STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035100	A. BUILDING _____ B. WING _____	**02/06/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HAVASU NURSING CENTER	**3576 KEARSAGE DRIVE LAKE HAVASU CITY, AZ 86406**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0600 **Level of harm -** Actual harm **Residents Affected -** Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident and staff interviews, facility documents and policies and procedures, the facility failed to provide the necessary care and services to prevent neglect, by failing to ensure one resident (#9) was adequately supervised while outside and as a result, sustained prolonged sun exposure resulting in hospitalization . Findings include: Resident #9 was admitted on (MONTH) 12, (YEAR), with [DIAGNOSES REDACTED]. Review of a quarterly MDS (Minimum Data Set) assessment dated (MONTH) 12, (YEAR) revealed the resident had a BIMS (Brief Interview for Mental Status) score of 9, which indicated moderate cognitive impairment. The MDS included the resident used a wheelchair for locomotion on and off the unit and required supervision (oversight, encouragement or cueing). A care plan for cognitive loss related to impaired memory and forgetfulness was updated on (MONTH) 14, (YEAR). An intervention was the resident needed reminders to call for assistance. A care plan updated on (MONTH) 14, (YEAR) for the potential for falls related to weakness and impaired mobility, included to continue frequent checks, remind the resident to call for assistance and that the resident can be impulsive. According to a care plan for alteration in fluid intake updated on (MONTH) 25, (YEAR) included that resident #9 had two plus [MEDICAL CONDITION] in both legs. Interventions included to assure adequate fluid intake. An additional intervention initiated on (MONTH) 26, (YEAR) included to monitor the resident for side effects of diuretic use, including electrolyte imbalance and dehydration. A nurses note dated (MONTH) 1, (YEAR) at 5:00 p.m. revealed the resident had been found outside by a nurse on the patio, his color was flushed, skin dry, and he was unresponsive to verbal commands. Vital signs were as follows: temperature was 103.3, pulse was 107 and blood pressure was 96/69. Cooling measures were initiated and 911 was called, and the resident was transported to the hospital. A hospital physician's history and physical report dated (MONTH) 1, (YEAR) included that resident #9 had a history of [REDACTED]. The resident was found outside of the nursing facility after a period estimated to be a couple of hours. The resident had significant sunburns noted to the back of his neck, the anterior aspect of his upper chest, his arms, the medial aspect of his torso, and the anterior aspect of both thighs. The resident complained of generalized pain and weakness throughout his body. In the emergency department the resident was given a liter of chilled saline. The report further included the resident had heat exposure, heat stress and acute kidney injury, secondary to heat exposure and dehydration. A hospital discharge note dated (MONTH) 2, (YEAR) revealed the following discharge Diagnoses: [REDACTED]. A nurses note dated (MONTH) 2, (YEAR) included the resident returned to the facility. Review of the incident report revealed that on (MONTH) 1, (YEAR) at 5 p.m., the resident was found outside in the courtyard. The resident had memory impairment and impaired decision making ability, and self propelled his wheelchair in and out of courtyards frequently without difficulty. The report included the resident was sunburned, his face and neck were flushed and there was a fluid filled blister on the back of his neck. Cool compresses were applied. The resident was unresponsive to verbal commands and 911 was called. The type of incident documented was heat exposure/sunburn. Review of the facility's investigation report revealed that on (MONTH) 1, (YEAR) at approximately 4:30 p.m., resident #9 was found to be asleep outside in an interior courtyard. The resident was brought inside by a LPN (licensed practical nurse/staff #71). The resident was found to be lethargic and was not responding to verbal stimuli. The resident had a red face, neck and hands with blisters forming on his neck. Cool towels were placed over the resident's head, neck and arms and cool water was provided to the resident to drink. The resident was sent to the emergency department and was treated for [REDACTED]. The report included that the courtyard is visible from inside of the facility. Per the report, the day shift (6a-2p) CNA reported that the resident was in bed at shift change that afternoon, and the 2p-10p CNA reported that she saw the resident in the television room around 3:00 p.m., and in the hallway around 3:15 p.m. The report further included that staff did not visualize the resident again until he was found asleep in the courtyard at 4:30 p.m. Further review of the investigation report revealed a witness statement signed by staff #71. In the statement, staff #71 stated that the resident was last seen by staff at 3:00 p.m., and was found in the courtyard at 5:00 p.m. (which differs from the time documented in the investigation report at 4:30 p.m.). Review of the dispatch Pre-Hospital Care Report dated (MONTH) 1, (YEAR), revealed the call was received at 5:24 p.m., paramedics were on scene at 5:27 p.m., and the resident was transported to the hospital at 5:40 p.m. During an interview with resident #9 conducted on (MONTH) 4, 2019 at 12:10 p.m., he stated that last (MONTH) (he did not remember the exact date), he had fallen asleep while he was outside in the courtyard, but did not remember how long. The resident stated that he woke up when staff were carrying him inside and that he got burned pretty bad. An observation of the facility's non-smoking courtyard where the resident had been found revealed the courtyard had glass doors on two opposing sides. One set of glass doors lead into the main hallway and the other set of glass doors lead into the television room. The television room had multiple windows, so the courtyard was visible from this room and from the main hallway. In addition, the courtyard was surrounded by multiple resident rooms with windows that faced the courtyard. An Internet source (Time and Date.com) was reviewed on (MONTH) 5, 2019 at 2:36 p.m., and revealed the weather on (MONTH) 1, (YEAR) from 2:56 p.m. until 4:56 p.m. was sunny, with a temperature of 105 degrees F. An interview was conducted on (MONTH) 5, 2019, with the Director of Nursing (DON/staff #19). The DON stated that on (MONTH) 1, (YEAR), resident #9 was found sleeping out on the non-smoking courtyard. The DON said the resident was independently mobile with his wheelchair and was able to let himself in and out of the courtyard independently. The DON said at the time of the incident, staff were checking the courtyard hourly, but was done informally and was not documented, and no specific staff was assigned to check the courtyard. The DON also stated that the resident's assigned CNA (certified nursing assistant) should have known that he had gone out to the courtyard. An interview was conducted on (MONTH) 5, 2019 at 2:56 p.m., with a random CNA (staff #40). Staff #40 stated that in (MONTH) (YEAR), the facility air conditioning system maintained cool temperatures in the facility, and resident #9 was known by staff to go outside on the courtyard several times a day to warm up. Staff #40 said they were aware that resident #9 went outside frequently and they monitored him while in the courtyard. The CNA stated that staff would bring the resident inside after 10-15 minutes to prevent the resident from overheating. The CNA also stated that water was not maintained in the courtyard for residents to drink. An interview was conducted on (MONTH) 6, 2019 at 9:38 a.m., with a LPN (staff #71). Staff #71 stated she was walking down

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035100	A. BUILDING _____ B. WING _____	02/06/2019

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HAVASU NURSING CENTER	3576 KEARSAGE DRIVE LAKE HAVASU CITY, AZ 86406

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0600 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 1) the hallway and noticed that resident #9 was out on the non-smoking courtyard asleep in his wheelchair, and his legs were stretched out in front of him and his head was tucked down onto his chest. She said she went out and attempted to wake the resident up, but he was non-responsive. Staff #71 said she immediately wheeled the resident to the nurses station and with additional staff assistance, placed cold towels around the residents neck. She said the resident had reddened skin on his face and neck and 911 was called. Staff #71 stated that staff monitored the courtyard by looking out onto the courtyard as they went by, but there was no structured program for monitoring the courtyard, there was no specific staff assigned to monitor the courtyard, and the monitoring was not documented. Staff #71 said resident #9 was able to use his wheelchair independently to go in and out of the courtyard, and he frequently went outside and napped in the sun, and this was common knowledge among the staff. She added that she was not his assigned nurse on (MONTH) 1, (YEAR) and did not know how long the resident had been outside when she found him. A policy and procedure titled, Resident Hydration and Prevention of Dehydration included This facility will endeavor to provide adequate hydration and to prevent and treat dehydration. An intervention included that nursing will assess for signs and symptoms of dehydration during daily care. Review of a policy and procedure titled, Safety and Supervision of Residents which was current on (MONTH) 1, (YEAR) revealed the following: Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. The policy included Due to their complexity and scope, certain resident risk factors and environmental hazards are addressed in dedicated policies and procedures. These risk factors and environmental hazards include: Outdoor safety (outings, courtyards, etc). Hourly courtyard checks. A policy and procedure titled, Abuse Prevention Program included the objective of the policy was zero tolerance of abuse and neglect by employees. Neglect was defined as the failure of the facility, its employees or service providers to provide goods and services to a resident necessary to avoid physical harm, pain, mental anguish, or emotional distress. The policy included that resident's have the right to be free of abuse and neglect.
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 review, staff interviews, facility documents and policies and procedures, the facility failed to implement their Abuse policy, by failing to identify an incident of neglect involving one resident (#9), and by failing to report an incident of neglect to the State Survey Agency within two hours as required and to law enforcement. Findings include: Resident #9 was admitted on (MONTH) 12, (YEAR), with [DIAGNOSES REDACTED]. Review of a quarterly MDS (Minimum Data Set) assessment dated (MONTH) 12, (YEAR) revealed the resident had a BIMS (Brief Interview for Mental Status) score of 9, which indicated moderate cognitive impairment. The MDS included the resident used a wheelchair for locomotion on and off the unit and required supervision (oversight, encouragement or cueing). A nurses note dated (MONTH) 1, (YEAR) at 5:00 p.m. revealed the resident had been found outside by a nurse on the patio, his color was flushed, skin dry, and he was unresponsive to verbal commands. Vital signs were as follows: temperature was 103.3, pulse was 107 and blood pressure was 96/69. Cooling measures were initiated and 911 was called, and the resident was transported to the hospital. A hospital physician's history and physical report dated (MONTH) 1, (YEAR) included that resident #9 had a history of [REDACTED]. The resident was found outside of the nursing facility after a period estimated to be a couple of hours. The resident had significant sunburns noted to the back of his neck, the anterior aspect of his upper chest, his arms, the medial aspect of his torso, and the anterior aspect of both thighs. The resident complained of generalized pain and weakness throughout his body. In the emergency department the resident was given a liter of chilled saline. The report further included the resident had heat exposure, heat stress and acute kidney injury, secondary to heat exposure and dehydration. A hospital discharge note dated (MONTH) 2, (YEAR) revealed the following discharge Diagnoses: [REDACTED]. A nurses note dated (MONTH) 2, (YEAR) included the resident returned to the facility. Review of the incident report revealed that on (MONTH) 1, (YEAR) at 5 p.m., the resident was found outside in the courtyard. The resident had memory impairment and impaired decision making ability, and self propelled his wheelchair in and out of courtyards frequently without difficulty. The report included the resident was sunburned, his face and neck were flushed and there was a fluid filled blister on the back of his neck. Cool compresses were applied. The resident was unresponsive to verbal commands and 911 was called. The type of incident documented was heat exposure/sunburn. Review of the facility's investigation report revealed that on (MONTH) 1, (YEAR) at approximately 4:30 p.m., resident #9 was found to be asleep outside in an interior courtyard. The resident was brought inside by a LPN (licensed practical nurse/staff #71). The resident was found to be lethargic and was not responding to verbal stimuli. The resident had a red face, neck and hands with blisters forming on his neck. Cool towels were placed over the resident's head, neck and arms and cool water was provided to the resident to drink. The resident was sent to the emergency department and was treated for [REDACTED]. The report included that the courtyard is visible from inside of the facility. Per the report, the day shift (6a-2p) CNA reported that the resident was in bed at shift change that afternoon, and the 2p-10p CNA reported that she saw the resident in the television room around 3:00 p.m., and in the hallway around 3:15 p.m. The report further included that staff did not visualize the resident again until he was found asleep in the courtyard at 4:30 p.m. Further review of the investigation report revealed a witness statement signed by staff #71. In the statement, staff #71 stated that the resident was last seen by staff at 3:00 p.m., and was found in the courtyard at 5:00 p.m. (which differs from the time documented in the investigation report at 4:30 p.m.). Review of the dispatch Pre-Hospital Care Report dated (MONTH) 1, (YEAR), revealed the call was received at 5:24 p.m., paramedics were on scene at 5:27 p.m., and the resident was transported to the hospital at 5:40 p.m. The investigation report further revealed that the incident had not been identified as neglect, and that the incident was not reported to the State Survey Agency until (MONTH) 2, (YEAR) at 4:45 p.m., which was over the two hour time frame for reporting. In addition, there was no evidence that law enforcement was notified. An interview was conducted on (MONTH) 5, 2019 at 12:05 p.m., with the Director of Nursing (DON/staff #19). The DON stated that she did not know that the facility was supposed to report allegations of neglect or abuse to the State Survey Agency within 2 hours. Staff #19 said that she thought allegations of neglect or abuse were supposed to be reported within 24 hours. She also stated that she did not notify the police of the allegation of neglect, because she was not aware of the regulatory requirement to notify the police for allegations of neglect if there is bodily injury. An interview was conducted on (MONTH) 6, 2019 at 11:30 a.m., with the Administrator (staff #31) and the Director of Nursing (staff #19). Staff #31 stated that the police were not notified of the allegation of neglect, because serious bodily injury was not initially reported to him by the staff member, only that the resident had reddened skin. Staff #31 stated that an allegation of neglect is reported only if there is serious injury to the resident. Review of a policy titled, Abuse Prevention Program revealed the objectives included zero tolerance of abuse and neglect by employees, and to establish an atmosphere conducive to reporting any allegations of abuse and neglect. The policy included to develop and implement a system for identifying, investigating, preventing and reporting any incident or suspected incident of abuse, neglect and mistreatment. The policy defined neglect as the failure of the facility, its employees or service providers to provide goods and services to a resident necessary to avoid physical harm, pain, mental anguish, or emotional distress. The policy also included the following: -Incidents of abuse and neglect should be reported to the supervisor and immediately reported to the Director of Nursing/Administrator. -Reports are to be made as soon as the incident or potential incident is make known. -Authorities to be notified include: police department and the State Survey Agency. - If the events that cause the allegation involve abuse or result in serious bodily injury to a resident, a report must be made immediately, but not later that two hours after receiving the allegation. -The facility will report any allegation of abuse, neglect or a crime against a resident to the required government agencies and local law enforcement in accordance with the law.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035100	A. BUILDING _____ B. WING _____	02/06/2019

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HAVASU NURSING CENTER	3576 KEARSAGE DRIVE LAKE HAVASU CITY, AZ 86406

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 0607 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2)
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 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 review, facility documents and policies and procedures, the facility failed to report an incident of neglect to law enforcement involving one resident (#9), who sustained serious bodily injury requiring hospitalization . Findings include: Resident #9 was admitted on (MONTH) 12, (YEAR), with [DIAGNOSES REDACTED]. A nurses note dated (MONTH) 1, (YEAR) at 5:00 p.m. revealed the resident had been found outside by a nurse on the patio, his color was flushed, skin dry, and he was unresponsive to verbal commands. Vital signs were as follows: temperature was 103.3, pulse was 107 and blood pressure was 96/69. Cooling measures were initiated and 911 was called, and the resident was transported to the hospital. A hospital physician's history and physical report dated (MONTH) 1, (YEAR) included that resident #9 had a history of [REDACTED]. The resident was found outside of the nursing facility after a period estimated to be a couple of hours. The resident had significant sunburns noted to the back of his neck, the anterior aspect of his upper chest, his arms, the medial aspect of his torso, and the anterior aspect of both thighs. The resident complained of generalized pain and weakness throughout his body. In the emergency department the resident was given a liter of chilled saline. The report further included the resident had heat exposure, heat stress and acute kidney injury, secondary to heat exposure and dehydration. A hospital discharge note dated (MONTH) 2, (YEAR) revealed the following discharge Diagnoses: [REDACTED]. Review of the incident report revealed that on (MONTH) 1, (YEAR) at 5 p.m., the resident was found outside in the courtyard. The resident had memory impairment and impaired decision making ability, and self propelled his wheelchair in and out of courtyards frequently without difficulty. The report included the resident was sunburned, his face and neck were flushed and there was a fluid filled blister on the back of his neck. Cool compresses were applied. The resident was unresponsive to verbal commands and 911 was called. The type of incident documented was heat exposure/sunburn. Review of the facility's investigation report revealed that on (MONTH) 1, (YEAR) at approximately 4:30 p.m., resident #9 was found to be asleep outside in an interior courtyard. The resident was brought inside by a LPN (licensed practical nurse/staff #71). The resident was found to be lethargic and was not responding to verbal stimuli. The resident had a red face, neck and hands with blisters forming on his neck. Cool towels were placed over the resident's head, neck and arms and cool water was provided to the resident to drink. The resident was sent to the emergency department and was treated for [REDACTED]. The report included that the courtyard is visible from inside of the facility. Per the report, the day shift (6a-2p) CNA reported that the resident was in bed at shift change that afternoon, and the 2p-10p CNA reported that she saw the resident in the television room around 3:00 p.m., and in the hallway around 3:15 p.m. The report further included that staff did not visualize the resident again until he was found asleep in the courtyard at 4:30 p.m. Further review of the investigation report revealed a witness statement signed by staff #71. In the statement, staff #71 stated that the resident was last seen by staff at 3:00 p.m., and was found in the courtyard at 5:00 p.m. (which differs from the time documented in the investigation report at 4:30 p.m.). Review of the dispatch Pre-Hospital Care Report dated (MONTH) 1, (YEAR), revealed the call was received at 5:24 p.m., paramedics were on scene at 5:27 p.m., and the resident was transported to the hospital at 5:40 p.m. The investigation report further revealed there was no evidence that the incident of neglect with bodily injury was reported to law enforcement. An interview was conducted on (MONTH) 5, 2019 at 12:05 p.m. with the Director of Nursing (staff #19). Staff #19 stated that she did not notify the police of the allegation of neglect, because she was not aware of the regulatory requirement to notify the police for allegations of neglect if there was bodily injury. An interview was conducted on (MONTH) 6, 2019 at 11:30 a.m. with the Administrator (staff #31) and the Director of Nursing. Staff #31 stated that the police were not notified of the allegation of neglect for resident #9, because serious bodily injury was not initially reported to him by the staff member, only that the resident had reddened skin. Staff #31 stated that an allegation of neglect is reported only if there is serious injury to the resident. A policy titled, Abuse Prevention Program included that if the events that cause the allegation involve abuse or result in serious bodily injury to a resident, a report must be made immediately but not later that two hours after receiving the allegation. Authorities to be notified include the police department. The policy also included that the facility will report any allegation of neglect against a resident to 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 review, staff interview, facility documents, review of the State Agency Data Base and policies and procedures, the facility failed to report an incident of neglect to the State Survey Agency within two hours for one resident (#9). Findings include: Resident #9 was admitted on (MONTH) 12, (YEAR), with [DIAGNOSES REDACTED]. A nurses note dated (MONTH) 1, (YEAR) at 5:00 p.m. revealed the resident had been found outside by a nurse on the patio, his color was flushed, skin dry, and he was unresponsive to verbal commands. Vital signs were as follows: temperature was 103.3, pulse was 107 and blood pressure was 96/69. Cooling measures were initiated and 911 was called, and the resident was transported to the hospital. A hospital physician's history and physical report dated (MONTH) 1, (YEAR) included that resident #9 had a history of [REDACTED]. The resident was found outside of the nursing facility after a period estimated to be a couple of hours. The resident had significant sunburns noted to the back of his neck, the anterior aspect of his upper chest, his arms, the medial aspect of his torso, and the anterior aspect of both thighs. The resident complained of generalized pain and weakness throughout his body. In the emergency department the resident was given a liter of chilled saline. The report further included the resident had heat exposure, heat stress and acute kidney injury, secondary to heat exposure and dehydration. A hospital discharge note dated (MONTH) 2, (YEAR) revealed the following discharge Diagnoses: [REDACTED]. A nurses note dated (MONTH) 2, (YEAR) included the resident returned to the facility. Review of the incident report revealed that on (MONTH) 1, (YEAR) at 5 p.m., the resident was found outside in the courtyard. The resident had memory impairment and impaired decision making ability, and self propelled his wheelchair in and out of courtyards frequently without difficulty. The report included the resident was sunburned, his face and neck were flushed and there was a fluid filled blister on the back of his neck. Cool compresses were applied. The resident was unresponsive to verbal commands and 911 was called. The type of incident documented was heat exposure/sunburn. Review of the facility's investigation report revealed that on (MONTH) 1, (YEAR) at 4:30 p.m., resident #9 was found asleep outside in an interior courtyard. The resident was brought inside by a LPN (licensed practical nurse/staff #71). The resident was found to be lethargic and was not responding to verbal stimuli. The resident had a red face, neck and hands with blisters forming on his neck. Cool towels were placed over the resident's head, neck and arms and cool water was provided to the resident to drink. The resident was sent to the emergency department and was treated for [REDACTED]. The report included that the courtyard is visible from inside of the facility. Per the report, the day shift (6a-2p) CNA reported that the resident was in bed at shift change that afternoon, and the 2p-10p CNA reported that she saw the resident in the television room around 3:00 p.m., and in the hallway around 3:15 p.m. The report further included that staff did not visualize the resident again until he was found asleep in the courtyard at 4:30 p.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035100	A. BUILDING _____ B. WING _____	02/06/2019

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HAVASU NURSING CENTER	3576 KEARSAGE DRIVE LAKE HAVASU CITY, AZ 86406

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 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) Further review of the investigation report revealed a witness statement signed by staff #71. In the statement, staff #71 stated that the resident was last seen by staff at 3:00 p.m., and was found in the courtyard at 5:00 p.m. (which differs from the time documented in the investigation report at 4:30 p.m.). Review of the dispatch Pre-Hospital Care Report dated (MONTH) 1, (YEAR), revealed the call was received at 5:24 p.m., paramedics were on scene at 5:27 p.m., and the resident was transported to the hospital at 5:40 p.m. Review of the State Agency data base and the facility's investigation revealed that the incident of neglect occurred on (MONTH) 1, (YEAR), however, was not reported to the State Survey Agency until (MONTH) 2, (YEAR) at 4:45 p.m., which was over the two hour time frame for reporting. An interview was conducted on (MONTH) 5, 2019 at 12:05 p.m., with the Director of Nursing (DON/staff #19). The DON stated that she did not know that the facility was supposed to report allegations of neglect or abuse to the State Survey Agency within 2 hours. Staff #19 said that she thought allegations of neglect or abuse were supposed to be reported within 24 hours. Review of a policy and procedure titled, Abuse Prevention Program revealed that events which include abuse/neglect are to be reported as soon as the incident is made known. If the events that cause the allegation involve abuse or result in serious bodily injury to a resident, a report must be made immediately, but not later that two hours after receiving the allegation to the State Survey Agency.
F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure services provided by the nursing facility meet professional standards of quality.** **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 a physician's order was in place regarding the crushing of medications per their policy for one resident (#96). Findings include: Resident #96 was admitted to the facility on (MONTH) 9, (YEAR), with [DIAGNOSES REDACTED]. The physician orders dated (MONTH) 9, (YEAR) revealed the resident was prescribed multiple medications that were to be administered orally. The medications included [MEDICATION NAME] (anti-[MEDICAL CONDITION]), [MEDICATION NAME] (anticoagulant), aspirin (nonsteroidal anti-[MEDICAL CONDITION] drug), Atorvastatin (reduces cholesterol levels), [MEDICATION NAME] (lowers blood sugar) and [MEDICATION NAME] (antihypertensive). Additional physician orders dated (MONTH) 9, (YEAR) revealed the resident was to be evaluated by speech therapy for swallowing. The orders included a pureed diet with thickened liquids, due to swallowing difficulties. Review of the nursing notes from (MONTH) 10 through (MONTH) 23, (YEAR) revealed on some occasions medications were crushed and on other occasions the mediations were administered to the resident whole. Review of the Medication Administration Record (MAR) dated (MONTH) (YEAR), revealed the medications were administered. Also included on the MAR was a handwritten note without a date to crush the resident's medications. However, review of physician orders through (MONTH) 23, (YEAR) revealed no evidence of an order to crush the resident's medications. An interview was conducted with a Licensed Practical Nurse (LPN/staff #67) on (MONTH) 6, 2019 at 11:37 a.m. She stated a resident with swallowing difficulties would be considered high risk for aspiration concerns. Staff #67 further stated resident #96 was on a pureed diet with thickened liquids and that would also indicate high risk for swallowing concerns, so the crushing of medications would be common. The LPN stated a physician's order was necessary for crushing medications prior to the nurses administering crushed medications. She also stated the order would be transcribed onto the MAR and all nurses would then know the oral medications have to be crushed. During an interview conducted with the Director of Nursing (staff #19) on (MONTH) 6, 2019 at 12:47 p.m., she stated a physician's order was needed for medications to be crushed before the resident is administered crushed medications. The facility's policy regarding crushing medications revealed medications shall only be crushed when it is consistent with physician orders. The policy also included the MAR or other documentation must indicate why it was necessary to crush the medication.
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 clinical record review, staff interviews, and policy review, the facility failed to ensure a physician's order was in place prior to the administration of oxygen for one resident (#96). Findings include: Resident #96 was admitted to the facility on (MONTH) 9, (YEAR) with [DIAGNOSES REDACTED]. A review of nursing notes revealed the following regarding oxygen: -February 9, (YEAR) admission note: Oxygen on 2 Liters (L) via Nasal Cannula (NC). -February 9, (YEAR) afternoon shift: Oxygen on 2.5 [MI] -February 10, (YEAR) afternoon shift: Oxygen on 2.5 [MI] -February 10, (YEAR) night shift: Oxygen on 2.5 L via NC. -February 11, (YEAR): Oxygen on 2.5 L via NC. -February 12, (YEAR): Oxygen on 2 L via NC. -February 13, (YEAR): Oxygen on 2 L via NC. -February 20, (YEAR): Oxygen on 2 L via NC. -February 23, (YEAR): Oxygen on 2 L via NC. -February 25, (YEAR): Oxygen on 2 L via NC. -February 27, (YEAR): Oxygen on 3 L via NC. -February 22, (YEAR): Oxygen on 2 L via NC. Review of the Medication Administration Record [REDACTED]. However, review of the clinical record revealed no evidence of a physician's order for the administration of oxygen. An interview was conducted with a Licensed Practical Nurse (staff #67) on (MONTH) 6, 2019 at 11:37 a.m. She stated a physician's order needed to be obtained for the administration of oxygen. Staff #67 further stated the order would then be transcribed onto the MAR indicated [REDACTED]. During an interview conducted with the Director of Nursing (staff #19) on (MONTH) 6, 2019 at 12:47 p.m., she stated a physician's order is necessary for the continuous administration of oxygen. The facility's policy regarding oxygen administration included verifying that there is a physician's order and reviewing the physician's order for oxygen administration.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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 interviews, and policy and procedure, the facility failed to ensure expired medications were not available for use. Findings include: During a medication storage room observation conducted on (MONTH) 6, 2019 at 8:14 AM on hallway 1 with a registered nurse (staff #18), the following expired medications were observed: -[MEDICATION NAME] (antiulcer agent) 10 mg (milligrams) tablets with an expiration date of (MONTH) 2019 -Vitamin D (supplement) 400 IU (International Unit) capsules with an expiration date of (MONTH) (YEAR) -[MEDICATION NAME] inhalation suspension (anti-asthmatic/corticosteroid) 0.5 mg/2 mL (milliliters) with an expiration date of (MONTH) (YEAR) -[MEDICATION NAME] inhalation suspension 0.5 mg/2 mL with an expiration date of (MONTH) (YEAR)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035100	A. BUILDING _____ B. WING _____	**02/06/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HAVASU NURSING CENTER	**3576 KEARSAGE DRIVE LAKE HAVASU CITY, AZ 86406**

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 0761 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 4) -[MEDICATION NAME] sulfate inhalation solution ([MEDICATION NAME][MEDICATION NAME]) 0.083% 2.5 mg/3 mL with an expiration date of (MONTH) (YEAR). Following the storage room observation, an observation was conducted of a medication cart on hallway 1. The following medications were observed expired for two different residents: -[MEDICATION NAME] (antihypertensive) 5 mg tablets with an expiration date of (MONTH) 31, (YEAR) -[MEDICATION NAME] (anxiolytic) 0.5 mg tablets with an expiration date of (MONTH) 31, (YEAR). An interview was conducted with a Licensed Practical Nurse (LPN/staff #25) on (MONTH) 6, 2019 at 9:27 AM. She stated that she restocks her medication cart from either the medication room or central supply. The LPN said her process was to sign the medication/supplement out on the sign-out sheet and then put the medication/supplement in her cart for use. At 12:28 PM on the same day, the LPN stated that before administering medications to residents, she checks the expiration date. She stated that she kept the expired medications in her cart in the lower drawer as overflow medications. The LPN stated So, when I run out, I would pull from them. She also stated that this procedure was not according to the facility policy that she should give the expired medications to the Director of Nursing (DON/staff #19). On (MONTH) 6, 2019 at 12:35 PM, an interview was conducted with the DON (staff #19). She stated that when medications are expired, they should be destroyed in a sharps container. The DON stated that expired medications clearly need to be pulled out of the cart. She also stated that if the medication has been discontinued, it may be returned to the pharmacy for credit. The DON stated that the pharmacy collects returns twice a month. The facility's policy on Storage of Medications states the facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. The policy included all such drugs shall be returned to the dispensing pharmacy or destroyed.