STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035180	A. BUILDING _____ B. WING _____	06/27/2019

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HAVEN OF DOUGLAS	1400 NORTH SAN ANTONIO AVENUE DOUGLAS, AZ 85607

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 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 observations, clinical record review, staff interviews and review of the Resident Assessment Instrument (RAI) manual, the facility failed to ensure that the Minimum Data Set (MDS) assessments accurately reflected the status of one of 14 sampled residents (#25) reviewed for MDS accuracy. The deficient practice could result in an inaccurate plan of care and lack of interventions to meet the resident's needs. Findings include: Resident #25 was admitted to the facility on (MONTH) 11, (YEAR), with the most recent re-entry date of (MONTH) 9, 2019. [DIAGNOSES REDACTED]. Review of a care plan dated (MONTH) 8, 2019 revealed the resident was at risk for pressure ulcer development related to decreased mobility and disease processes. One of the interventions was for a pressure relieving/reduction device on the bed/chair. Review of the clinical record revealed the resident had documentation of pressure reducing devices in place to the bed and chair. Review of the nutritional data collection and assessment dated (MONTH) 9, 2019 revealed the resident was on a mechanical soft diet and had chewing difficulties, related to a decreased ability to masticate regular foods, as evidenced by poor dentition. A physician's orders [REDACTED]. Review of the nutritional data collection and assessment dated (MONTH) 11, 2019 revealed the resident was on a pureed diet. Review of a significant change in status MDS assessment dated (MONTH) 11, 2019 revealed the resident was rarely/never understood and had memory problems. In the swallowing/nutritional status section, the documentation included the resident did not have a mechanically altered diet. Under the skin condition section, the documentation included the resident was not at risk for developing pressure ulcers. The skin section further noted that the resident did not have any pressure reducing devices in place. A weekly skin check and a wound assessment dated (MONTH) 29, 2019 revealed the resident had a pressure relieving device to the wheelchair. Review of a quarterly MDS assessment dated (MONTH) 30, 2019 revealed the resident was not on a mechanically altered diet, was not at risk of developing pressure ulcers and did not have any pressure reducing devices in place. An observation of the resident was conducted on (MONTH) 25, 2019 at 1:52 p.m. During the observation, there were pressure reducing devices on the bed and the chair. An observation was conducted on (MONTH) 27, 2019 at 9:30 a.m. of the resident sleeping in bed with an air mattress overlay in place. An interview was conducted with a Certified Nursing Assistant (CNA/staff #67) on (MONTH) 27, 2019 at 9:43 a.m. She stated that the resident has a special pad in the wheelchair and an air mattress on the bed. She stated the resident has also had an air mattress for about three months and has had a cushion in the chair for at least 6 months. She stated the resident has been on a pureed diet for the last couple of months and before that was on a mechanical soft diet. An interview was conducted with a Registered Nurse (RN/staff #50) on (MONTH) 27, 2019 at 10:05 a.m. She stated the resident has been on a pureed diet for about three months and a mechanical soft diet before that. She stated the resident has had an air mattress on the bed for about 3 months and a chair cushion since (MONTH) (YEAR). She stated this resident is at risk for skin breakdown, because he is unable to reposition, is incontinent of bowel and he needs a lot of encouragement to eat. An interview was conducted with a LPN (Care Coordinator/staff #45) and the Director of Nursing (DON/staff #42) on (MONTH) 27, 2019 at 10:36 a.m. Staff #45 stated the expectation is that she ensures that everything is coded correctly on the MDS, so it accurately reflects the status of the residents. Staff #45 stated that accuracy is important because it helps the facility to make and maintain the plan of care and will reflect any significant changes in the resident. Staff #45 said the facility uses the RAI manual for accuracy in lieu of a facility policy. After review of the RAI manual directions and the clinical record, staff #45 stated the (MONTH) 11, 2019 Significant Change MDS for resident #25 was not coded accurately in the dietary section, as the resident was receiving a mechanical soft diet. Staff #42 also acknowledged that the pressure ulcer section was not accurate, as the resident was at risk for pressure ulcer development and had a pressure reducing device for the wheelchair. Staff #45 further stated that the (MONTH) 30, 2019 quarterly MDS assessment was not coded accurately, as the resident was receiving a mechanical soft diet, was at risk for developing pressure ulcers and had a pressure reducing device in place for the wheelchair. Staff #45 stated the risk from inaccurate MDS's was that the plan of care may not be accurate. During this same interview, staff #42 stated that he expects staff to code the MDS assessments accurately. He said the Significant Change MDS dated (MONTH) 11, and the quarterly MDS dated (MONTH) 30, were not coded correctly and did not meet the expectation for accuracy. He stated that they use the RAI manual in lieu of a facility policy for directions on completing the MDS. Review of the (MONTH) (YEAR) RAI manual revealed the following: -In regards to a mechanically altered diet; a mechanically altered diet is a diet that is specifically prepared to alter the texture or consistency of food to facilitate oral intake and is to be coded in the MDS if the nutritional approach was used within the 7-day look back period. -In regards to pressure ulcer/injury risk; the resident's risk for pressure ulcer/injury development is based on clinical assessment. A clinical assessment could include a head-to-toe physical examination of the skin and observation or medical record review of pressure ulcer/injury risk factors. An example of risk factors included the following: impaired/decreased mobility and decreased functional ability; co-morbid conditions such as end stage [MEDICAL CONDITION] and cognitive impairment, urinary and fecal incontinence and malnutrition and hydration deficits. -In regards to pressure reducing devices: a pressure reducing device redistributes pressure. Code for a pressure reducing device for the chair or bed if applied in the last 7 days of the MDS date.
F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, staff interviews and policy and procedure, the facility failed to provide services according to accepted standards of clinical practice, by failing to ensure that medication was administered as ordered by the physician for 1 of 5 sampled residents (#4). The deficient practice resulted in the resident receiving more medication than ordered and could result in increased side effects and/or adverse reactions. Findings include:

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

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

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F 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) Resident #4 was initially admitted to the facility on (MONTH) 2, (YEAR) with a [DIAGNOSES REDACTED]. The quarterly minimum data set (MDS) assessment dated (MONTH) 11, 2019 revealed the resident had moderate cognitive impairment, had an active [DIAGNOSES REDACTED]. A care plan for resident #4 included for the use of an antidepressant medication ([MEDICATION NAME]) related to depression, as evidenced by tearful episodes and statements of depression. Interventions included to give antidepressant medication as ordered by the physician and to monitor and document side effects and effectiveness. A physician's orders [REDACTED]. Notify physician of signs and symptoms of adverse reaction to gradual dose reduction (GDR). A nursing note dated (MONTH) 13, 2019 included that an order for [REDACTED]. The note included the resident was aware of the decrease and approved the treatment. Review of the (MONTH) 2019 MAR (Medication Administration Record) revealed the above order for [MEDICATION NAME] 75 mg by mouth daily. Per the MAR, staff initials indicated that [MEDICATION NAME] 75 mg was administered in the am from (MONTH) 14-25. A medication administration observation was conducted on (MONTH) 26, 2019 at 8:08 a.m., with a Registered Nurse (RN/staff #50). During the observation, staff #50 was observed to administer [MEDICATION NAME] 100 mg to resident #4, instead of 75 mg as ordered. An interview was conducted with staff #50 on (MONTH) 26, 2019 at 9:31 a.m. Staff #50 said that she had given the resident the wrong dose. She stated the discontinued dose (of 100 mg) had not been removed from the cart. Staff #50 then found the correct medication card of [MEDICATION NAME] 75 mg in the bottom drawer of the medication cart, in which no doses had been removed. An interview with the Director of Nursing (DON/staff #42) was conducted on (MONTH) 26, 2019 at 9:59 a.m. The DON stated his expectation is for the nurse to follow policy and procedures for medication administration and to follow the doctor's orders. He stated that when a GDR is ordered, the Assistant Director of Nursing (ADON/staff #43) puts the order in the computer and notifies the cart nurse that there was a change in the medication. Review of a facility policy regarding Medication Administration revealed that medications must be administered in accordance with the orders. The policy stated that the individual administering the medication must check the label three times to verify the right resident, right medication, right dosage, right time and right method of administration, before giving the medication.