Director of Nursing (DON/staff #24) and the Medical Director regarding the incident. The resident's health deteriorated and he became unresponsive. Staff started Cardiopulmonary Resuscitation (CPR) and RT suctioned the resident to clear any secretions. The paramedics arrived and took over care. The resident expired at 4:34 a.m. on [DATE]. The resident's wife, daughter, the NP (staff #197), Medical Director, DON, and Unit Manager were notified. Review of the facility's investigative report regarding the resident's death revealed that the physician concluded that the likely cause of death was aspiration pneumonia. A telephonic interview was attempted at 8:49 a.m. on [DATE] with LPN #40. A message was left for a return call and no return call was received. On [DATE] at 10:30 a.m. an interview was conducted with the DON (staff #24). She stated that the facilty does have a policy that any change of condition would require provider notification. She stated that she would have expected that the LPN (staff #40) would have contacted the provider after the resident self induced vomiting. She said the resident has a history of aspiration pneumonia. She said that especially in this case since the resident's sputum had noted changes after he vomited. An interview was conducted on [DATE] at 10:55 a.m. with a NP (staff #197). She stated that she was not notified of the self induced vomiting that the resident experienced and that she should have been notified about this vomiting when it occurred. In an interview with a CNA (staff #70) on [DATE] at 11:40 a.m., she said that she reported the vomiting to the LPN when it occurred. She said she saw the resident stick his fingers in his mouth to the point where he made himself throw up. She said that she knew the LPN was going to chart on this incident but did not know if the LPN notified the provider. Review of the facility's change of condition policy, revised [DATE], revealed it is the policy of the facility to identify, inform the provider, and intervene to provide medical or nursing care for a resident experiencing an acute medical change of condition in a timely manner. The policy included that upon noting or receiving report of a change in a resident's physical, mental, or psychosocial status, the nurse will evaluate the resident's condition and after assuring the resident's safety will notify the resident's provider of the clinical findings and note/implement new orders by the provider. The policy included to keep the resident and/or the resident's representative notified of the change of condition, new orders, and/or the need to seek acute medical intervention.
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** Based on clinical record reviews, facility documentation, staff interviews, and policy review, the facility failed to ensure an allegation of resident to resident abuse regarding two residents (#9 and #7) was reported to the State Survey Agency within the required timeframe and failed to provide a completed investigation to the State Survey Agency regarding one resident's death (#1). The sample size was four residents. The deficient practice could result in abuse allegations as well as the results of investigations not being reported to the State Survey Agency. Findings include: -Resident #9 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of an annual Minimum Data Set (MDS) dated [DATE] revealed the resident scored a 4 on the Brief Interview for Mental Status (BIMS) indicating he had severely impaired cognition. Review of the nursing notes from [DATE] through 21, 2020 revealed no documentation regarding any incidents involving this resident. -Resident #7 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The resident's quarterly Minimum Data Set (MDS) dated [DATE] included that the resident scored 7 on the Brief Interview for Mental Status (BIMS) indicating severely impaired cognition. A progress note dated [DATE] at 11:40 a.m. written by a Licensed Practical Nurse (LPN/staff #94) noted that the resident was touching another resident (resident #9) inappropriately. The

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) residents were immediately separated from each other. The incident was reported to both charge nurses immediately. The charge nurses included a Licensed Practical Nurse (LPN/staff #198) and a Registered Nurse (RN/staff #199). A progress note dated [DATE] at 12:34 p.m. written by a LPN charge nurse (staff #198) stated that the resident was found in another resident's room masturbating with her pants around her knees. She was informed that she can only do these activities in her own room. The note included that after this incident, the resident was found to have her hand down a male resident's (resident #9) brief performing sexual activities on the resident. The resident was again educated that this was not appropriate behavior especially in public areas. The resident did not respond meaningfully and rolled away. The facility investigation dated [DATE] included an interview with a housekeeper (staff #200) and a Certified Nursing Assistant (CNA/staff #8). In the interviews, the staff both reported they witnessed an incident involving resident #7 on [DATE] at approximately 11:00 a.m. where the resident was touching another resident (resident #9) inappropriately in the dining room. Resident #7 had her hand in another resident's brief (resident #9) and resident #9 had one hand in resident #7's shirt and the other hand in her brief. Staff #8 and Staff #200 stated the incident was reported to a RN charge nurse (staff #199). The incident on [DATE] is not included in the clinical record. The investigation included that the resident again had her hands down resident #9's pants on [DATE]. The facility investigation included a statement from a LPN charge nurse (staff #198) dated [DATE] which included that the CNAs reported that the resident was found in an empty room belonging to another resident masturbating. It was also reported that the resident was seen in the back hall attempting to put hands down another resident's pants (resident #9) on [DATE] to perform a sexual act. The investigation documentation stated that both residents had their hands in each other's brief. The resident was educated she could only masturbate in her room with privacy drawn and no other residents could be touched in that way. The statement does not include that the incident was reported to anyone else. The facility investigation also included a statement from a RN charge nurse (staff #199) dated [DATE] who said no physical inappropriate sexual behavior was observed, reported, or shared with her. Review of the State complaint data system revealed the incident on [DATE] at 11:00 a.m. and the incident on [DATE] at 11:40 a.m. were not reported to the State Agency until [DATE] at 11:08 a.m. Review of the employee files for staff #198 and staff #199 revealed that both staff were terminated for failure to report sexual abuse and both were reported to the State Board of Nursing. A phone interview was attempted on [DATE] at 12:35 p.m. with staff #199. The number provided was no longer in service. A voicemail was left for staff #198 on [DATE] at 12:37 p.m. and was not returned. An interview was conducted on [DATE] at 1:32 p.m. with the Director of Nursing (DON), the administrator (staff #34), and the regional clinical director (staff #201). The administrator acknowledged that the incident was not reported within the required timeframe of 2 hours. He stated the nurses who received the first report should have followed up and reported the incident to himself or the DON for a timely investigation. The administrator stated that during the interview with staff #198 regarding the incident, staff #198 stated he did not think the incident was sexual abuse and therefore did not think he was required to report it. The administrator stated staff #199 continued to deny that anything was reported to her. -Resident #1 was readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A physician's progress note dated [DATE] at 2:13 p.m. included that the resident had a medical history that included [MEDICAL CONDITION] with septic shock. The note included that the resident was alert, oriented, sitting up in bed, weak appearing, on oxygen support via trach, and the resident's lung sounds were clear. An admission MDS (Minimum Data Set) assessment dated [DATE] revealed that the resident scored a 10 on the Brief Interview for Mental Status (BIMS) indicating that he had moderately impaired cognition. The resident was coded as being totally dependent on staff for care and was to receive nothing by mouth. The assessment also included that the resident received oxygen therapy, suctioning,[MEDICAL CONDITION], and tube feeding. The resident's cognitive function care plan revealed that he had impaired cognitive function related to cerebral infarction and his [MEDICAL CONDITION]. An intervention included to monitor any changes in his cognitive function and to report these to the provider. Review of progress notes dated [DATE] included the following entries: -At 10:15 p.m. a note entered by a Respiratory Therapist (RT/staff #203) revealed that resident self induced a large amount of brownish vomit in front of a Certified Nursing Assistant (CNA/staff #79). The CNA cleaned the resident up and the RT suctioned the resident after the resident had small brownish secretions. The resident's heart rate was 136 beats per minute (bpm), his respiratory rate was 20 breaths per minute, and the resident's oxygen saturation was 91% on room air. The resident was noted to be in no distress and the nurse was notified of the situation. The note indicated [MEDICAL CONDITION] was done and the inner cannula was changed. -At 11:01 p.m. a late entry note for 10:15 p.m. entered by a RT revealed the resident may have aspirated small amounts when he self induced vomiting. -At 10:42 p.m. a note entered by a Licensed Practical Nurse (LPN/staff #40) documented that the resident was alert and oriented, able to make needs known, and was in no respiratory distress. The note indicated the resident had vomited once during the evening when he self induced vomiting in front of a CNA (staff #79) who reported that the resident placed his entire fingers in his mouth to the back of his throat, gagged, and then vomited. The resident's heart rate on a continuous pulse oximeter was at 141 bpm but when taken manually it was 112 bpm. The note indicated that the LPN would continue to monitor for acute changes. Review of the progress notes dated [DATE] included the following entries: -At 07:46 a.m. a note entered by a LPN (staff #202) noted a decrease in the resident's oxygen concentration as it was reading 85% on 5 liters of oxygen, and the resident's heart rate was 49 bpm at 2:30 a.m. The LPN notified the Nurse Practitioner (NP/staff #197). The NP ordered to increase the resident's oxygen until saturations are at 90% or higher and to monitor the resident's vital signs. The note indicated that at 3:00 a.m., there were no positive results. The NP was notified again and the resident was to be sent to the hospital. The LPN also notified the Director of Nursing (DON/staff #24) and the Medical Director regarding the incident. The resident's health deteriorated and became unresponsive. Staff started Cardiopulmonary Resuscitation (CPR) and RT suctioned the resident to clear any secretions. The paramedics arrived and took over care. The resident expired at 4:34 a.m. on [DATE]. The resident's wife, daughter, the NP (staff #197), Medical Director, DON, and Unit Manager were notified. Review of the State complaint data system revealed this incident was initially reported to the State Survey Agency on [DATE] at 10:58 a.m. The initial report stated that an unexpected death occurred in the facility on [DATE] at 4:24 a.m. There was no evidence that the facility submitted any further documentation to the State Survey Agency concluding the results of their investigation of the unexpected death. An interview was conducted on [DATE] at 9:50 a.m., with the administrator (staff #34) who stated that initially the facility reported the resident's death as unexpected but then when they discussed the death with the team including the physician, it looked like it was a death from the comorbidities he came in including his history of aspiration pneumonia. He said the resident was really ill and had recently been hospitalized . The team concluded it was not an unexpected death. He said a final report should have been submitted to the State Survey Agency. In an interview on [DATE] at 10:30 a.m. with the DON (staff #24) she acknowledged that if she had known this incident was reported to the State Survey Agency, she would have completed the five day investigation and submitted it. She said that she was not aware that it had been reported and she was surprised that it was reported. Review of the facility's abuse prohibition policy revealed that all incidents of suspected or alleged abuse will be promptly investigated. The policy included that the facility will report all allegations of abuse within the regulatory timeframes. This included that all allegations of abuse, neglect, exploitation, or mistreatment even if there is no reasonable suspicion will be reported within two hours to the State Survey Agency. The policy included that at the conclusion of the investigation, and no later than five working days of the incident, the facility must report the results of the investigation.
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation, staff interviews, and facility policy, the facility failed to thoroughly investigate an unexpected death for one resident (#1). The sample size was four residents. The deficient practice could result in additional investigations not being thoroughly investigated. Findings include: Resident #1 was readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A physician's progress note dated [DATE] at 2:13 p.m. included that the resident had a medical history that included [MEDICAL CONDITION] with septic shock. The note included that the resident was alert, oriented, sitting up in bed, weak appearing, on oxygen support via trach, and the resident's lung sounds were clear. An admission MDS (Minimum Data Set) assessment dated [DATE] revealed that the resident scored a 10 on the Brief Interview for Mental Status (BIMS) indicating that he had moderately impaired cognition. The resident was coded as being totally dependent on staff for care and was to receive nothing by mouth. The assessment also included that the resident received oxygen therapy, suctioning,[MEDICAL CONDITION], and tube feeding. The resident's cognitive function care plan revealed that he had impaired cognitive function related to cerebral infarction and his [MEDICAL CONDITION]. An

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F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) intervention included to monitor any changes in his cognitive function and to report these to the provider. Review of progress notes dated [DATE] included the following entries: -At 10:15 p.m. a note entered by a Respiratory Therapist (RT/staff #203) revealed that resident self induced a large amount of brownish vomit in front of a Certified Nursing Assistant (CNA/staff #79). The CNA cleaned the resident up and the RT suctioned the resident after the resident had small brownish secretions. The resident's heart rate was 136 beats per minute (bpm), his respiratory rate was 20 breaths per minute, and the resident's oxygen saturation was 91% on room air. The resident was noted to be in no distress and the nurse was notified of the situation. The note indicated [MEDICAL CONDITION] was done and the inner cannula was changed. -At 11:01 p.m. a late entry note for 10:15 p.m. entered by a RT revealed the resident may have aspirated small amounts when he self induced vomiting. -At 10:42 p.m. a note entered by a Licensed Practical Nurse (LPN/staff #40) documented that the resident was alert and oriented, able to make needs known, and was in no respiratory distress. The note indicated the resident had vomited once during the evening when he self induced vomiting in front of a CNA (staff #79) who reported that the resident placed his entire fingers in his mouth to the back of his throat, gagged, and then vomited. The resident's heart rate on a continuous pulse oximeter was at 141 bpm but when taken manually it was 112 bpm. The note indicated that the LPN would continue to monitor for acute changes. Review of the progress notes dated [DATE] included the following entries: -At 07:46 a.m. a note entered by a LPN (staff #202) noted a decrease in the resident's oxygen concentration as it was reading 85% on 5 liters of oxygen, and the resident's heart rate was 49 bpm at 2:30 a.m. The LPN notified the Nurse Practitioner (NP/staff #197). The NP ordered to increase the resident's oxygen until saturations are at 90% or higher and to monitor the resident's vital signs. The note indicated that at 3:00 a.m., there were no positive results. The NP was notified again and the resident was to be sent to the hospital. The LPN also notified the Director of Nursing (DON/staff #24) and the Medical Director regarding the incident. The resident's health deteriorated and he became unresponsive. Staff started Cardiopulmonary Resuscitation (CPR) and RT suctioned the resident to clear any secretions. The paramedics arrived and took over care. The resident expired at 4:34 a.m. on [DATE]. The resident's wife, daughter, the NP (staff #197), Medical Director, DON, and Unit Manager were notified. Review of the State complaint data system revealed this incident was initially reported to the State Survey Agency on [DATE] at 10:58 a.m. The initial report stated that an unexpected death occurred in the facility on [DATE] at 4:24 a.m. There was no evidence that the facility submitted any further documentation to the State Survey Agency concluding the results of their investigation of the unexpected death. Review of the facility's investigative report, obtained onsite, regarding the resident's death revealed that the physician concluded that the likely cause of death was aspiration pneumonia. Further review of the investigative report revealed that the facility had obtained statements from staff involved in the care of the resident. However, there was no statement from the LPN who was first notified that the resident had self induced vomiting (staff #40). In an interview on [DATE] at 10:30 a.m. with the DON (staff #24) she acknowledged that if she had known this incident was reported to the State Survey Agency, she would have completed the five day investigation and submitted it. She said that she was not aware that it had been reported and she was surprised that it was reported. She said that if she had been made aware, a more thorough investigation looking into all aspects of the incident would have been completed. Review of the facility's abuse prohibition policy revealed that all incidents of suspected or alleged abuse, mistreatment, and injuries of unknown origin will be promptly investigated and that the investigation report shall include interviews with any witnesses to the alleged incident and others that may have additional information. The policy also included that the investigative report should include interviews with facility staff members who had contact with the resident during the period of alleged incident.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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** Based on clinical record reviews, facility documentation, staff interviews, and policy review, the facility failed to ensure adequate supervision was provided to two residents (#9 and #7). The sample size was five residents. The deficient practice could result in further incidents between residents. Findings include: -Resident #9 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of an annual Minimum Data Set (MDS) dated [DATE] revealed the resident scored a 4 on the Brief Interview for Mental Status (BIMS) indicating he had severely impaired cognition. Review of the nursing notes from April 18 through 21, 2020 revealed no documentation regarding any incidents involving this resident. A behavior care plan was initiated on April 21, 2020 and included that the resident had a history of [REDACTED]. A physician's orders [REDACTED]. The order was discontinued on May 1, 2020. Review of the clinical record revealed documentation that the resident was on 15 minute checks from April 21 through May 1, 2020. -Resident #7 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The resident's quarterly Minimum Data Set (MDS) dated [DATE] included that the resident scored 7 on the Brief Interview for Mental Status (BIMS) indicating severely impaired cognition. A progress note dated April 19, 2020 at 11:40 a.m. written by a Licensed Practical Nurse (LPN/staff #94) noted that resident #7 was touching another resident (resident #9) inappropriately. The residents were immediately separated from each other. The incident was reported to both charge nurses immediately. The charge nurses included a Licensed Practical Nurse (LPN/staff #198) and a Registered Nurse (RN/staff #199). A progress note dated April 19, 2020 at 12:34 p.m. written by a LPN charge nurse (staff #198) stated that the resident was found in another resident's room masturbating with her pants around her knees. She was informed that she can only do these activities in her own room. The note included that after this incident, the resident was found to have her hand down a male resident's (resident #9) brief performing sexual activities on the resident. The resident was again educated that this was not appropriate behavior especially in public areas. The resident did not respond meaningfully and rolled away. A care plan was initiated April 21, 2020 that stated the resident has a behavior of inappropriately touching peers and public masturbation. Interventions included frequent checks for inappropriate behaviors, monitoring the resident closely around other residents, and that every attempt should be made to keep other residents safe including actively attempting to separate the resident from other residents. A physician's orders [REDACTED]. Review of the clinical record revealed that the frequent checks were completed from April 21, 2020 until the resident's discharge on May 29, 2020. The facility investigation of the incident dated April 24, 2020 included an interview with a housekeeper (staff #200) and a Certified Nursing Assistant (CNA/staff #8). In the interviews, the staff both reported they witnessed an incident involving resident #7 on April 18, 2020 at approximately 11:00 a.m. where the resident had her hand in another resident's brief (resident #9) and resident #9 had one hand in resident #7's shirt and the other hand in her brief. Staff #8 and Staff #200 stated the incident was reported to a RN charge nurse (staff #199). Review of the clinical records for both residents revealed no documentation of the incident on April 18, 2020. The facility investigation included that the April 19 progress notes regarding the inappropriate touching were discovered during an audit on April 21, 2020. The investigation documentation stated that both residents had their hands in each other's brief. The investigation also included that the residents were put on frequent checks for inappropriate sexual behavior on April 21, 2020. Review of the clinical records for both residents revealed no orders or documentation of increased supervision between April 18 and April 21, 2020. An interview was conducted on June 29, 2020 at 12:20 p.m. with a LPN (staff #131) who stated sexual contact between residents is always reported to a charge nurse or the Director of Nursing. The LPN stated residents who are observed or known to have inappropriate behaviors are checked often to ensure they are not being inappropriate. The LPN stated the order and the care plan state how often the resident should be checked on. An interview was conducted on June 30, 2020 at 1:32 p.m. with the Director of Nursing (DON/staff #24), the administrator (staff #34), and the regional clinical director (staff #201). The DON stated both residents had their care plans updated to include the inappropriate behaviors and increased monitoring as soon as she was aware of the incident. The administrator and DON stated the incident between residents #7 and #9 should have been reported to them on April 18, and the residents should have been put on frequent checks for behaviors immediately following the incident. The Facility policy Resident Supervision and Monitoring was reviewed and included that residents are provided with intense supervision when they present with conditions that may place other residents and /or themselves at risk for harm.
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

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F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) Based on clinical record review, and staff interviews, the facility failed to ensure that documentation in one resident's (#1) medical record was complete. The deficient practice could result in inaccurate medical records. Findings include: Resident #1 was readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the progress notes dated [DATE] included the following entries: -At 07:46 a.m. a note entered by a Licensed Practical Nurse (LPN/staff #202) noted a decrease in the resident's oxygen concentration as it was reading 85% on 5 liters of oxygen, and the resident's heart rate was 49 beats per minute (bpm) at 2:30 a.m. The LPN notified the Nurse Practitioner (NP/staff #197). The NP ordered to increase the resident's oxygen until saturations are at 90% or higher and to monitor the resident's vital signs. The note indicated that at 3:00 a.m., there were no positive results. The NP was notified again and the resident was to be sent to the hospital. The LPN also notified the Director of Nursing (DON/staff #24) and the Medical Director regarding the incident. The resident's health deteriorated and he became unresponsive. Staff started Cardiopulmonary Resuscitation (CPR) and RT suctioned the resident to clear any secretions. The paramedics arrived and took over care. The resident expired at 4:34 a.m. on [DATE]. The resident's wife, daughter, the NP (staff #197), Medical Director, DON, and Unit Manager were notified. Review of Human Remains Release Form (HRRF) dated [DATE], revealed that the section which asks if the death was reported was left blank. An interview was conducted with the administrator (staff #34) and the DON (staff #24) on [DATE] at 2:00 p.m. They stated that the section regarding if the death was reported should not have been left blank. They said that the expectation is that the form be filled out completely.