STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035169	A. BUILDING _____ B. WING _____	12/06/2019

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DESERT HIGHLANDS CARE CENTER	**1081 KATHLEEN AVE KINGMAN, AZ 86401**

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 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews and policy review, the facility failed to ensure that physician orders [REDACTED].#8) advanced directive choices regarding code status. The deficient practice could result in resident's wishes not being honored in an emergency medical situation. The facility census was 76. Findings include: Resident #8 was admitted to the facility on (MONTH) 3, 2019, with [DIAGNOSES REDACTED]. A quarterly Minimum Data Set assessment dated (MONTH) 29, 2019 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. Review of a facility form signed by the resident and a witness on (MONTH) 31, 2019, revealed the following verbiage: In the event you become unable to make your wishes known during an emergency you may take the opportunity to make these wishes clear in advance. The selection on the form regarding Cardiopulmonary Resuscitation (CPR) was marked Yes for the following statement: If heart and breathing stop, mouth to mouth and chest compressions are to be started and 911 called for emergency transport to the hospital. A social services progress note dated (MONTH) 31, 2019 indicated the resident's code status was a Full Code as of (MONTH) 31, 2019. However, according to the resident's face sheet dated (MONTH) 25, 2019, the documentation included the resident was a DNR (Do Not Resuscitate). Review of the physician's orders [REDACTED]. However, the physician's orders [REDACTED]. A social services progress note dated (MONTH) 30, 2019 indicated the resident's code status was a Full Code. Review of the Care Plan Conference Summary dated (MONTH) 30, 2019 revealed the resident had a Do Not Resuscitate code status.Review of the physician's orders [REDACTED]. Review of the current care plan revealed that the information bar at the top of each care plan page indicated the resident had a code status of Do Not Resuscitate. An interview was conducted on (MONTH) 5, 2019 at 1:45 p.m., with the Registered Nurse Manager (RN/staff #3) for station 1. She stated that if a patient is coding, the nurse would check the chart for the resident's code status. She stated the physician's orders [REDACTED]. She stated that if the information available does not match the resident's choice, the resident would receive CPR, when they did not want it done or would not receive CPR and they wanted it done. On review of the clinical record for resident #8, staff #3 said the resident had signed for a full code and the order should not be for DNR. She stated that the facility expectation/policy regarding advance directives was not followed for this resident, as the order did not match the code status the resident had chosen. An interview was conducted with the Director of Nursing (DON/staff #34) on (MONTH) 5, 2019 at 1:54 p.m. She stated that the physician's orders [REDACTED]. She stated if the resident chooses to change the code status during their stay, the nurse would get an order to match the resident's choice and update the code status sheet. She stated if the order did not match the resident's chosen code status, the resident may receive/may not receive the chosen intervention which they had indicated. She stated the facility expectation/policy regarding advance directives was not followed for this resident, as the order did not match the code status chosen by the resident. Review of the policy for Advance Directives revealed that advance directives will be respected in accordance with state law and facility policy. The policy included that the plan of care for each resident will be consistent with his or her documented treatment preferences and/or advance directive. The policy stated that the DON or designee will notify the attending physician of advance directives so that appropriate orders can be documented in the resident's medical record and plan of care.
F 0583 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Keep residents' personal and medical records private and confidential.** Based on observation, clinical record review, staff interviews and policy and procedures, the facility failed to ensure privacy was provided to one random resident, who was receiving an insulin injection. The deficient practice could result in residents not being provided privacy during treatments and promoting an environment which does not respect resident rights.Findings include: During an observation conducted on 12/2/19 at 12:20 p.m., a Licensed Practical Nurse (LPN/staff #62) entered the dining room and approached a resident, who was seated at a table with three other residents. At this time, staff #62 lifted the resident's top and then pulled down the top part of her pants and injected a medication (insulin) in her abdomen. An interview with staff #62 was conducted on 12/2/19 at 12:25 p.m. She said that she gave the insulin to the resident, because she was running late. Staff #62 confirmed it might bother the residents who were in the dining room. In an interview with the Director of Nursing (DON/staff #34) on 12/2/19 at 1:20 p.m., she stated that insulin injections should not be administered in the dining room. An interview was conducted on 12/05/19 at 8:14 a.m., with a resident who was in the dining room at the time of the injection. He said giving insulin at the dining table was inappropriate and that this happens 2-3 times a week. An interview with a LPN (staff #12) was conducted on 12/05/19 at 9:00 a.m. She stated that a nurse should never give insulin in the dining room or in a common area. During an interview with a LPN (staff #13) on 12/05/19 at 9:15 a.m., staff #13 stated you should never give insulin in the dining room, as other residents don't want to see that. Review of a policy regarding Dignity revealed that Federal and state laws guarantee certain basic rights to all residents in this facility. These rights include .privacy and confidentiality.
F 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.**

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

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F 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, staff interviews, facility documentation and policies and procedures, the facility failed to ensure that one resident (#57) was free from sexually inappropriate behavior by another resident (#17). The deficient practice has the potential for further abuse resulting in harm to residents. Findings include: -Resident #57 was admitted to the facility on (MONTH) 15, 2013, with [DIAGNOSES REDACTED]. The annual MDS (Minimum Data Set) assessment dated (MONTH) 25, 2019 included the resident had short and long-term memory problems, and was moderately impaired with cognitive skills for daily decision making. The MDS also included the resident required extensive to total dependence with activities of daily living. The nursing note dated (MONTH) 25, 2019 revealed that a male resident (#17) was rubbing his hands on the legs of resident #57 up to her upper thigh. The residents were separated and resident #17 was told to keep his hands to himself. Per the documentation, the incident was reported to the DON (Director of Nursing). A nursing note dated (MONTH) 26, 2019 included the resident was smiling and waving at various staff members but during her shower, the resident was resistant in letting the CNA (certified nursing assistant) wash her abdomen, breast and peri area. A care plan dated (MONTH) 26, 2019 included the resident was at risk for mental or emotional distress, related to alteration in mental status. The goal was for the resident to be free of emotional distress. Approaches included for staff to monitor and document signs and symptoms of mental or emotional distress every shift for the next 72 hours; watch for non-verbal indicators and behavior changes; and to notify responsible party and physician immediately with any changes in mental or emotional status. -Resident #17 was admitted to the facility on (MONTH) 13, (YEAR), with [DIAGNOSES REDACTED]. The resident was discharged from the facility on (MONTH) 27, 2019. The annual MDS assessment dated (MONTH) 2, 2019 included a BIMS (Brief Interview for Mental Status) score of 13, which indicated the resident had intact cognition. Review of the initial psychiatry evaluation dated (MONTH) 26, 2019 revealed the resident was seen for an evaluation of mental status. Under Review of Systems it was documented that the resident had paranoid delusions, disorganized/incoherent speech and/or behavior, disruptive/repetitive behaviors/vocalizations, verbal aggression and severe restlessness. Mental Status examination included the resident was alert and oriented to person and place, was non-cooperative, has hostile and guarded appearance, an irritable affect and an agitated mood. [DIAGNOSES REDACTED]. Per the documentation, the resident was evasive, guarded, hostile at times and there appears to have been incarceration that he is very evasive about. The monthly nursing summary dated (MONTH) 4, 2019 included resident #17 was alert, oriented, confused, friendly, cooperative and had verbally aggressive behaviors. The documentation did not include details of the resident's verbally aggressive behaviors. The monthly nursing summary dated (MONTH) 9, 2019 included the resident was alert and oriented, was friendly, cooperative and expresses according to the situation. A nursing note dated (MONTH) 18, 2019 revealed that resident #17 attempted to grab at the CNA's during cares and attempts at re-direction were unsuccessful. Per the note, the resident also attempted to touch other female residents at meal times. The nursing note dated (MONTH) 25, 2019 included that it was reported to the nurse by a CNA that resident #17 put his hand on another female resident's (#57) upper thigh. It also included his hands were removed from the female resident and the incident was reported to the DON. Another nursing note dated (MONTH) 25, 2019 included that resident #17 was removed from area of occurrence and assisted to the northeast side of the building, which is opposite of the building where the female resident resides. The note included that resident #17 stated he was just going to stay in his room. A care plan dated (MONTH) 26, 2019 included the resident exhibited inappropriate sexual behavior which was escalating. The goal was to maintain resident and staff safety. Approaches included arranging for transfer to an appropriate behavioral facility immediately and 1:1 supervision around the clock, until appropriate transfer to a higher level of care. Review of a physician's progress note dated (MONTH) 26, 2019 revealed the resident had an incident of inappropriate touching of female residents and staff. Under the assessment section, it included a conduct disorder (inappropriate touching of females) and the plan was to transfer resident to another facility. A physician's orders [REDACTED]. A nursing note dated (MONTH) 27, 2019 stated the resident was discharged to another facility. Further review of the clinical record revealed no evidence that the resident was provided 1:1 supervision immediately after the incident (on (MONTH) 25) until discharged . Review of the facility's investigative report revealed the incident between resident #57 and #17 happened on (MONTH) 25, 2019 at 6:30 p.m., in the common area on the West hall. The report included a CNA (staff #85) saw resident #17 touch the upper inner thigh of resident #57. The report included a written statement from staff #85 who reported that resident #17 was rubbing his hands on resident's #57 upper thigh. Staff #85 explained to resident #17 that the behavior was not okay, and the residents were separated. Staff #85 reported the incident to the nurse (staff #9) and they both went to the DON to report the incident. Staff #85 reported that resident #17 was moved to the Northeast hall, per the instructions of the DON. According to the facility's investigative report, the incident type was documented as an allegation/incident of abuse. An attempt was made to conduct an interview with resident #57 on (MONTH) 2, 2019 at 2:28 p.m. However, she was unable to respond to questions appropriately. An interview was conducted on (MONTH) 4, 2019 at 9:28 a.m., with staff #85 who witnessed the incident. She said resident #17 was sitting in his wheelchair on the right side of where resident #57 was sitting. She said she saw the right hand of resident #17 stroking and/or rubbing resident #57's upper thigh and was so close to her private area and that resident #57 appeared uncomfortable. She said she separated the two residents and told resident #17 that what he did was not appropriate and was not acceptable. She said resident #17 just laughed. She said there were no other witnesses to the incident, because staff were inside the dining room assisting residents with dining or taking the residents out of the dining room. She stated that she then reported the incident to the nurse (staff #9) and both reported it to the DON that same day. She stated that resident #17 was placed on 1:1 supervision, until he was transferred to another facility. An interview was conducted on (MONTH) 4, 2019 at 10:59 a.m. with a licensed practical nurse (LPN/staff #9), who was the nurse on shift when the incident happened. Staff #9 stated she did not witness the incident, but she was the nurse on shift that day. She stated that around 6:00-6:30 p.m., staff #85 reported that she saw resident #17 rubbing his hand up and down the upper inner thigh up to or close to the groin area of resident #57. She stated that she told resident #17 that what he did was inappropriate. She said resident #17 just laughed about it. She further stated that she and staff #85 went to the DON to report the incident the same day. Regarding resident #57, staff #9 stated the resident is non-verbal, is cognitively impaired and loves to hold someone's hand. She stated the following day after the incident, it was resident #57's shower day. She said that during the shower, resident #57 was resistive and was pushing staff away when they tried to clean her private area. Regarding resident #17, staff #9 said that resident #17 was alert and oriented, with periods of confusions. She stated resident #17 did not have any behaviors, but some residents found him to be creepy. She stated there was one resident's family who instructed staff to not let resident #17 near the resident. Staff #9 further stated that resident #17 would hold the hand of resident #57, but that's about it and nothing sexual had happened. She stated this is the first incident of a sexual nature between resident #57 and #17. During an interview with the DON (staff #34) conducted on (MONTH) 4, 2019 at 12:59 p.m., she stated she was in the building when the incident happened. She stated she was at the nurse's station when staff #9 and #85 reported that resident #17 touched resident #57 on her right leg. She said both staff reported that they were afraid the hand of resident #17 might go towards the private area of resident #57. She stated at that time, she did not think there was something to it. She stated the way the incident was reported to her led her to picture resident #17's hand on resident #57's leg and there was nothing sexual to it. She stated staff #9 and #85 did not tell her that resident #17 was rubbing his hand on her upper inner thigh. Staff #34 stated she asked staff whether this incident was the first incident between the two residents; and no staff could recall or was able to say whether there were other incidents in the past. Further, she stated she was not aware that the clinical record of resident #17 had documentation on (MONTH) 18, 2019 that resident #17 attempted to touch other female residents at meal times. Following the incident, staff #34 said that resident #17 was taken out of the common are on the West hall and was placed back in his room. She stated resident #17 was upset and never left his room the rest of the shift.

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F 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) She further stated that resident #17 was placed on 1:1 supervision, meaning there was one staff assigned to care and follow resident #17 the entire shift. However, the facility was unable to provide any documentation that 1:1 supervision was provided following the incident through discharge. In an interview with the Administrator (staff #75) conducted on (MONTH) 4, 2019 at 2:09 p.m., he stated the incident was reported to him the next day. He stated that he then met with the DON and the regional nurse consultant (staff #96) to discuss the incident. He stated that he spoke with resident #17 the following day of the incident and he denied touching resident #57. He said the residents were separated and were monitored. He said that resident #17 remained in his room, until he was transferred to another facility. He stated it was his understanding that 1:1 supervision was started the following day of the incident. He stated there was documentation that a CNA was assigned to conduct 1:1 supervision for resident #17, but there was no documentation that 1:1 supervision was provided as care planned. Review of the Abuse Prevention Program policy revealed that resident's have the right to be free of all forms of abuse. The policy included an objective of zero tolerance of verbal, sexual, physical and mental abuse, corporal punishment, involuntary seclusion, neglect, exploitation, or misappropriation of resident property, by employees, family members, visitors or other residents. It also included that the facility will have a system in place to prevent abuse. The policy defined abuse as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish. Willful means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Sexual abuse was defined in the policy as non-consensual sexual contact of any type with a resident.
F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, staff interviews, facility documentation and policies and procedures, the facility failed to implement their policy regarding reporting and investigating an allegation of sexual abuse involving two residents (#57 and #17). The deficient practice could result in the appropriate State Agencies not being notified and allegations of abuse not being thoroughly investigated. Findings include: -Resident #57 was admitted at the facility on (MONTH) 15, 2013 with [DIAGNOSES REDACTED]. The annual MDS (Minimum Data Set) assessment dated (MONTH) 25, 2019 included the resident had short and long-term memory problems, and was moderately impaired with cognitive skills for daily decision making. The MDS also included the resident required extensive to total dependence with activities of daily living. -Resident #17 was admitted at the facility on (MONTH) 13, (YEAR) with [DIAGNOSES REDACTED]. The annual MDS assessment dated (MONTH) 2, 2019 included a BIMS (Brief Interview for Mental Status) score of 13, which indicated the resident had intact cognition. A nursing note dated (MONTH) 18, 2019 revealed that resident #17 attempted to grab at the CNA's during cares and attempts at re-direction were unsuccessful. Per the note, the resident also attempted to touch other female residents at meal times. Review of the facility's investigative report revealed the incident between resident #57 and #17 happened on (MONTH) 25, 2019 at 6:30 p.m., in the common area on the West hall. The report included a CNA (staff #85) saw resident #17 touch the upper inner thigh of resident #57. The report included a written statement from staff #85 who reported that resident #17 was rubbing his hands on resident's #57 upper thigh. Staff #85 explained to resident #17 that the behavior was not okay, and the residents were separated. Staff #85 reported the incident to the nurse (staff #9) and they both went to the DON to report the incident. Staff #85 reported that resident #17 was moved to the Northeast hall, per the instructions of the DON. According to the facility's investigative report, the incident type was documented as an allegation/incident of abuse. Continued review of the facility's investigative report revealed the incident was not reported to the State Agency and APS (Adult Protective Services) until (MONTH) 26, 2019 at 12:45 p.m., which was the next day following the incident. In addition, the facility's investigation was not thorough, as the report did not include any interviews with residents and other staff who may have knowledge of the incident. The report also did not include if the facility substantiated abuse or not. An interview was conducted on (MONTH) 4, 2019 at 9:28 a.m., with a CNA (staff #85) who witnessed the incident. She said she saw the right hand of resident #17 stroking and/or rubbing resident #57's upper thigh and was so close to her private area. She said resident #57 appeared uncomfortable. She said that she separated the two residents and told resident #17 that what he did was not appropriate and not acceptable. She stated she then reported the incident to the nurse (staff #9) and both of them reported the incident to the DON that same day. She said she reported the incident to the nurse and the DON, because the incident was a form of abuse. An interview was conducted on (MONTH) 4, 2019 at 10:59 a.m. with a licensed practical nurse (LPN/staff #9). Staff #9 stated she did not witness the incident, but she was the nurse on shift that day. She stated around 6:00 p.m. to 6:30 p.m., a CNA (staff #85) came to her and reported that she saw resident #17 rubbing his hand up and down the upper inner thigh up to or close to the groin area of resident #57. She further stated that she and the CNA (staff #85) went to the DON to report the incident the same day. During an interview with the DON (staff #34) conducted on (MONTH) 4, 2019 at 12:59 p.m., she stated she was in the building when the incident happened. She stated she was at the nurse's station when staff #9 and staff #85 reported that resident #17 touched resident #57 on her right leg. She stated both staff reported that they were afraid the hand of resident #17 might go towards the private area of resident #57. She stated at that time she did not think there was something to it. She stated the way the incident was reported to her led her to picture resident #17's hand on resident #57's leg and there was nothing sexual to it. She stated staff #9 and staff #85 did not tell her that resident #17 was rubbing his hand on the upper inner thigh of resident #57. She stated this is the reason why she did not report the incident to the appropriate State Agencies until the next day. She stated she, the Administrator (staff #75) and the regional nurse consultant (staff #96) had a meeting the next day and discussed the incident and decided that the incident had to be reported to the State agency and APS. She stated that she interviewed multiple staff at the time of the incident, but she does not have any documentation of the interviews. An interview with the Administrator (staff #75) was conducted on (MONTH) 4, 2019 at 2:09 p.m. He stated the incident was reported to him the following day of the incident. He stated he met with the DON (staff #34) and the regional nurse consultant (staff #96) the following day of the incident, and as a result of the meeting, the incident was reported to the State Agency and APS. He stated he interviewed resident #17 but he does not have any documentation of the interview. Review of the Abuse Prevention Program revealed an objective of zero tolerance of verbal, sexual, physical and mental abuse, corporal punishment, involuntary seclusion, neglect, exploitation, or misappropriation of resident property, by employees, family members, visitors or other residents. The policy included that any person(s) observing or having reason to suspect resident abuse, neglect, mistreatment exploitation or misappropriation of resident property, is to report the concern to either their supervisor or the charge nurse immediately. If an allegation or suspected incident of abuse, neglect, mistreatment or misappropriation of resident property occurs, the Administrator or designee will report to the State Survey Agency and APS. The Administrator or Director of Nursing Services shall report allegations of abuse to the State Agency immediately, but not later than 2 hours after the allegation is made. Further review of the policy revealed that if an incident occurs or there is any allegation that an incident might have occurred of abuse, neglect, mistreatment, exploitation or misappropriation of resident property, the Administrator or designee will investigate. The facility must have evidence that all alleged violations are thoroughly investigated and the results of all investigations must be reported to the administrator of his designated representative and to other officials in accordance with State law, including to the State Survey and Certification agency within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
F 0608 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement policies and procedures to ensure (1) employees report any suspicion of a crime against any resident, according to timelines; (2) post the notice**

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F 0608 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) **of employee rights; and (3) prohibit and prevent retaliation for reporting.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, staff interviews, facility documentation and policies and procedures, the facility failed to ensure that an allegation of abuse involving two residents (#57 and #17) was reported to the police, within 24 hours as required. The deficient practice could result in local enforcement agencies not being notified of incidents of abuse. Findings include: -Resident #57 was admitted to the facility on (MONTH) 15, 2013 with [DIAGNOSES REDACTED]. -Resident #17 was admitted to the facility on (MONTH) 13, (YEAR) with [DIAGNOSES REDACTED]. A nursing note dated (MONTH) 18, 2019 revealed that resident #17 attempted to grab at the CNA's during cares and attempts at re-direction were unsuccessful. Per the note, the resident also attempted to touch other female residents at meal times. The nursing note dated (MONTH) 25, 2019 included that it was reported to the nurse by a CNA that resident #17 put his hand on another female resident's (#57) upper thigh. It also included his hands were removed from the female resident and the incident was reported to the DON. Review of a physician's progress note dated (MONTH) 26, 2019 revealed the resident had an incident of inappropriate touching of female residents and staff. Under the assessment section, it included a conduct disorder (inappropriate touching of females) and the plan was to transfer resident to another facility. Review of the facility's investigative report revealed the incident between resident #57 and #17 happened on (MONTH) 25, 2019 at 6:30 p.m., in the common area on the West hall. The report included a CNA (staff #85) saw resident #17 touch the upper inner thigh of resident #57. The report included a written statement from staff #85 who reported that resident #17 was rubbing his hands on resident's #57 upper thigh. Staff #85 explained to resident #17 that the behavior was not okay, and the residents were separated. Staff #85 reported the incident to the nurse (staff #9) and they both reported the incident to the DON. Staff #85 reported that resident #17 was moved to the Northeast hall, per the instructions of the DON. According to the facility's investigative report, the incident type was documented as an allegation/incident of abuse. However, further review of the facility's investigation revealed there was no evidence that the incident of abuse was reported to the police. An interview was conducted on (MONTH) 4, 2019 at 9:28 a.m., with a CNA (staff #85) who witnessed the incident. She said she saw the right hand of resident #17 stroking and/or rubbing resident #57's upper thigh and was so close to her private area. She said resident #57 appeared uncomfortable. She said that she separated the two residents and told resident #17 that what he did was not appropriate and not acceptable. She stated she then reported the incident to the nurse (staff #9) and both of them reported the incident to the DON that same day. She said she reported the incident to the nurse and the DON, because the incident was a form of abuse. During an interview with the Director of Nursing (DON/staff #34) conducted on (MONTH) 4, 2019 at 12:59 p.m., she stated that she was in the building when the incident happened. She stated staff #9 and staff #85 reported the incident to her. She stated both staff reported they were afraid that the hand of resident #17 might go towards the private area of resident #57. She stated at that time she did not think there was something to it. She stated the way the incident was reported to her led her to picture resident #17's hand on resident #57's leg and there was nothing sexual to it. She stated she did not report the incident to the police, because the Administrator (staff #75) was supposed to do the reporting to the police, as she was responsible for completing the paperwork for the incident and the online reporting of the incident. An interview with the Administrator was conducted on (MONTH) 4, 2019 at 2:09 p.m. He stated the incident was reported to him the day after the incident. He stated he met with the DON and the regional nurse consultant (staff #96) the day after the incident, and as a result of the meeting the incident was reported to the State Agency and Adult Protective Services (APS), but was not reported to the police and he does not know why. Review of the policy on the Abuse Prevention Program revealed the owners, operators, managers, employees, agents and contractors for long term care facilities must report to local law enforcement any allegation of a crime against a resident. The policy included the facility will report any allegation of abuse, neglect, or crime against a resident to the required government agencies and local law enforcement in accordance with the law.
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, staff interviews, facility documentation and policies and procedures, the facility failed to ensure that an allegation of abuse involving two residents (#57 and #17) was reported to the State Agency and Adult Protective Services (APS), within two hours after the allegation was made. The deficient practice could result in the appropriate State Agencies not being notified as required. Findings include: -Resident #57 was admitted at the facility on (MONTH) 15, 2013 with [DIAGNOSES REDACTED]. -Resident #17 was admitted at the facility on (MONTH) 13, (YEAR) with [DIAGNOSES REDACTED]. The resident was discharge to another facility on (MONTH) 27, 2019. A nursing note dated (MONTH) 18, 2019 revealed that resident #17 attempted to grab at the CNA's during cares and attempts at re-direction were unsuccessful. Per the note, the resident also attempted to touch other female residents at meal times. The nursing note dated (MONTH) 25, 2019 included that it was reported to the nurse by a CNA that resident #17 put his hand on another female resident's (#57) upper thigh. It also included his hands were removed from the female resident and the incident was reported to the DON. Review of a physician's progress note dated (MONTH) 26, 2019 revealed the resident had an incident of inappropriate touching of female residents and staff. Under the assessment section, it included a conduct disorder (inappropriate touching of females) and the plan was to transfer resident to another facility. Review of the facility's investigative report revealed the incident between resident #57 and #17 happened on (MONTH) 25, 2019 at 6:30 p.m., in the common area on the West hall. The report included a CNA (staff #85) saw resident #17 touch the upper inner thigh of resident #57. The report included a written statement from staff #85 who reported that resident #17 was rubbing his hands on resident's #57 upper thigh. Staff #85 explained to resident #17 that the behavior was not okay, and the residents were separated. Staff #85 reported the incident to the nurse (staff #9) and they both reported the incident to the DON. Staff #85 reported that resident #17 was moved to the Northeast hall, per the instructions of the DON. According to the facility's investigative report, the incident type was documented as an allegation/incident of abuse. Further review of the facility's investigation revealed that the allegation of abuse was not reported to the State Agency and APS until (MONTH) 26, 2019 at 12:45 p.m., which was the next day following the incident. An interview was conducted on (MONTH) 4, 2019 at 9:28 a.m., with a CNA (staff #85) who witnessed the incident. She said she saw the right hand of resident #17 stroking and/or rubbing resident #57's upper thigh and was so close to her private area. She said resident #57 appeared uncomfortable. She said that she separated the two residents and told resident #17 that what he did was not appropriate and not acceptable. She stated she then reported the incident to the nurse (staff #9) and both of them reported the incident to the DON that same day. She said she reported the incident to the nurse and the DON, because the incident was a form of abuse. During an interview with the Director of Nursing (DON/staff #34) conducted on (MONTH) 4, 2019 at 12:59 p.m., she stated she was in the building when the incident happened. She stated staff #9 and staff #85 reported that resident #17 touched resident #57 on her right leg and reported that they were afraid the hand of resident #17 might go towards the private area of resident #57. She stated at that time she did not think there was something to it. She stated the way the incident was reported to her led her to picture resident #17's hand on resident #57's leg and there was nothing sexual to it. She stated staff #9 and staff #85 did not tell her that resident #17 was rubbing his hand on the upper inner thigh of resident #57. She stated this is the reason why she did not report the incident to the appropriate State agencies until the next day. She stated she, the Administrator (staff #75) and the regional nurse consultant (staff #96) had a meeting the next day and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035169	A. BUILDING _____ B. WING _____	12/06/2019

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4) discussed the incident and decided that the incident had to be reported to the State agency and APS. An interview with the Administrator was conducted on (MONTH) 4, 2019 at 2:09 p.m. He stated the incident was reported to him the following day of the incident. He stated he met with the DON and the regional nurse consultant the following day of the incident, and as a result the incident was reported to the State Agency and APS. He stated that he did not know why there was a delay in the reporting the incident to the State Agency and APS. Review of the Abuse Prevention Program policy revealed that any person(s) observing, or having reason to suspect resident abuse, neglect, mistreatment exploitation or misappropriation of resident property, is to report the concern to either their supervisor or the charge nurse immediately. If an allegation or suspected incident of abuse, neglect, mistreatment or misappropriation of resident property occurs, the Administrator or designee will report to the State Agency, Adult Protective Services (APS), and Police (if an injury or crime is involved). Per the policy, the Administrator or Director of Nursing shall report allegations of abuse to the State Agency immediately, but not later than two hours after the allegation is made. The policy also included the facility will report any allegation of abuse, neglect, or crime against a resident to required government agencies and local law enforcement in accordance with the law.
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 reviews, facility documentation, staff interviews and policy and procedures, the facility failed to ensure that an allegation of abuse was thoroughly investigated involving two residents (#17 and #57). The deficient practice could result in abuse not being addressed and investigated. Findings include: -Resident #57 was admitted to the facility on (MONTH) 15, 2013 with [DIAGNOSES REDACTED]. -Resident #17 was admitted to the facility on (MONTH) 13, (YEAR) with [DIAGNOSES REDACTED]. A nursing note dated (MONTH) 18, 2019 revealed that resident #17 attempted to grab at the CNA's during cares and attempts at re-direction were unsuccessful. Per the note, the resident also attempted to touch other female residents at meal times. The nursing note dated (MONTH) 25, 2019 included that it was reported to the nurse by a CNA that resident #17 put his hand on another female resident's (#57) upper thigh. It also included his hands were removed from the female resident and the incident was reported to the DON. Review of a physician's progress note dated (MONTH) 26, 2019 revealed the resident had an incident of inappropriate touching of female residents and staff. Under the assessment section, it included a conduct disorder (inappropriate touching of females) and the plan was to transfer resident to another facility. Review of the facility's investigative report revealed the incident between resident #57 and #17 happened on (MONTH) 25, 2019 at 6:30 p.m., in the common area on the West hall. The report included a CNA (staff #85) saw resident #17 touch the upper inner thigh of resident #57. The report included a written statement from staff #85 who reported that resident #17 was rubbing his hands on resident's #57 upper thigh. Staff #85 explained to resident #17 that the behavior was not okay, and the residents were separated. Staff #85 reported the incident to the nurse (staff #9) and they both reported the incident to the DON. Staff #85 reported that resident #17 was moved to the Northeast hall, per the instructions of the DON. According to the facility's investigative report, the incident type was documented as an allegation/incident of abuse. However, further review of the facility's investigation revealed that the allegation of abuse was not thoroughly investigated, as the report did not include any interviews with residents and other staff who may have knowledge of the incident. The report also did not include if the facility substantiated abuse or not. An interview was conducted on (MONTH) 4, 2019 at 9:28 a.m., with a CNA (staff #85) who witnessed the incident. She said she saw the right hand of resident #17 stroking and/or rubbing resident #57's upper thigh and was so close to her private area. She said resident #57 appeared uncomfortable. She said that she separated the two residents and told resident #17 that what he did was not appropriate and not acceptable. She stated she then reported the incident to the nurse (staff #9) and both of them reported the incident to the DON that same day. She said she reported the incident to the nurse and the DON, because the incident was a form of abuse. During an interview with the Director of Nursing (DON/staff #34) conducted on (MONTH) 4, 2019 at 12:59 p.m., she stated that she was in the building when the incident happened. She stated she was at the nurse's station when staff #9 and staff #85 reported that resident #17 touched resident #57 on her right leg. She stated both staff reported they were afraid that the hand of resident #17 might go towards the private area of resident #57. She stated at that time she did not think there was something to it. She stated the way the incident was reported to her led her to picture resident #17's hand on resident #57's leg and there was nothing sexual to it. She stated staff #9 and staff #85 did not tell her that resident #17 was rubbing his hand on the upper inner thigh of resident #57. She stated she conducted interviews with multiple staff after the incident, but no staff could recall whether there were other similar incidents in the past between the residents involved. However, she stated she does not have any documentation of these interviews. An interview with the Administrator (staff #75) was conducted on (MONTH) 4, 2019 at 2:09 p.m. He stated the incident was reported to him the following day. He stated that he interviewed resident #17, who denied touching resident #57, however, he does not have any documentation of the interview. Review of the Abuse Prevention Program policy revealed that if an incident occurs, or there is any allegation that an incident might have occurred of abuse, neglect, mistreatment, exploitation or misappropriation of resident property, the Administrator or designee will investigate. The facility must have evidence that all alleged violations are thoroughly investigated and the results of all investigations must be reported to the Administrator of his designated representative and to other officials in accordance with State law (including to the State survey and certification agency within 5 working days of the incident) and if the alleged violation is verified appropriate corrective action must be taken.
F 0622 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed clinical record review, staff interviews, and review of policy and procedures, the facility failed to ensure one sampled resident's (#83) clinical record contained the transfer information which was conveyed to the receiving provider when transferred to the hospital. The deficient practice could result in an unsafe and ineffective transition of care. Findings include: Resident #83 was admitted to the facility on [DATE], with acute pancreatitis, [MEDICAL CONDITION] and high blood pressure. Review of the clinical record revealed the resident was discharged to the hospital on [DATE], due to continued nausea and vomiting. Further review of the clinical record revealed there was no documentation of the information which was conveyed to the receiving provider when transferred to the hospital, such as reason for transfer, special instructions or precautions regarding the resident's care, medications, treatments, diagnoses, allergies [REDACTED]. During an interview with a Registered Nurse (staff #3) on 12/5/19 at 12:35 p.m., she stated that transfer forms are filled out and are sent to the hospital with the resident, but no copies are kept. She reviewed the clinical record for resident #83 and was unable to find documentation of the information which was sent to the receiving hospital. During an interview with the Director of Nursing on 12/5/19 at 1:00 p.m., she stated her expectation is for the nurses to fill out the transfer paperwork and put copies in the resident's chart. She confirmed there was no documentation in the clinical record of the transfer information, which was provided to the hospital when the resident was transferred on 10/7/19. Review of the policy regarding Medical Records revealed the facility will maintain clinical medical records on all residents in accordance with accepted professional standards, policies and in accordance with standards set by the American Medical Records Association and State and Federal regulations. Per the policy, medical records are started and maintained on each

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	035169	A. BUILDING _____ B. WING _____	12/06/2019

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F 0622 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 5) resident from the time of admission to the time of discharge or death. The policy also included that medical records of residents who are transferred will contain the following: date of transfer, reason for transfer, condition on transfer, destination upon transfer and method of transfer.
F 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, resident and staff interviews and policies and procedures, the facility failed to ensure that comprehensive care plans were developed for five residents (#8, #54, #55, #69 and #32). The deficient practice could result in resident's needs not being met and a lack of services being provided. Findings include: -Resident #54 was readmitted to the facility on (MONTH) 21, (YEAR), with [DIAGNOSES REDACTED]. The physician recapitulation of orders for (MONTH) 2019 included an order for [REDACTED]. The physician recapitulation of orders for (MONTH) 2019 included an order for [REDACTED]. A hospice admission note dated (MONTH) 28, 2019 included the resident had a terminal prognosis of [MEDICAL CONDITION] disease, had disabling dyspnea at rest, was poorly or unresponsive to [MEDICATION NAME][MEDICATION NAME] resulting in decreased functional capacity, and was hypoxic at rest on room air or was hypercapnic. Per the note, the resident was oxygen dependent at 3 LPM and was bedbound and has declined. The physician recapitulation of orders for (MONTH) 2019 revealed an order for [REDACTED]. Review of the significant change MDS (Minimum Data Set) assessment dated (MONTH) 7, 2019, included a BIMS (Brief Interview for Mental Status) score of 7, indicating the resident had severe cognitive impairment. The MDS also included the resident had shortness of breath or trouble breathing when lying flat and was receiving hospice services, however oxygen therapy was not coded. Despite documentation that the resident was under hospice services and was on oxygen, the clinical record revealed no evidence that comprehensive care plans were developed to address the resident's hospice and oxygen needs. During observations conducted on (MONTH) 2, 2019 at 12:43 p.m., (MONTH) 3, 2019 at 8:19 a.m., (MONTH) 4, 2019 at 8:24 a.m. and (MONTH) 5 at 8:10 a.m., the resident was observed to be on oxygen, via nasal cannula. An interview with a certified nursing assistant (CNA/staff #66) was conducted on (MONTH) 5, 2019 at 10:31 a.m. She stated the resident was alert and oriented to self, does not always know what's going on around her, was recently placed on hospice services and the resident is on oxygen all of the time. During an interview conducted on (MONTH) 5, 2019 at 11:06 a.m., resident #54 said that she has to have oxygen on at all times. An interview with a licensed practical nurse (LPN/staff #12) was conducted on (MONTH) 5, 2019 at 11:08 a.m. Staff #12 stated the resident currently is under hospice services and is on continuous oxygen at 4 LPM, via nasal cannula. In an interview with a registered nurse (RN/staff #3) conducted on (MONTH) 5, 2019 at 1:12 p.m., she stated the MDS coordinator develops the comprehensive care plan based on the assessment conducted and will revise the care plan as appropriate to reflect the resident's needs. She stated if the MDS coordinator missed an area that needed to be addressed, the nurses can revise care plans as needed. At this time, the clinical record was reviewed with staff #3, who stated that the comprehensive care plans for resident #54 did not address the resident's needs related to hospice services and oxygen use. An interview with the MDS coordinators (staff #31 and #82) was conducted on (MONTH) 5, 2019 at 1:38 p.m. Both stated they are responsible for creating and revising the care plan based on the assessment they conducted. Staff #31 stated the care plan is not necessarily developed or revised specific to the current identified issue when the area is already on another area of the care plan. Staff #82 stated there is no point in developing a care plan specific to hospice and/or the use of oxygen for resident #54, if the services are already being provided to the resident. In an interview with a LPN (staff #9) conducted on (MONTH) 6, 2019 at 8:41 a.m., she stated the facility conducts care plan meetings where areas of concerns/needs are identified, and should be included in the resident's care plan. Staff #3 joined the interview and stated that the baseline care plan is developed by the admitting nurse within 48 hours of admission and the MDS staff develops the comprehensive care plan. Staff #3 stated the nurses can revise and add to the care plan any time if new needs are identified. During an interview with the Director of Nursing (DON/staff #34) conducted on (MONTH) 6, 2019 at 8:46 a.m., she stated that care plans are developed by the MDS staff, and the nurses can add to it as the need arise. She stated it is her expectation that residents on oxygen must be care planned and there should be something in the care plan that would indicate the resident was on hospice services. -Resident #8 was admitted to the facility on (MONTH) 3, 2019, with [DIAGNOSES REDACTED]. Review of a quarterly MDS assessment dated (MONTH) 29, 2019 revealed that resident #8 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. Review of a facility form signed by resident #8 and a witness on (MONTH) 31, 2019 revealed the resident wanted cardiopulmonary resuscitation (CPR) to be started if her heart and breathing stopped. A social services progress note dated (MONTH) 30, 2019 revealed that the resident was a Full Code status. However, review of the resident's current comprehensive care plans revealed there was no care plan developed regarding the resident's choice to receive CPR/Full Code status, nor any interventions that addressed this issue. An interview was conducted with the DON (staff #34) on (MONTH) 5, 2019 at 1:54 p.m. She stated that the resident's code status should be addressed in the comprehensive care plan. Review of the facility policy on Advance Directives revealed that the attending physician will provide information to the resident and legal representative regarding the resident's health status, treatment options and expected outcomes during the development of the initial comprehensive assessment and care plan. The policy included that the plan of care for each resident will be consistent with his or her documented treatment preferences and/or advance directive. -Resident #32 was admitted to the facility on (MONTH) 18, (YEAR), with [DIAGNOSES REDACTED]. Review of the physician's orders revealed an order dated (MONTH) 15, 2019 for oxygen via nasal cannula to keep oxygen saturations over 89%. Review of the monthly summary dated (MONTH) 2, 2019 revealed the resident was receiving oxygen at 2 liters per minute. Review of the (MONTH) 2019 Treatment Administration Record (TAR) revealed documentation that the resident was receiving oxygen at 2 liters per minute continuously to keep oxygen saturations above 89%. Review of the physician recapitulation orders for (MONTH) 2019 revealed an order for [REDACTED]. A provider note dated (MONTH) 2, 2019 revealed the resident had [MEDICAL CONDITION] and [MEDICAL CONDITION], and was to receive oxygen via nasal cannula to maintain oxygen saturations above 89%. Review of the (MONTH) 2019 TAR revealed documentation that the resident was receiving continuous oxygen at 2 liters per minute to keep her oxygen saturations above 89%. However, review of the current comprehensive care plans for resident #32 revealed there was no care plan which had been developed that addressed the resident's respiratory and oxygen needs. An observation of resident #32 was conducted on (MONTH) 4, 2019 at 2:08 p.m., and the resident had oxygen in place at 2 liters per minute via nasal cannula. An interview was conducted with a LPN (staff #12) on (MONTH) 5, 2019 at 9:38 a.m. She stated that resident #32 should have a care plan for oxygen use, so staff know what her needs are. An interview was conducted with the DON (staff #34) on (MONTH) 5, 2019 at 10:24 a.m. She stated there should be an active care plan for resident #32 addressing oxygen use. Review of the Oxygen Administration policy revealed the purpose of this procedure is to provide guidelines for safe oxygen administration and to review the resident's care plan to assess for any special needs of the resident. Review of the policy for respiratory therapy revealed the purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment among residents and staff. The policy included to review the

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F 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 6) resident's care plan to assess for any special circumstances or precautions related to the resident. -Resident #55 was admitted to the facility on (MONTH) 21, (YEAR), with [DIAGNOSES REDACTED]. A nurse progress note dated (MONTH) 19, 2019 included the resident pushed back on her over bedside table making the soup splash onto her abdomen, causing her abdomen to be red. A nurse progress note dated (MONTH) 21, 2019 revealed that as a result of spilled soup, resident #55 had an 11 by 15 centimeter (cm) area on her abdomen which was moderately pink with a few intact blisters, and a few broken blisters with a small amount of serous drainage. Review of an undated hot beverage/soup safe handling assessment form for resident #55 revealed the resident was safe in drinking hot fluids or eating hot soup, unsupervised with the recommendation for lids. An annual MDS assessment dated (MONTH) 25, 2019 revealed the resident had a BIMS score of 13, which indicated intact cognition. Review of the resident's current comprehensive care plans revealed they did not address the history of the burn injury or the intervention of the need of lids for hot fluids/soup. An interview was conducted with the DON on (MONTH) 4, 2019 at 11:01 a.m. She stated that the hot beverage/soup safe handling assessment recommended lids to be used for resident #55 for any hot beverages or soup. She stated that lids would not always work for soups and that it depended on the type of soup being served. She stated the burn and the precautions should have been included on a current care plan but were not; therefore; staff did not meet her expectations regarding care planning. Review of the facility policy on precautions for handling hot beverages/soups revealed that staff will monitor, serve and hold hot beverages/soups in a safe manner to prevent potential burns. The policy included that additional precautions may be initiated based on the needs of each resident and include: assessing and identifying those individuals served who are at high risk for burning themselves with hot beverages on admission and quarterly; and ensuring staff monitors the identified high risk resident during meal times and/or when hot beverages are served. -Resident #69 was admitted to the facility on (MONTH) 31, 2019, with [DIAGNOSES REDACTED]. Review of the (MONTH) 26, 2019 hospital history and physical revealed that resident #69 received [MEDICAL TREATMENT] and had [MEDICAL CONDITIONS] and [MEDICAL CONDITION]. Review of the current care plans revealed a nutrition care plan dated (MONTH) 31, 2019 that included for a renal diet with large protein portions and a 1200 fluid restriction. An admission MDS assessment dated (MONTH) 7, 2019 revealed a BIMS score of 15, which indicated intact cognition. The assessment further revealed a [DIAGNOSES REDACTED]. A nurse progress note dated (MONTH) 30, 2019 revealed the resident received [MEDICAL TREATMENT] on Tuesday, Thursday and Saturday. However, there was no evidence that a comprehensive care plans had been developed to address the resident's needs related to [MEDICAL TREATMENT] and the [MEDICAL TREATMENT] and [MEDICAL CONDITION]. An interview was conducted with a LPN (staff #12) on (MONTH) 5, 2019 at 9:42 a.m. She stated that resident #69 would be expected to have a care plan for [MEDICAL TREATMENT], because the care pan lets staff know the care that the resident needs.An interview was conducted with the DON on (MONTH) 5, 2019 at 10:31 a.m. She stated the care plans should have addressed the [MEDICAL TREATMENT] treatments and needs for this resident. She stated the lack of a [MEDICAL TREATMENT] care plan did not meet expectations for care planning. Review of the policy on care of the resident with end stage [MEDICAL CONDITION] revealed that residents with end stage [MEDICAL CONDITION] will be cared for according to current recognized standards of care. The policy included that agreements between the facility and the contracted [MEDICAL CONDITION] facility include all aspects of how the resident's care will be managed, including how the care plan will be developed and implemented. The policy also stated that the resident's comprehensive care plan will reflect the resident's needs related to [MEDICAL CONDITION]/[MEDICAL TREATMENT] care. Review of a policy on Care Plans revealed that a comprehensive, person centered care plan which includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs should be developed and implemented for each resident. The policy included that each resident's comprehensive person-centered care plan will be consistent with the resident's rights to participate in the development and implementation of his or her plan of care. The policy stated that the comprehensive, person centered care plan will include: measurable objectives and time frames; describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; incorporate identified problem areas; incorporate risk factors associated with identified problems; reflect the resident's expressed wishes regarding care and treatment goals; identify professional services that are responsible for each element of care; aid in preventing or reducing decline in the resident's functional status and/or functional levels; and reflect currently recognized standards of practice for problem areas and conditions. The policy further included that identifying problem areas and their causes, and developing interventions that are targeted and meaningful to the resident, are the endpoint of an interdisciplinary process. The policy stated that assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.
F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews and review of policies and procedures, the facility failed to ensure one resident (#55) was provided care and treatment in accordance with professional standards of practice. The deficient practice could result in complications related to skin issues and lack of follow-up and appropriate interventions. Findings include: Resident #55 was admitted to the facility on (MONTH) 29, 2013, with [DIAGNOSES REDACTED]. Review of a quarterly Minimum Data Set (MDS) assessment dated (MONTH) 3, 2019, revealed a Brief Interview for Mental Status score of 9, which indicated the resident had moderate cognitive impairment. The MDS included the resident was totally dependant on two staff with bed mobility and transfers and required supervision/set up with meals. A nurse progress note dated (MONTH) 19, 2019 revealed the following: When tray was set on table, resident pushed back on the table making soup splash onto her abdomen. The abdomen was red and that cool wash cloths and an ice pack were applied. Review of an incident/accident report dated (MONTH) 19, 2019 revealed the resident spilled hot soup on her abdomen causing a burn, which was treated with cool wash rags and an ice pack and Tylenol was given for pain. A physician's order dated (MONTH) 20, 2019 included to apply aloe vera protectant cream to midriff area two times a day until healed. A second order included for [MEDICATION NAME] 50 milligram (mg) one tablet by mouth as needed two times a day for pain. A nurse progress note dated (MONTH) 20, 2019 revealed that a new order was obtained for the midriff area and that the area was slightly pink. Review of the (MONTH) 2019 Medication Administration Record [REDACTED]. A nurse progress note dated (MONTH) 21, 2019 included documentation that the midriff region measured 11 cm by 15 cm and was moderately pink with few intact blistering and a few broken diffuse blister like areas, with a small amount of serous drainage and there were no signs or symptoms of infection. However, there was no clinical record documentation that the physician was notified that the burn area had developed blisters. A skin assessment dated (MONTH) 22, 2019 revealed a red blistered area to the midriff. Review of a nurse progress note dated (MONTH) 22, 2019 revealed the pinkness had decreased to the midriff region, with a few remaining blisters intact. The note included no drainage observed, no signs or symptoms of infection and that aloe vera cream was applied as ordered. A second nurse progress note revealed that the midriff was dark pink, with fluid filled areas on the top and lower area. The note included the resident had stated that the aloe vera cream burned the affected area. However, there was no documentation that the physician was notified of this.

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F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 7) A physician's order dated (MONTH) 24, 2019 included for [MEDICATION NAME] cream 1% two times a day and to cover the burn with an abdominal dressing. Review of a nurse progress note dated (MONTH) 26, 2019 revealed a registered Nurse (RN) assessed the resident's burn on the midriff and noted open blisters. The note included that wound care orders were clarified to include application of an [MEDICATION NAME] dressing with [MEDICATION NAME] cream already in place, due to the abdominal pad adhering to the wound and to gently irrigate wound with wound cleanser before applying cream and [MEDICATION NAME]. Review of the physician's orders revealed a clarification order dated (MONTH) 26, 2019 that stated to apply [MEDICATION NAME] 1% cream to burn two times a day, gently irrigate surface area with wound wash, gently pat dry with gauze, apply cream and cover with [MEDICATION NAME] layer and abdominal dressing. A nurse progress note dated (MONTH) 28, 2019 revealed the resident was seen by the doctor and orders were received for Keflex (antibiotic) for infection [MEDICATION NAME] for burn on abdomen/chest and to apply [MEDICATION NAME]. A physician's note dated (MONTH) 28, 2019 revealed the resident had a burn on the abdomen, with open blister. The note indicated abdominal [MEDICAL CONDITION] and included Keflex. Review of the physician's orders dated (MONTH) 28, 2019 revealed orders for Keflex 500 mg by mouth three times a day for seven days to prevent infection to burn. A second order included to discontinue the [MEDICATION NAME] and apply [MEDICATION NAME] two times a day for 10 days to burn. Review of the (MONTH) 2019 MAR indicated [REDACTED]. A care plan for at risk of skin breakdown included the following interventions: report changes in skin status to the physician and notify the nurse immediately of any new areas of skin breakdown, redness, blisters, bruises, discoloration. However, the care plan was not revised to reflect the burn injury or any interventions for the care of the burn. Review of a skin assessment dated (MONTH) 6, 2019 revealed the resident's abdomen was pink with open area. Review of the (MONTH) 2019 MAR indicated [REDACTED]. A skin assessment dated (MONTH) 12, 2019 revealed the resident's abdomen was pink. Review of a quarterly MDS assessment dated (MONTH) 15, 2019 revealed that in the section to document if the resident had a burn (either second or 3rd degree), the section was left blank. A skin assessment dated (MONTH) 20, 2019 did not address the condition of the resident's abdomen. A skin assessment dated (MONTH) 27, 2019 included the resident's midriff was healed. An interview was conducted with resident #55 on (MONTH) 3, 2019 at 9:48 a.m. She stated that soup had spilled on her chest and that she thinks the facility staff put something on the area to reduce the burning. An interview was conducted with a former facility Certified Nursing Assistant (CNA/staff #98) on (MONTH) 3, 2019 at 1:26 p.m. She stated that she was working and remembered when resident #55 had pushed on her tray and soup splashed on her. She stated that she got the nurse and the nurse dried the resident off and placed ice packs from the freezer, wrapped in a pillow case over the resident's stomach. An interview was conducted with a Licensed Practical Nurse (LPN/staff #9) on (MONTH) 4, 2019 at 10:47 a.m. She stated that she was caring for resident #55 at the time of the incident. She stated the CNA came and got her and she lifted the resident's gown and there was a very red decent sized burn which she covered with a cool washcloth, and then contacted the doctor for direction. She stated that she did not put a freezer ice pack on the burn. She stated the doctor ordered cream and a bandage. An interview was conducted with the Director of Nursing (DON/staff #34) on (MONTH) 4, 2019 at 11:01 a.m. She stated that she was out of the building at the time of the burn incident for resident #55. She stated that her expectation regarding a burn injury, would be that staff do first aid, call the doctor, fill out an incident report, contact the administrator or the DON, and then have the doctor come in to see the resident or send the resident out to the emergency room to be assessed. She stated that appropriate first aid would be cold water and cool compresses. She stated that the application of an ice pack would not be appropriate, because it could cause more tissue damage and increased third spacing. She stated that a nurse would be expected to know not to use ice on a burn, based on her professional knowledge. She also stated that the burn should have been on the care plan and that staff did not meet her expectations for care planning. Another interview was conducted with staff #9 on (MONTH) 4, 2019 at 12:02 p.m. She reviewed the (MONTH) 19, 2019 incident report that she had completed for the burn injury on resident #55 and noted that the documentation included an ice pack was administered and stated that she had applied an ice pack. She said the ice pack was covered with a towel or a washcloth, as she would not put an uncovered ice pack on a burn, because if would damage the tissues by decreasing circulation. Another interview was conducted with the DON on (MONTH) 4, 2019 at 12:08 p.m. She stated that the physician should have been called when the wound developed blisters for potential order changes. Another interview was conducted with the DON on (MONTH) 5, 2019 at 9:27 a.m. She stated that if the treatment was not signed on the administration record she would not be able to show that the care was provided as ordered. She stated her expectations are that treatments are done as ordered and documented in the administration record or the progress note. She stated that any care not documented did not follow her expectations or facility policy. Review of the facility policy on wound and skin care protocols revealed the purpose was to promote a systematic approach and monitoring process for the care of residents with existing wounds, with an objective to maintain skin integrity and promote wound healing. A policy on charting and documentation revealed all services provided to the resident shall be documented in the resident's medical record. The policy included that treatments performed are to be documented in the resident's medical record. Review of the policy on First Aid Treatment revealed that residents who experience minor injuries shall be treated at the facility and if the injuries cannot be treated with basic first aid intervention, the emergency medical system will be activated. The policy included that the goal is to enable employees to provide basic life support and/or first aid intervention to injured residents. The policy stated that basic first aid intervention includes interventions for burns. Review of an article dated (MONTH) 3, 2019 written by the Mayo Clinic revealed that first aid for a burn included to cool the burn. The article stated that the burned area should be held under cool (not cold) running water or to apply a cool, wet compress until the pain eases. The article included don't use ice. Putting ice directly on a burn can cause further damage to the tissue.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, observations, facility documentation, resident and staff interviews, and review of policies and procedures, the facility failed to ensure an intervention to prevent accidents was implemented for one resident (#55) and adequate supervision was provided for three residents (#333, #37 and #68) to prevent accidents. The deficient practice could result residents being at risk for accidents and injury. Findings include: -Resident #55 was admitted on (MONTH) 21, (YEAR) with [DIAGNOSES REDACTED]. A quarterly Minimum Data Set (MDS) assessment dated (MONTH) 3, 2019 revealed a Brief Interview for Mental Status (BIMS) score of 9 which indicated the resident had moderately impaired cognition. The assessment included the resident required setup help and supervision for eating and had no range of motion impairment in the upper extremities. Review of a nursing progress note dated (MONTH) 19, 2019 revealed that when the meal tray was set on the table, the resident pushed back on the table making the soup splash onto her abdomen resulting in the abdomen being red. The note included cool wash cloths and an ice pack were applied and Tylenol was given for pain. Review of an incident/accident report dated (MONTH) 19, 2019 revealed the Certified Nursing Assistant (CNA) put the dinner tray on the over side table and that the resident pushed the tray causing the hot soup to splash which resulted in a burn to the abdomen. A nursing note dated (MONTH) 21, 2019 revealed the midriff region burn area measured 11.0 centimeter (cm) by 15 cm, had moderate pink skin with a few intact blisters and a few broken diffuse blister-like areas having small amount of serous drainage. No odor and no signs or symptoms of infection. Aloe-Vera cream was applied to the entire affected skin area. The

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 8) note included the resident's pain was managed with [MEDICATION NAME]. Review of an annual MDS assessment dated (MONTH) 25, 2019 revealed the resident had a BIMS score of 13, which indicated the resident had intact cognition. The assessment included the resident required setup help and supervision for eating and had no range of motion impairment in the upper extremities. An undated hot beverage/soup safe handling assessment form revealed the resident was safe to drink hot fluids or eat hot soup with lids unsupervised. The assessment also included the resident had not had any past accidents/incidents with drinking fluids or eating soup. Review of the care plan did not reveal a care plan that addressed the resident needing lids on hot fluids and hot soup in order to eat unsupervised. Review of the staff communication form kardex of care needs did not include the resident needed lids on hot fluids and hot soup to eat unsupervised. During a lunch observation conducted of the resident on (MONTH) 2, 2019, no lid was observed on the resident's coffee cup. An interview was conducted with the resident on (MONTH) 3, 2019 at 9:48 a.m. The resident stated that after the burn she sustained from spilled soup, she did not remember staff discussing prevention measures with her to prevent further accidents. An interview was conducted with a former CNA (staff #98) on (MONTH) 3, 2019 at 1:26 p.m. She stated that she was working and remembered when resident #55 had pushed her tray causing the soup to splash on her. She stated that following the incident, she did not received any training relating to the incident or burn risk and that there were no changes in the process of tray delivery from (MONTH) until (MONTH) 2, 2019 when her employment ended. In an interview conducted with the Director of Nursing (DON/staff #34) on (MONTH) 4, 2019 at 11:01 a.m., the DON stated the Hot Beverage/soup safe handling assessment should have been dated and that it would have been implemented after (MONTH) 2019. She stated the CNAs would have been made aware of the recommendation for lids on hot fluids and hot soup from the kardex. She stated the resident should have a lid on her coffee and staff should document if the resident refused the lid. The DON also stated the recommendation should have been care planned and it was not. During another observation conducted of the resident on (MONTH) 4, 2019 at 12:56 p.m., the resident's coffee cup on her tray was observed without a lid in place. Review of the facility's guideline and procedure regarding precautions for handling hot beverages revealed staff will monitor, serve and hold hot beverage/soup in a safe manner to prevent potential burns. Additional precautions will be based on the needs of each resident and will include assessing and identifying those individuals served who are at high risk for burning themselves with hot beverages, ensuring staff monitors the identified high risk resident during meal times and/or when hot beverages are served, and educating resident, family and staff about the risk related to hot beverage. -Resident #333 was admitted on (MONTH) 8, 2019 with [DIAGNOSES REDACTED]. Review of the clinical record revealed a non-emergent Medical Transportation risk/benefit Statement dated (MONTH) 8, 2019 was signed by the resident. Review of the care plan with an onset date of (MONTH) 8, 2019 revealed the resident had impaired cognitive skills as evidenced by poor memory and impaired decision making. The goal was that the resident would participate in simple decisions to the extent possible. Interventions included explaining care before providing it and that staff will give the resident simple but limited choices and give reasonable time for responses. The significant change MDS assessment dated (MONTH) 2, 2019 revealed a BIMS score of 7 which indicated the resident had severe cognitive impairment. The assessment included the resident had no behaviors and that he required extensive/total 2+ person assistance for most activities of daily living (ADL). A daily skilled nurse's note dated (MONTH) 25, 2019 included the resident displayed impaired decision making and disorganized thinking. Review of the facility's incident/accident report for (MONTH) 21, 2019 revealed a statement from a CNA (staff #85) that while pulling the resident who was in a wheelchair out of the transport van, the resident pushed back on the floor, causing his wheelchair to flip back down the ramp. The resident did not hit his head. The report included the resident cut his leg which required 4 stitches. The report did not include whether the attending physician and family were notified, any comments and/or steps taken to prevent recurrences nor the signature of the person completing the form. A late entry nursing progress note dated (MONTH) 22, 2019, for (MONTH) 21, 2019, revealed the resident was being transported by the medical transportation company. The resident tipped over backwards in his wheelchair on the van's ramp, causing a laceration to his left lower leg. During the resident's doctor's appointment, the laceration was sutured. The note included the wound showed no signs of infection. Further review of the clinical record revealed no evidence the resident's attending physician or the resident's family were notified of the incident, any follow-up information, and whether any corrective action was taken. An interview was conducted with the CNA (staff #85) on (MONTH) 4, 2019 at 8:12 a.m. She stated that on the afternoon of (MONTH) 21, 2019, she went with the resident to his physician appointment which was out of state. She stated the resident was transported to the physician's office in a small van provided by the transportation company. Staff #85 stated that during transport, the resident sat in his wheelchair which was secured in the rear of the vehicle. She stated that upon arrival to the appointment, she got out of the van and gathered the resident's paperwork. She stated that she was able to observe the resident through the open passenger door. Staff #85 said the driver got out of the vehicle and walked to the tailgate, where he opened the rear door and put the wheelchair ramp down. The CNA stated the driver unfastened the resident's wheelchair from the hooks that had held it stationary during the drive. She stated the driver then walked to the side of the van, where he was out of her view. She said the wheelchair wheels were still locked. The CNA said she saw the resident place his feet on the floor of the van and push himself backwards and saw his feet fly into the air. She said she did not know where the driver was in relation to the resident at that time. She stated the resident's wheelchair went backwards through the back door of the van and landed onto the wheelchair ramp. The CNA said she ran to the back of the van to see if the resident was injured. She said after she checked the resident for injuries; she and the driver sat the resident back up. The CNA stated that she observed a laceration on the resident's left lower leg which was approximately 2 inches long. She stated that she took the resident inside the physician's office and that the physician sutured the laceration. The CNA stated that she notified the facility immediately after the resident was situated in the physician's office with the office staff. On (MONTH) 4, 2019 at 10:07 a.m., an interview was conducted with the DON (staff #34). She stated that her expectation is for the CNAs to monitor residents during transportation. She stated that the transportation company is responsible for securing the wheelchair and releasing the wheelchair from being secured before and after the transport. She stated it is the transportation company's responsibility to roll the resident on to and off of the van. The DON stated her expectation is that unsecured residents are to remain the responsibility of the transportation service until the residents are completely off the van. Regarding an incident between resident #68 and #37: -Resident #68 was admitted on (MONTH) 5, (YEAR) and readmitted on (MONTH) 20, 2019, with [DIAGNOSES REDACTED]. A quarterly MDS assessment dated (MONTH) 13, 2019 revealed the resident's cognitive skills for daily decision making was moderately impaired. Review of the care plan with an onset date of (MONTH) 24, 2019 revealed the resident had impaired cognitive skills as evidenced by poor memory with periods of confusion. The goal was the resident would be able to communicate needs to the staff. Interventions included explaining all care before providing care and providing cues, prompting, and demonstration if the resident is unable to complete a task independently. -Resident #37 was readmitted on (MONTH) 21, (YEAR), with [DIAGNOSES REDACTED]. Review of the care plan with an onset date of (MONTH) 10, (YEAR) revealed the resident had alteration in behaviors related to dementia and confusion and will yell and get into arguments with other residents. The goal was that the resident would not have more than two episodes of behaviors a week. Interventions included staff will try to redirect (not always easy), providing a calm, non-rushed environment with structured familiar activities, and redirecting the resident when wandering into other residents rooms. Review of the annual MDS assessment dated (MONTH) 15, 2019 revealed the resident's cognitive skills for daily decision making was severely impaired.

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 9) The facility's investigation report dated (MONTH) 9, 2019 revealed that on (MONTH) 3, 2019 at 6:30 p.m., resident #37 was seated next to resident #68 at the assisted dining table when resident #37 began hitting resident #68 unexpectedly on the left arm with an open hand. A certified nursing assistant (CNA/staff #8) was present and requested resident #37 to stop and separated the residents. Resident #37 was redirected to a common area. Resident #68 denied pain and resident #68's left arm was assessed to be without redness and injury. The report also included resident #37 sits at arm's length from all residents during meal services and is monitored for behavior. The report included a witness statement from the CNA (staff #8) that on (MONTH) 3, 2019 at the dinner table, resident #37 hit resident #68's arm three times with an open hand. The statement included the CNA asked resident #37 to stop and redirected resident #37 to the common area away from resident #68. An interview was conducted on (MONTH) 4, 2019 at 9:52 a.m. with the CNA (staff #8). She stated that she witnessed the altercation between resident #37 and resident #68 on (MONTH) 3, 2019. Staff #8 stated that resident #37 was sitting next to resident #68 at the assisted dining table when resident #37 turned to resident #68 and hit her on the arm three times. Staff #8 stated the residents were separated and there have been no other issues with the two residents. During an interview conducted with the Director of Nursing (DON/staff #34) on (MONTH) 5, 2019 at 8:21 a.m., the DON stated that on (MONTH) 3, 2019 it would have been ideal if staff would have been able to intervene before resident #37 hit resident #68. She stated that in this case staff was unable to intervene in time to prevent the altercation. The facility's policy titled Accidents and Incidents - Investigating and Reporting revealed all accidents or incidents involving residents occurring on their premises shall be investigated and reported to the administrator. The nurse supervisor/charge nurse/ and/or the department director or supervisor shall promptly initiate and document the investigation of the accident or incident. The Report of Incident/Accident form shall include the time the injured person's attending physician was notified, as well as the time the physician responded and his or her instructions, the date/time the injured person's family was notified and by whom, any corrective action taken, follow-up information, other pertinent data as necessary or required, and the signature of the person completing the report. The policy also included the incident/accidents reports will be reviewed by the Safety Committee for trends related to accidents or safety hazards in the facility and to analyze any individual resident vulnerabilities.
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, resident and staff interviews, and policy review, the facility failed to ensure two residents (#32 and #54) who needed oxygen therapy was provided such care consistent with professional standards of practice. The deficient practice could result in respiratory care needs not being met. Findings include: -Resident #32 was admitted to the facility on (MONTH) 1, (YEAR) and readmitted on (MONTH) 18, (YEAR) with [DIAGNOSES REDACTED]. Review of the clinical record revealed a care plan that the resident was on oxygen as needed with an onset date of (MONTH) 2, (YEAR). The goal was that the resident would have adequate saturation. Interventions included monitoring the oxygen saturation as ordered and that the oxygen saturation was to be 92% or greater. The recap of physician orders [REDACTED]. Further review of the care plan did not reveal a care plan that the resident was on oxygen continuously at 2 liters or that the oxygen saturations were to be greater than 89%. Review of a quarterly Minimum Data Set (MDS) assessment dated (MONTH) 9, 2019 revealed a Brief Interview for Mental Status (BIMS) score of 4, which indicated the resident had severely impaired cognition. The assessment did not include the resident received oxygen therapy. Review of the Treatment Administration Record (TAR) for (MONTH) 2019 revealed no documentation the resident was administered oxygen on (MONTH) 2 and 3, 2019 from 7 a.m. to 7 p.m. During an observation conducted of resident #32 on (MONTH) 2, 2019 at 11:46 a.m., the oxygen was turned on as ordered however, the resident was observed wearing the oxygen nasal cannula with the prongs pointed towards her mouth. Another observation was conducted of the resident on (MONTH) 4, 2019 at 10:26 a.m. The resident was observed wearing the nasal cannula correctly however, the oxygen was not turned on. An interview was conducted with a Licensed Practical Nurse (LPN/staff #12) on (MONTH) 5, 2019 at 9:38 a.m. She stated that if a resident is receiving oxygen, the nurse would check the oxygen saturations and make sure they are above the range specified by the physician. She stated that the nasal cannula prongs should be positioned into the resident's nares. Staff #12 stated that resident #32 moves the oxygen nasal cannula and that she has had to reposition the nasal cannula frequently. She stated the resident would be at risk for altered breathing and decreased oxygen saturations if the oxygen concentrator was off. Staff #12 also stated there should be a care plan for oxygen use. An interview was conducted with the Director of Nursing (DON/staff #34) on (MONTH) 5, 2019 at 10:24 a.m. She stated that she expects oxygen to be administered as ordered by the physician. She stated the Certified Nursing Assistants (CNA) had been educated to make sure the oxygen tubing was connected to the oxygen concentrator and the concentrator was turned on when the resident was in the room. She stated that if the oxygen is not delivered as ordered it would increase the resident's risk for respiratory distress or [MEDICAL CONDITION], cardiac events, and inhibition of wound healing. She stated that resident #32 should have an active care plan addressing the resident's requirement for oxygen. -Resident #54 was readmitted to the facility on (MONTH) 21, (YEAR) with a [DIAGNOSES REDACTED]. The physician recapitulation of orders for (MONTH) 2019 included an order for [REDACTED]. The hospice admission note dated (MONTH) 28, 2019 included the resident was oxygen dependent at 3 liters. The hospice medication profile dated (MONTH) 29, 2019 included an order for [REDACTED]. The hospice nurse visit note dated (MONTH) 7, 2019 revealed the resident was on oxygen at 3 liters. Review of the clinical record revealed no evidence the discrepancy in the amount of oxygen the resident was to receive was addressed. The significant change MDS assessment dated (MONTH) 7, 2019 revealed a BIMS score of 7 indicating the resident had severe cognitive impairment. The MDS assessment also revealed oxygen therapy was not coded. Review of the care plan did not reveal a care plan was developed that addressed the resident's need for oxygen. Observations were conducted of the resident with oxygen on via nasal cannula. The following oxygen flow rate was observed: -December 2, 2019 at 12:43 p.m., the oxygen was at 1 and 1/2 liters -December 3, 2019 at 8:19 a.m., the oxygen was at 1 and 1/2 liters -December 4, 2019 at 8:24 a.m., the oxygen was at 1 and 1/2 liters -December 5, 2019 at 8:10 a.m. the oxygen was at 2 liters Further review of the clinical record did not reveal evidence the order for oxygen had changed. During an interview conducted with resident #54 on (MONTH) 5, 2019 at 11:06 a.m., resident #54 stated her oxygen has to be on continuously and that she does not know how much oxygen she is to receive. The resident was observed to have oxygen on at 2 liters. In an interview conducted with a LPN (staff #12) on (MONTH) 5, 2019 at 11:08 a.m., she stated the resident is on oxygen therapy and currently under hospice care. The LPN reviewed the clinical record and stated that the resident has an order for [REDACTED].#12. Staff #12 stated the resident is receiving oxygen at 2 liters via nasal cannula which was different from the order. She stated hospice may have changed the order. She also stated that if hospice changes an order, it will be flagged in the clinical record. She stated no orders were flagged when she reported for duty. In an interview conducted with a registered nurse (staff #3) on (MONTH) 5, 2019 at 1:37 p.m., she stated resident #54 is receiving oxygen but that she did not know how much oxygen the resident was supposed to be receiving. During an interview conducted with the DON (staff #34) on (MONTH) 6, 2019 at 8:46 a.m., she stated that staff are to administer oxygen to resident #54 as ordered by the physician. The facility's policy on Oxygen Administration revised (MONTH) 2010 revealed the purpose was to provide guidelines for safe oxygen administration. It also included verifying that there is a physician order [REDACTED]. The facility's policy regarding Administering Medications revealed medications are administered in accordance with the prescriber's orders. The policy included The individual administering the medication checks the label three times to verify

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F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 10) the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.
F 0698 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Past noncompliance - remedy proposed** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policy review, the facility failed to ensure one sampled resident (#69) received [MEDICAL TREATMENT] services consistent with professional standards of practice. The deficient practice could result in [MEDICAL TREATMENT] related complications not being identified and treated timely. Findings include: Resident #69 was admitted to the facility on (MONTH) 31, 2019 with [DIAGNOSES REDACTED]. Review of the admission physician orders [REDACTED]. However, upon receipt of the requested copies, an undated handwritten note [MEDICAL TREATMENT] T, TH, Sat was noted. Review of a skin assessment dated (MONTH) 31, 2019 revealed the resident had an intravenous port to the right upper arm, [MEDICAL TREATMENT] fistula present. Review of a nurse progress note dated (MONTH) 31, 2019 revealed also has [MEDICAL TREATMENT] fistula. However, review of the clinical record did not reveal evidence the [MEDICAL TREATMENT] site was assessed daily from (MONTH) 23, 2019 to (MONTH) 1, 2019. The admission Minimum Data Set assessment dated (MONTH) 7, 2019 revealed the resident had a Brief Interview for Mental Status score of 15 which indicated the resident had intact cognition intact. The assessment included the resident was receiving [MEDICAL TREATMENT] treatments. Continued review of the clinical record revealed no evidence of pre and post [MEDICAL TREATMENT] assessments for (MONTH) 5, 12, 19, 21, 26, 28, or 30, 2019 and (MONTH) 3, 5, or 6, 2019. An interview was conducted with a Licensed Practical Nurse (LPN/staff #12) on (MONTH) 5, 2019 at 9:42 a.m. She stated that care for the resident pre [MEDICAL TREATMENT] would include checking the resident's weight, the [MEDICAL TREATMENT], and filling out the pre [MEDICAL TREATMENT] section of the pre and post [MEDICAL TREATMENT] assessment form before sending the resident to [MEDICAL TREATMENT]. She stated that the nurse receiving the resident back from the [MEDICAL TREATMENT] would complete the post [MEDICAL TREATMENT] portion of the form which would include obtaining the resident's vitals signs and checking the dressing over the [MEDICAL TREATMENT]. The LPN stated that if the sheets for pre and post [MEDICAL TREATMENT] could not be located it would mean they were misplaced or the assessments were not done. The LPN stated a resident should have an order for [REDACTED].>An interview was conducted with the Director of Nursing (DON/staff #34) on (MONTH) 5, 2019 at 10:31 a.m. She stated that a physician order [REDACTED]. She stated that prior to and after returning from [MEDICAL TREATMENT], the resident's vital signs and weight should be obtained and the [MEDICAL TREATMENT] site should be assessed. The DON also stated the [MEDICAL TREATMENT] site should be checked at least once daily. Review of the facility's policy regarding the care of a resident with [MEDICAL CONDITION] revealed residents with [MEDICAL CONDITION] will be cared for according to currently recognized standards of care. The policy included residents will be assessed pre and post [MEDICAL TREATMENT], and weights will be taken per physician order. The policy also revealed the residents will receive care that included monitoring the resident for signs and symptoms or worsening condition and/or complications of [MEDICAL CONDITION] and assessment of the access site.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interview, and policy review, the facility failed to ensure expired medications in one medications cart was not available for resident use. The deficient practice could result in expired medications being administered. Findings include: During an observation conducted on (MONTH) 3, 2019 at 8:15 a.m. of the medication cart for the central hallway with the Director of Nursing (DON/staff #34), a resident's bottle of [MEDICATION NAME] 25 milligrams (mg) tablets was observed with an expiration date of (MONTH) 13, 2019 and a bottle of [MEDICATION NAME] 3 mg tablets were observed with an expiration date of (MONTH) 8, 2019. During an interview conducted on (MONTH) 3, 2019 at 9:00 a.m. with the DON (staff #34), she stated that the medications should not have been on the cart as they were expired. An interview was conducted with a Licensed Practical Nurse (staff #12) on (MONTH) 3, 2019 at 9:10 a.m. Staff #12 stated that the expired bottles of [MEDICATION NAME] and [MEDICATION NAME] should not be in the cart. She further stated that she would have to order new medications for the resident. During an interview conducted on (MONTH) 3, 2019 at 12:26 p.m. with the pharmacist for the facility, she stated the medications should have been discarded on the discard date and that they could not vouch for the effectiveness of the medication after the discard date. Additionally, she stated that they had refilled a new prescription for [MEDICATION NAME] on (MONTH) 24, 2019. Review of the facility's policy for Storage of Medications revised (MONTH) 2109 revealed the facility stores all drugs and biologicals in a safe, secure, and orderly manner. The policy included discontinued, outdated, or deteriorated drugs or biologicals are returned to the pharmacy or destroyed.