STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035107	A. BUILDING _____ B. WING _____	**01/16/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HAVEN OF PHOENIX	**4202 NORTH 20TH AVENUE PHOENIX, AZ 85015**

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 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, clinical record review, and staff and resident interviews, the facility failed to ensure one resident (#286) with dysphagia was monitored by a nurse while taking medications. Findings include: Resident #286 was admitted to the facility on (MONTH) 2, 2019, with [DIAGNOSES REDACTED]. Review of the admission Minimum Data Set (MDS) assessment dated (MONTH) 9, 2019, revealed the resident scored a 15 on the Brief Interview for Mental Status (BIMS), which indicated the resident was cognitively intact. An observation was conducted on (MONTH) 14, 2019 at 8:51 a.m., of resident #286 standing in front of a sink, across from the nurses station. The resident was observed with a medication cup which contained approximately 4 pills. At this time, there was no nurse with the resident. The resident then left the medication cup on the sink and turned away and walked approximately three steps away from the sink. A licensed practical nurse (staff #55/LPN) then walked up to the medication cart which was in front of the resident. The resident asked staff #55 for some water. After giving the resident water, staff #55 walked away. The resident returned to the sink and started taking the medications. The resident then stated to this surveyor that he normally does not take medications out in the hallway, however, today staff wanted to watch him take his pills to monitor for aspiration. The resident stated he needed more water and then waited for the nurse who was coming down the hall. Staff #55 then gave the resident more water and remained at the medication cart. A nurse practitioner was then observed talking to the resident and was overheard saying that he had finished all of his pills. The resident then returned to his room. Shortly thereafter, staff #55 stated to another staff member that she did not stay with the resident, while he took his medications. An interview was conducted on (MONTH) 16, 2019 at 10:03 a.m., with a LPN (staff #48). She stated the nurses are to stay with the resident until all medications have been taken. She stated for a resident to self administer medications there must be an order and it must be care planned. An interview was conducted on (MONTH) 16, 2019 at 11:08 a.m., with a LPN (staff #55). She stated when administering medications, the process is to stay with the resident to ensure all medications have been taken. She stated she was caring for resident #286 that morning and was also training a new nurse (staff #107). She stated she did not dispense the resident's medications and that staff #107 dispensed the medications. She stated the resident often stands outside of his door and the nurse will stay at the cart and ensure he took all of the medications. She stated that she did not watch him take the medications and assumes that he did. She stated that staff #107 should have stayed with the resident, as he took the medications. At this time, she reviewed the Medication Administration Record [REDACTED]. Staff #55 said that staff #107 was using her login, and that she did not witness the resident take the medications. An interview was conducted on (MONTH) 16, 2019 at 11:36 a.m. with a registered nurse (staff #107). She stated that she started working on (MONTH) 14, and is currently on orientation with staff #55. She stated that during medication administration, the nurse is to stay with the resident to ensure that all medications are taken and then document it on the MAR. She stated on (MONTH) 14, the resident requested to take the medications out in the hall. She stated they went out to the hall and she figured the other nurse (staff #55) could watch the resident, while she went to get ice for the resident. She stated that after returning with the ice, staff #55 verbalized that she would stay with the resident and to her knowledge she did. She stated at that time, she did not have a login and was using staff #55's login. An interview was conducted on (MONTH) 16, 2019 at 11:53 a.m., with the Director of Nursing (staff #29/DON). He stated the nurses are expected to ensure that a resident takes their medication. He stated the nurses are to ensure that medications are administered and to document the administration. Staff #29 stated the nurses are to watch the resident take the medications, unless the resident has a preference to not be watched and that would be included in the care plan. He stated if the resident is not ready to take the medication, then the nurse can take the medication until the resident is ready.
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 observations, clinical record review, staff interviews and policy review, the facility failed to ensure the resident environment remains free of accident hazards as is possible, by failing to ensure safety measures were implemented for one resident (#14), who had a history of [REDACTED]. Findings include: Resident #14 was admitted to the facility on (MONTH) 10, (YEAR), with [DIAGNOSES REDACTED]. Per a quarterly Minimum Data Set assessment dated (MONTH) 7, (YEAR), the resident was assessed to have severe cognitive impairment and was assessed to have had a fall in the facility since admission. A care plan dated (MONTH) 7, (YEAR) identified that the resident was at high risk for falls, due to being unaware of safety needs. The goal was for the resident to be free from falls. An intervention included to always keep a floor mat next to the bed. Review of the clinical record revealed the resident sustained [REDACTED]. -April 1, (YEAR): fall without injury. Care plan reviewed and intervention of floor mats next to the bed continued. -April 17, (YEAR): fall without injury. Care plan reviewed and intervention of floor mats next to the bed continued. -August 18, (YEAR): fall with a hematoma/laceration of head. Care plan reviewed and intervention of floor mats next to the bed continued. -November 16, (YEAR): fall with skin tear with subsequent treatment in the emergency room . Care plan reviewed and intervention of floor mats next to the bed continued. -December 30, (YEAR): fall and landed on floor mat, no injury. Care plan reviewed and intervention of floor mats next to the bed continued. An observation was conducted on (MONTH) 14, 2019 at 9:27 a.m. of the resident laying in bed. However, there were no floor mats that were next to the bed. Additional observations this same day were conducted at 10:48 a.m. and at 2:13 p.m., and the resident was laying in bed, with no mats on the floor next to the bed. An interview was conducted with a Certified Nursing Assistant (CNA/staff #71) on (MONTH) 16, 2019 at 10:29 a.m. She stated that she is assigned to care for resident #14 and knew the resident was at high risk for falls and needed floor mats next to the bed. She stated she looked in the resident's room this morning and could not find any floor mats, so she called maintenance staff and they brought the floor mats to the resident's room. Staff #71 said this resident needs the floor

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

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F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) mats, because she has a history of falls from her bed. An interview was conducted with a Licensed Practical Nurse (staff #46) on (MONTH) 16, 2019 at 10:34 a.m. She stated the resident is at high risk for falls and needs floor mats next to the bed. Staff reviewed the current care plan, with documentation of the intervention of floor mats to be used when in bed and stated that since there is no where in the clinical record for staff to actually document that the mats are in place, it is more difficult to ensure they are on the floor next to her bed. Staff stated it is the responsibility of all nurses and CNA's to make sure the floor mats are next to the bed. An interview was conducted with the Director of Nursing (staff #29) on (MONTH) 16, 2019 at 10:48 a.m. He stated the resident is known to him and is at high risk for falls. He said that an in-service was done previously regarding the need for placement of floor mats for residents at high risk for falls, such as resident #14. Staff #29 stated it was their policy for all nurses and CNA's to be responsible to make sure the floor mats are in place and that care plans are followed. A policy regarding falls included that this facility is to develop a culture of safety for our residents to thrive. The policy included that residents assessed to be at high risk for falls will have a care plan in place, with individual interventions. The Director of Nursing oversees all steps of the fall program and coordinates implementation of individualized care plans.
F 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews and policy review, the facility failed to ensure that two containers of cookies were stored properly, and failed to discard multiple boxes of orange juice, which had expired. Findings include: The initial tour of the kitchen was conducted on [DATE] at 8:52 AM, with the Assistant Food Service Manager (staff #222). In the dry storage area on a shelf, there were two containers of cookies which were open to air, and there were 16 boxes of orange juice, which were expired by one month. On another shelf, there were 16 boxes of orange juice with an expiration date of (MONTH) (YEAR). An interview was conducted on [DATE] at 9:11 AM, with staff #222. She stated that it appears someone forgot to cover and seal the cookies from the previous days meals. She also stated that she had no idea that the orange juice was expired, and both would be thrown out immediately. An interview with the Food Service Manager (staff #223) was conducted on [DATE] at 9:40 AM. The manager stated that he suspects that over the weekend the employees had not followed the food storage protocol, and that the expired orange juice was missed on his last inspection. He also stated that there is no excuse for not following food storage safety standards. A review of the facility's Food Storage and Date Marking policy revealed that perishable food items must be stored in tight-fitting containers and must be labeled and dated with legible writing. Date marking is to be used with all food items which may expire using an open date. The policy also stated that expired food items should be discarded.