STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035093	A. BUILDING _____ B. WING _____	05/02/2019

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HAVEN OF COTTONWOOD	197 SOUTH WILLARD STREET COTTONWOOD, AZ 86326

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0640 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and the Resident Assessment Instrument (RAI) manual, the facility failed to ensure discharge Minimum Data Set (MDS) assessments were completed and submitted to the Centers for Medicare and Medicaid Services (CMS) System within the required timeframe for 2 of 21 sampled residents (#2 and #3). The deficient practice could result in lack of resident specific information for quality measure purposes. Findings include: -Resident #2 was admitted on (MONTH) 22, (YEAR) with [DIAGNOSES REDACTED]. Review of the discharge assessment revealed the resident was discharged home on (MONTH) 13, (YEAR). However, review of the clinical record and the CMS System did not reveal a discharge MDS assessment had been completed and submitted to the CMS System. -Resident #3 was admitted on (MONTH) 29, (YEAR) with [DIAGNOSES REDACTED]. Review of the discharge assessment revealed the resident was discharged home on (MONTH) 11, (YEAR). However, review of the clinical record and the CMS System did not reveal a discharge MDS assessment had been completed and submitted to the CMS System. An interview was conducted the MDS Coordinator (staff #47) on (MONTH) 1, 2019 at 11:18 a.m. Staff #47 stated that discharge MDS assessments have to completed and submitted to the CMS System within 14 days. Staff #47 stated that a discharge MDS assessment was completed for resident #2 but not submitted to the CMS System. Staff #47 stated that a discharge MDS assessment for resident #3 was initiated (MONTH) 7, (YEAR) but was not completed and submitted to the CMS System. He also stated that he did not know why the assessments had not been submitted to the CMS System. During an interview conducted with another MDS Coordinator (staff #12) on (MONTH) 1, 2019 at 12:20 p.m., staff #12 stated that the discharge assessments for resident #2 and resident #3 were not completed. An interview was conducted with Director of Nursing (DON/staff #65) on (MONTH) 2, 2019 at 11:03 a.m. The DON stated that there was no system in place to ensure MDS assessments were submitted. The DON also stated the expectation is that the MDS Coordinators review the assessments to ensure the assessments are complete and submitted to the CMS System. The RAI manual revealed a discharge MDS assessment must be completed when a resident is discharged from the facility to a private residence. The RAI manual also included the discharge MDS assessment must be completed within 14 days after the discharge date . The RAI manual instructs discharge MDS assessments must be transmitted (submitted and accepted into the MDS database) electronically no later than 14 calendar days after the MDS assessment completion date.
F 0641 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, staff interviews, and the Resident Assessment Instrument (RAI) manual, the facility failed to ensure Minimum Data Set (MDS) assessments for 2 of 21 sampled residents (#119 and #69) were accurate. This deficient practice could affect continuity of care. Findings include: -Resident #119 was readmitted to the facility on (MONTH) 13, (YEAR), with [DIAGNOSES REDACTED]. A health status note dated (MONTH) 18, (YEAR) at 11:08 a.m., revealed the resident had a fall at approximately 10:50 a.m. The note included the resident sustained [REDACTED]. It also included the resident was sent to the ER (emergency room) at approximately 11:05 a.m. A health status note dated (MONTH) 18, (YEAR) at 1:05 p.m., revealed the resident returned to the facility. The Interdisciplinary Team Fall Review note dated (MONTH) 19, (YEAR), revealed the resident had a fall on (MONTH) 18, (YEAR) at 6:40 p.m. The resident stated that he was in his wheelchair and reached for something on the floor, and slid out of the wheelchair scraping his back on the edge of the bed. The note included the skin tear to the back was 5 cm (centimeter) x 3 cm. However, review of the admission/5 day MDS assessment dated (MONTH) 20, (YEAR) revealed the resident had only one fall with injury (not major) since admission or the prior assessment. During an interview conducted with the MDS Coordinator (staff #12) on (MONTH) 2, 2019 at 10:53 a.m., he stated that he uses the RAI manual to code falls. Staff #12 stated that he obtains the fall report that that contains the number of falls a resident has had. He further stated that when a resident has two falls on the same day, there should be a report for each fall. Staff #12 stated that the fall report only reflected one fall on (MONTH) 18, (YEAR). In an interview with the Director of Nursing (DON/staff #65) conducted on (MONTH) 2, 2019 at 1:18 p.m., she stated that the IDT review note dated (MONTH) 19, (YEAR) was for the fall documented in the health status note dated (MONTH) 18, (YEAR). She stated the different time in the two notes was a typographical error. She said that the different locations of skin tears in the two notes was because the staff completing the fall incident report can only enter one wound site. An interview was conducted with another MDS Coordinator (staff #47) on (MONTH) 2, 2019 at 1:42 p.m. Staff #47 stated that she was the one who documented the health status note regarding the fall the resident was sent to the ER for. The MDS Coordinator stated that based on the IDT note, there were two falls on (MONTH) 18, (YEAR) and that only one of the falls was coded on the MDS assessment. An interview was conducted with the Assistant DON (ADON/staff #11) on (MONTH) 2, 2019 at 1:59 p.m. She stated that she wrote the IDT note dated (MONTH) 19, (YEAR) and that the resident fell on ce on (MONTH) 18, (YEAR). Staff #11 stated that she could have easily screwed up the time of the fall and that the resident had left arm skin tears that she did not include. During another interview conducted with the DON (staff # 65) on (MONTH) 2, 2019 at 2:26 p.m., she stated that when a resident falls, the nurse documents the fall in the progress note and the IDT meet to discuss the fall. The DON stated that she understood why the inconsistencies in the documentation could be confusing. The RAI manual instructs to review incident reports, fall logs, and the medical record (physician, nursing, therapy, and nursing assistant note) to determine the number of falls that occurred from admission to the Assessment Reference Date. The manual includes if the resident had a fall code yes and code the level of fall-related injury for each fall. -Resident #69 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Review if the clinical record revealed a physician order [REDACTED]. Review of the Medication Administration Record [REDACTED]. However, review of the admission MDS assessment dated (MONTH) 10, 2019, revealed the resident was not administered any IV

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F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) medications during the 14 day look-back period. During an interview conducted with the ADON (staff #11) on 05/02/19 at 11:52 AM., the ADON stated that the expectation is that the MDS assessments are accurate. An interview was conducted with the MDS coordinator (staff #12) on 05/02/19 at 11:59 AM. Staff # 12 stated that he gathers data for the MDS assessments through interviews with the residents and staff. Staff #12 stated that the MDS assessment was coded incorrectly for the resident receiving IV medications because documentation confirms the resident was administered IV medications. The RAI manual instructs to review the resident's medical record to determine whether or not the resident received any IV medications within the last 14 days. The RAI manual also included .the importance of accurately completing and submitting the MDS cannot be over-emphasized. The MDS is the basis for the development of an individualized care plan . Federal regulations require that the assessment accurately reflects the resident's status.
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, interviews, and policy review, the facility failed to ensure one of two sampled residents (#16) received the necessary services to maintain good grooming and oral hygiene. This deficient practice could result in grooming and oral hygiene needs not being met. Findings include: Resident (#16) was admitted to the facility on (MONTH) 8, 2019 and readmitted on (MONTH) 8, 2019 with [DIAGNOSES REDACTED]. Review of the care plan initiated (MONTH) 8, 2019 revealed the resident had activities of daily living self-care performance deficit related to activity intolerance, fatigue, and impaired mobility. The goal was that the resident would improve the current level of function in personal hygiene and dressing. Interventions included the resident required staff participation with personal hygiene, oral care, and dressing. The admission Minimum Data Set assessment dated (MONTH) 15, 2019, revealed a score of 14 on the Brief Interview Mental Status which indicated the resident was cognitively intact. The MDS assessment included the resident required total assistance with dressing and extensive assistance with personal hygiene which included brushing teeth. Review of the oral care on the CNA Activities of Daily Living Task Sheet for (MONTH) 2019 revealed the resident received assistance with oral care or was provided set up only. The documentation also revealed the resident did not refuse oral care. During an initial interview conducted with the resident's family member on (MONTH) 29, 2019 at 10:24 a.m., the family member stated that the resident's pajama top is not being changed daily by staff. The family member stated that for the past week, the resident had worn the same purple pajama top that buttons down the front for about 5 days. The family member also stated that the resident stated the staff are not brushing the resident's dentures. The family member stated that they have been requesting the staff clean the resident's dentures for the last 2 to 3 months. The family member also stated that the resident is able to put the dentures in water, but that it does not always happen because the resident forgets and when the family member arrive in the morning, the resident is still wearing the dentures. On (MONTH) 1, 2019 at 12:55 p.m., an interview was conducted with resident #16 and the resident's family member. The resident was observed to be wearing a cream colored pajama top with long sleeves that buttoned up the front. The pajama top was wrinkled and had a brown stain running along the front of the pajama top by the buttons and another brown stain on the top right of the pajama top just below the collar. The resident's family member stated that the resident was wearing the cream colored pajama top yesterday. The resident stated that she asked the staff for a clean top and that staff replied they will help her change the top when they are not so busy. The resident stated that the staff do not come back. The resident also stated that the Certified Nursing Assistants (CNA) are not cleaning her dentures. The resident stated that she told staff that her gums are sore. The resident also stated that there is a denture cup available for her to put the dentures in at night, but that she does not always do it. During an observation conducted of the resident on (MONTH) 2, 2019 at 10:15 a.m., the resident was observed to be awake and wearing the same cream colored pajama top with brown stains. On (MONTH) 1, 2019 at 1:27 p.m., an interview was conducted with a CNA (staff #50) who said that the resident spills food and drinks when she is eating her meals. The CNA stated that she changes the resident clothes as needed which includes changing soiled clothing. The CNA also stated that the resident needs assistance with setup for oral hygiene. She stated that sometimes the resident is not able to complete her oral care because of pain. She stated that the resident is able to put the tablet for cleaning her dentures in the cup of water, but the cleaning of the dentures and the glue has to be done by a CN[NAME] During an interview conducted on (MONTH) 2, 2019 at 8:07 a.m. with another CNA (staff #56), staff #56 stated that the resident's clothing is changed every day, when the clothing is dirty, and when the resident wants to change clothes. An interview was conducted with a Registered Nurse, (RN/staff #34) on (MONTH) 2, 2019 at 8:12 a.m. The RN stated that staff assist with residents with dressing in clean clothes every morning. The RN also stated staff will change soiled clothing if the resident allows. Staff #34 stated that the dental task is to be done by a CNA every shift. She further stated that it would not be appropriate to provide setup assistance for a resident who needed extensive assistance. An interview was conducted with the Central Supply Manager (staff #13) on (MONTH) 2, 2019 at 8:35 a.m. Staff #13 stated that she and the Director of Nursing are responsible for checking that the activities of daily living documentation is completed by the CNAs, but that they do not check each entry. She stated that the resident is able to clean her dentures, which means the CNA only sets up the supplies needed for the resident to clean the dentures. She also said the resident may require additional assistance if she is having a bad day. Staff #13 stated a CNA may or may not be present to watch the resident clean her dentures and may come back later to put supplies away. The facility's policy titled Quality of Life - Accommodation of Needs revealed staff attitudes and behaviors must be directed towards assisting the residents in maintaining and/or achieving independent functioning, dignity and well-being. The policy included the resident's individual needs and preferences shall be acommodated to the extent possible.
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **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 1 of 2 sampled residents (#38) with pressure ulcers received the necessary treatment and services consistent with professional standards of practice. The deficient practice could result in delayed healing and/or worsening of pressure ulcers. Findings include: Resident #38 was readmitted on (MONTH) 26, 2019 with [DIAGNOSES REDACTED]. Review of the Pressure Ulcer Documentation and assessment dated (MONTH) 26, 2019 revealed the resident was admitted with an unstageable pressure ulcer to the right hip and a stage 3 pressure ulcer to the left heel. The assessment included the resident had a pressure reduction device to the wheelchair and had heel protectors. The Braden scale dated (MONTH) 26, 2019 revealed a score of 14 which indicated the resident was a moderate risk for pressure ulcers. A Nurse Practitioner (NP) progress note dated (MONTH) 29, 2019 revealed the resident was a severely medically complex resident with multiple advanced comorbidities and that ongoing decline and complications are unfortunately reasonably expected. The progress noted included a low air loss mattress was ordered for the resident. A nurse progress note dated (MONTH) 29, 2019 revealed the resident was declining and refusing care. Review of the Significant Change in Status Minimum Data Set assessment dated (MONTH) 2, 2019 revealed a score of 6 on the Brief Interview for Mental Status which indicated the resident had severe cognition impairment. The assessment also included the resident had one stage 3 pressure ulcer and one unstageable pressure ulcer that were present on admission. Review of the current care plan revealed the resident had one unstageable pressure ulcer to the right hip and one stage 3

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F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) pressure ulcer to the left heel. Interventions included following the facility policies/protocols for the prevention/treatment of [REDACTED]. A Braden scale dated (MONTH) 2, 2019 revealed a score of 12 indicating the resident was a high risk for pressure ulcers. Review of the clinical record revealed weekly skin checks were conducted and the pressure ulcers were assessed weekly. Regarding the right hip pressure ulcer: The Pressure Ulcer Documentation and assessment dated (MONTH) 26, 2019 revealed the right hip pressure ulcer measured 1 centimeter (cm) x 1 cm x UTD (depth unable to be determined). The assessment included there was necrotic tissue, no drainage, and no odor. Review of the clinical record revealed a physician order [REDACTED]. However, review of the Treatment Administration Record (TAR) for (MONTH) 2019 and (MONTH) 2019 revealed the order had not been transcribed onto the MAR for (MONTH) 26-31 and (MONTH) 1-7. Review of the progress notes for this time frame revealed no documentation the treatments were provided to the right hip. A physician order [REDACTED]. Review of the TAR for (MONTH) 2019 revealed no evidence the treatment was provided to the right hip on (MONTH) 11, 14, and 18. A wound observation was conducted on (MONTH) 1, 2019 at 10:01 a.m. with a Registered Nurse (RN/staff #34), RN (staff #83), and the Corporate nurse (staff #95). Staff #34 removed the dressing from the right hip and cleansed the area with normal saline. Staff #34 then measured the wound. The wound was 1.5 cm x 1.5 cm x UTD, had 70% slough, and was irregular shape with dark colored edges. Staff #34 then applied the ordered treatment. Regarding the left heel pressure ulcer: The Pressure Ulcer Documentation and assessment dated (MONTH) 26, 2019 revealed the pressure ulcer to the left heel measured 2 cm x 3 cm x 0.8 cm. The assessment included the wound bed was dull pink and that there was no odor or drainage. Review of the clinical record revealed a physician order [REDACTED]. Review of the TAR for (MONTH) 2019 revealed the treatment was transcribed onto the MAR and administered as ordered. A physician's orders [REDACTED]. Review of the TAR for (MONTH) 2019 revealed no evidence the treatment was provided to the left heel on (MONTH) 18, 2019. A wound observation was conducted on (MONTH) 1, 2019 at 10:01 a.m. with a RN (staff #34), RN (staff #83), and the Corporate nurse (staff #95). Staff #34 removed the dressing from the left heel and stated that the wound was healed. She then cleansed the heel with normal saline, and then put on a sock and the heel protector. An interview was conducted with a RN (staff #89) on (MONTH) 1, 2019 at 11:00 a.m. The RN stated that if a new wound is identified, the wound nurse and the physician are notified. She stated that treatment orders are obtained from the physician and transcribed onto the TAR. The RN stated that once the treatment has been administered, it is documented on the TAR. She stated the wound nurse does the weekly skin checks and weekly wound measurements and the floor nurses provide the treatments. The RN also stated that the resident has not refused any care from her. An interview was conducted with the wound RN (staff #34) on (MONTH) 1, 2019 at 12:39 p.m. The wound nurse stated that upon admission, the admission nurse documents any skin issues and that she conducts a skin assessment after admission. She stated that she obtains treatment orders from the physician for any wound identified. The RN stated that she does weekly measurements and assessments of the wound. She stated that the treatments are documented on the TAR. She stated that resident #38 bed was moved so he could lie on his left side and that the right hip wound is showing improvement. The wound nurse stated that the resident has a low loss air mattress, heel protector, and is turned every 2 hours. She also stated that the resident refusal of treatment varies. After reviewing the clinical record, she stated that the treatment for [REDACTED]. The RN stated that documentation that the right hip treatment was provided would be on the TAR unless the nurse wrote a progress note. An interview was conducted with the Director of Nursing (DON/staff #65) on (MONTH) 2, 2019 at 11:03 a.m. The DON stated that when a resident is admitted with a pressure ulcer, the wound nurse is notified and ensure the appropriate interventions are implemented and treatment is obtained. She stated a Braden scale is done and that if the resident is determined to be a high risk for pressure ulcer development, preventative interventions are implemented such as turning and repositioning, floating heels, etc. The DON stated that the nurses document the treatment was done on the TAR. She stated that the right hip order dated (MONTH) 26, 2019 was selected as a standard/FYI order and did not transmit to the TAR. She further stated that the right hip pressure ulcer went from unstageable to a stage 2 and did not worsen. The facility's policy titled Acute Condition Changes-Clinical Protocol revealed the physician will help identify and authorize appropriate treatments and the nurse will repeat any verbal orders to the physician to ensure accurate transcription. The policy also included the staff will monitor and document the resident's progress and responses to treatment. The facility's policy regarding Refusal of Treatment revealed that if a resident refuses treatment, the Unit Manager, Charge Nurse, or Director of Nursing will interview the resident to determine what and why the resident is refusing in order to try to address the resident's concerns and explain the consequences.
F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.** **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 of one sampled resident (#17) with limited range of motion consistently received appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This deficient practice could result in reduction in range of motion. Findings include: Resident #17 was readmitted to the facility on (MONTH) 26, (YEAR), with [DIAGNOSES REDACTED]. Review of the care plan initiated (MONTH) 7, (YEAR), revealed the resident had activities of daily living self-care deficits related to [MEDICAL CONDITION], fatigue, and activity intolerance. The goal was that the resident would improve current level of function in bed mobility, transfers, eating, dressing, toilet use and personal hygiene. Interventions included the resident required extensive assistance for toilet use, bed mobility, bathing, personal hygiene, and dressing, limited assistance for transfer, and set up assistance for eating. Review of the clinical record revealed a physician order [REDACTED]. The OT evaluation & plan of treatment with a (MONTH) 13, (YEAR) start of care date revealed the resting hand splint and shoulder orthosis had arrived that was ordered for the resident during her last OT therapy sessions. The short term goal was that the resident would tolerate the use of the resting hand splint for the RUE and the right shoulder orthosis to reduce sublux of right shoulder to promote comfort and increase functional use of the extremity. The long-term goal was educating the staff to the wearing schedule, proper donning/doffing, and the purpose of the splint and orthosis to assist the resident with wearing compliance. A quarterly Minimum Data Set assessment dated (MONTH) 15, (YEAR), revealed a score of 7 on the Brief Interview for Mental Status, which indicated the resident was severely impaired. The MDS assessment included the resident did not reject care. Review of the OT progress note dated (MONTH) 26, (YEAR), revealed the resident was observed not wearing the right shoulder orthosis. The note included the Certified Nursing Assistants (CNAs) were given instructions to don the shoulder orthosis in the AM and have the resident wear it until bedtime. The note also included the therapist spent time locating the shoulder orthosis, which was found in the dirty laundry. The orthosis was wiped off and placed on the resident. The resting hand splint was found in the top drawer. The note included the resident was a poor historian but reported the resting hand splint had not been donned at bedtime on her right hand. The note also included the therapist reviewed the purpose of the hand splint and shoulder orthosis. The OT progress note dated (MONTH) 28, (YEAR) revealed the resident was not wearing the shoulder orthosis or the hand splint and that the therapist assisted the resident with donning the shoulder orthosis and hand splint. The note also included the therapist remade the visuals for applying the shoulder orthosis and the hand splint for the caregivers.

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F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) Review of the OT progress note dated (MONTH) 10, (YEAR), revealed the resident was not wearing the shoulder orthosis or the hand splint. The brace was found in the side dresser and the splint was bent and needed to be straightened. The visual posters with the instructions on how to apply the equipment had been removed. The note included the therapist applied the shoulder orthosis and the hand splint and made new visual aids. The note also included the resident tolerated the orthosis and the splint throughout the therapy session. Review of the OT Discharge Summary dated (MONTH) 19, (YEAR), revealed the staff had been inconsistent with applying the hand splint and the shoulder orthosis. The note included the resident was generally found without the shoulder orthosis in place. The note also included visual posters for correct donning/doffing of the hand splint and the shoulder orthosis were placed at the nursing station for the entire staff. Review of the nursing progress notes for (MONTH) and (MONTH) (YEAR), revealed no documentation that the resident had refused the shoulder orthosis and hand splint or that the physician was notified of any refusals. On (MONTH) 2, 2019 at 1:47 p.m., an interview was conducted with an OT (staff #40). The OT stated the resident was supposed to wear a shoulder orthosis on the right arm and that the resident tolerated wearing the shoulder orthosis when she was receiving therapy. An interview was conducted on (MONTH) 2, 2019 at 2:08 p.m. with a Licensed Practical Nurse (LPN/staff #22). The LPN stated that if the resident was supposed to wear a shoulder orthosis and a hand splint, he would be the person responsible for ensuring they were applied. The LPN also stated that he had never seen the resident wearing the shoulder orthosis and the hand splint since he started working in (MONTH) (YEAR). During an interview conducted with the Director of Nursing (DON/staff #65) on (MONTH) 2, 2019 at 2:10 p.m., the DON stated that the resident refused to wear the shoulder orthosis and hand splint. The DON also stated that she would look for documentation that the resident refused to wear the shoulder orthosis and the hand splint. Another interview was conducted with OT (staff #40) on (MONTH) 2, 2019 at 3:00 p.m. The OT stated that the shoulder orthosis is to keep the right arm in the correct position and the hand splint was to keep the fingers from curling up. On (MONTH) 2, 2019 at 3:53 p.m., an interview was conducted with two Registered Nurses (RN/staff #34 and staff #83). Staff #34 stated that once therapy finishes their evaluation, they instruct nursing how to apply the equipment and the therapy schedule. Staff #34 stated the nurses observe and document the equipment was applied correctly by the CNAs. Staff #83 stated that the CNAs should document if the resident refuses to have the equipment applied and notify the nurse. Staff #83 also stated the nurse should document the refusal in the progress notes and notify the physician. Review of the facility's policy titled Resident Mobility and Range of Motion revised (MONTH) (YEAR), revealed residents with limited range of motion (ROM) will receive treatment and services to increase and/or prevent a further decrease in ROM. The policy included that residents with limited mobility will receive appropriate services, equipment and assistance to maintain or improve mobility unless reduction in mobility is unavoidable. The policy also included interventions may include therapies, the provision of necessary equipment, and/or exercises and will be based on professional standards of practice and be consistent with state laws and practice acts.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, staff interviews, and policy review, the facility failed to ensure a fall safety measure was implemented for one of five sampled residents (#120). This deficient practice could result in further falls with injury. Findings include: Resident #120 was admitted on (MONTH) 26, 2019 with [DIAGNOSES REDACTED]. Review of the fall risk evaluation dated (MONTH) 26, 2019, revealed the resident had no history of falls within the last 6 month. It also included a fall risk score of 10 which indicated the resident was a moderate risk for falls. A health status note dated (MONTH) 28, 2019 revealed the resident was found lying on the floor with his pillow under his head. The resident stated he just rolled out of bed. The note also included interventions to place the bed against the wall and put a fall mat on the floor. The IDT (interdisciplinary) Fall Review note dated (MONTH) 28, 2019 revealed the resident had a fall on (MONTH) 28, 2019 at 6:30 a.m. with no injury. The note included the resident's family reported the resident frequently rolls out of bed. The note also included a fall mat would be placed by the right side of the bed. Review of the fall care plan dated (MONTH) 28, 2019 revealed the resident was at risk for falls related to confusion and deconditioning. Interventions included wearing appropriate footwear, keeping the call light within reach, and placing a fall mat next to the right side of the bed. Further review of the clinical record revealed no documentation that the fall mat was implemented. During observations conducted on (MONTH) 29, 2019 at 10:00 a.m., 10:52 a.m. and at 12:00 p.m., the resident was observed sleeping in the bed which was against the wall. No fall mat was observed on the floor. An interview was conducted with two Registered Nurse (RN/staff #34 and staff #33) on (MONTH) 1, 2019 at 10:04 a.m. Staff #34 stated that a fall mat is an intervention implemented for a resident who is at risk for a fall. Staff #34 stated that resident #120 has a fall mat on the floor when he is in bed. Staff #33 stated that resident #120 does not have a fall mat in the room. Staff #34 then stated that there should be a fall mat in the resident's room. During an interview conducted with a Certified Nursing Assistant (CNA/staff #13) on (MONTH) 2, 2019 at 11:43 a.m., the CNA stated that they are informed of new fall interventions for a resident during report at the beginning of the shift and that the interventions are included in the resident's care plan. The CNA stated that the CNAs check the fall mats and document it under the CNA tasks. An interview was conducted with another CNA (staff #17) on (MONTH) 2, 2019 at 12:16 p.m. She stated the resident tends to roll over on his side and is at risk for falls. The CNA stated that is the reason the bed is against the wall. She further stated the night shift staff told her there was supposed to be a fall mat on the floor and that she does not know why the mat is not on the floor. Later that day at 2:07 p.m., staff #17 retracted her statement and stated that the resident does have a folded gray mat that is placed on the floor when the resident is in bed. At this time, the CNA pointed out the folded gray mat against the wall by the sink in the resident's room. She was unable to say where the fall mat was prior to this day. An interview was conducted with the Director of Nursing (DON/staff #65) on (MONTH) 2, 2019 at 2:26 p.m. The DON stated that after a resident has a fall, the IDT (interdisciplinary team) meet to discuss the events that led to the fall and develop fall interventions as appropriate. The DON stated that the expectation is that the staff implement the fall interventions. She stated the fall interventions are added to the care plan and the CNAs Kardex. She stated that the CNA tasks can include checking for mats on the floor and that the electronic record system will alert the CNA if the task is not complete. Regarding the fall mat is not being on the CNA tasks for resident #120, the DON stated that not all interventions are put in the CNAs tasks. Regarding the mat not being in place before (MONTH) 2, the DON had no comment. The facility's policy titled Fall Prevention Program revealed the DON coordinates implementation of the individualized care plans. The policy also revealed the Restorative Nursing Aide (RNA) acts as a leader among the frontline staff ensuring interventions are being properly followed.
F 0697 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide safe, appropriate pain management for a resident who requires such services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed clinical record review, staff interviews, and policy review, the facility failed to ensure one resident (#119) was administered pain medications consistent with professional standards of practice. The deficient practice could result in unrelieved pain. Findings include: Resident #119 was readmitted to the facility on (MONTH) 13, (YEAR) with [DIAGNOSES REDACTED]. The resident was discharged (MONTH) 3, (YEAR).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035093	A. BUILDING _____ B. WING _____	**05/02/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HAVEN OF COTTONWOOD	**197 SOUTH WILLARD STREET COTTONWOOD, AZ 86326**

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

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F 0697 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) The admission Minimum Data Set assessment dated (MONTH) 20, (YEAR) revealed a score of 11 on the Brief Interview for Mental Status which indicated the resident had moderately impaired cognition. The assessment included the resident almost constantly had pain and rated the pain intensity at a 6 on a scale of 0-10. Review of the clinical record revealed the following physician orders: -Tylenol 325 milligrams (mg) 2 tablets by mouth every 6 hours as needed for a mild pain level of 1-3 dated (MONTH) 13, (YEAR). -[MEDICATION NAME] 5-325 mg 1 tablet by mouth every 6 hours as needed for a moderate pain level 3-6 and 2 tablets by mouth every 6 hours as needed for a severe pain level of 7-10 dated (MONTH) 13, (YEAR) and discontinued (MONTH) 17, (YEAR). -[MEDICATION NAME]-[MEDICATION NAME] 5-325 mg 1 tablet by mouth for a pain level 3-6 and 2 tablets by mouth for a pain level 7-10 every 4 hours as needed dated (MONTH) 17, (YEAR) and discontinued on (MONTH) 28, (YEAR). -[MEDICATION NAME] 10 mg 1 tablet by mouth every 4 hours as needed for a pain level of 1-5 dated (MONTH) 26, (YEAR). -[MEDICATION NAME] 15 mg 1 tablet by mouth every 4 hours as needed for a pain level of 6-10 dated (MONTH) 26, (YEAR). Review of the Medication Administration Record [REDACTED]. Continued review of the MAR indicated [REDACTED]. Additional review of the MAR for (MONTH) (YEAR) revealed [MEDICATION NAME] 5 mg was administered on (MONTH) 17 for a pain level of 8 and on (MONTH) 20, 21, 24, and 28 for a pain level of 7. The MAR indicated [REDACTED]. Review of the MAR for (MONTH) (YEAR) revealed Tylenol was administered on (MONTH) 2 for a pain level of 8. Additional review of the MAR indicated [REDACTED]. Review of the clinical record revealed no documentation why the resident was administered pain medications outside of the ordered parameters and no documentation that the physician was notified. An interview was conducted with a Registered Nurse (RN/staff #33) on (MONTH) 1, 2019 at 10:04 a.m. The RN stated that pain medications are to be administered as ordered. She stated that if a resident's pain is outside of the ordered parameters for the pain medication, she would contact the physician for orders. The RN stated that if the resident requests a specific pain medication for a pain level that is not within the ordered parameters, she would administer the medication and notify the physician. During an interview conducted with the Director of Nursing (DON/staff #65) on (MONTH) 2, 2019 at 2:26 p.m., the DON stated the expectation is that the nurses assess a resident's complaint of pain, provide NPI (Non Pharmacological Intervention), and administer pain medications according to the ordered parameters. The DON stated that if a resident request a pain medication for a pain level outside of the ordered parameters, she would expect the nurse to administer the medication, notify the physician, and document it in the progress notes and/or eMAR administration notes. The facility's policy on Administering Medications revealed Medications shall be administered in a safe and timely manner and as prescribed. The policy also revealed medications must be administered in accordance with the orders, including any required time frame.