STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035172	A. BUILDING _____ B. WING _____	**08/15/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HAVEN OF SAFFORD	**1933 PEPPERTREE DRIVE SAFFORD, AZ 85546**

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** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident and staff interviews, facility documentation, and policy review, the facility failed to ensure one sampled resident (#37) was free from physical abuse from another resident (#33). The deficient practice could result in the potential for further resident to resident abuse. Findings include: Resident #37 was readmitted to the facility on (MONTH) 20, (YEAR), with [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS) assessment dated (MONTH) 30, 2019, revealed the resident was severely impaired regarding cognitive skills for daily decision making. The assessment included the resident did not exhibit aggressive verbal or physical behaviors -Resident #33 was readmitted to the facility on (MONTH) 19, 2019, with [DIAGNOSES REDACTED]. Review of a nurse progress note dated (MONTH) 16, 2019 revealed resident #33 hit another resident who was walking down the hall. Review of the care plan dated (MONTH) 18, 2019 revealed that resident #33 had the potential to demonstrate physical aggression towards staff and others. Interventions included providing physical and verbal cues to alleviate anxiety and intervening before agitation escalates by guiding the resident away from the source of agitation. A review of the initial psych evaluation dated (MONTH) 21, 2019, revealed resident #33 was combative and easily angered, which resulted in her cursing and swinging at staff and others. The quarterly MDS assessment dated (MONTH) 26, 2019, revealed the resident was moderately impaired regarding cognitive skills for daily decision making. The assessment included the resident displayed physical and verbal behavioral symptoms towards others 1 to 3 days of the 7 day look-back period. A nurse progress note dated (MONTH) 1, 2019 revealed resident #37 was asleep in her wheelchair when resident #33 pulled her hair. Resident #37 yelled, but did not retaliate. The note included the residents were separated by a Certified Nursing Assistant (CNA). Review of the facility's investigative report dated (MONTH) 9, 2019, revealed that on (MONTH) 1, 2019 at 2:15 p.m., resident #33 pulled resident #37's hair, while the residents were in the dining room. The residents were immediately separated and supervised. A nurse assessed both residents for injuries. Neither resident was able to recall the incident. The report also included a written statement from a CNA (staff #80), that she was in the dining room receiving report when she heard both residents yelling at each other. She looked up and saw resident #33 pulling resident #37's hair. Staff #80 said that she immediately separated the residents and reported the incident to the nurse. An interview was conducted on (MONTH) 13, 2019 at 2:10 p.m. with the CNA (staff #80) who stated that she knew resident #33 could be physically and verbally aggressive. She stated that resident #33 grabbed resident #37 by the hair, while she was sitting in her wheelchair sleeping. Staff #80 said that she was in the left corner of the dining room receiving report from the day shift CNA when the incident occurred. She stated that she and the day shift CNA looked up when the residents started yelling. She stated that she ran over to the residents because resident #33 was pulling resident #37's hair. She said that resident #33 wanted to talk to resident #37 and got angry when resident #37 would not answer. Staff #80 stated resident #33 also had a history of [REDACTED]. She said that prior to resident #33 pulling resident #37's hair, resident #33 had hit her in the arm and pressed her fingernails into her arm. She stated that she knew resident #33 needed to be supervised due to her aggressive behaviors. During an interview conducted on (MONTH) 14, 2019 at 8:26 a.m. with a Licensed Practical Nurse (LPN/staff #45), the LPN stated that prior to August, only one CNA was scheduled for each shift on the unit where the resident resided. She stated that the number of CNAs increased to two each shift after there was a resident to resident altercation. The LPN also stated that there were some concerns about residents needing more supervision, which included resident #33. An interview was conducted on (MONTH) 14, 2019 at 8:39 a.m. with a Registered Nurse (RN/staff #91). She said the facility recently increased CNA staffing to two CNAs on the unit the resident resides and that prior to that it was rough to supervise residents in the dining room and in the bedrooms. She stated that there were times when two residents needed more supervision, which included resident #33. Review of the facility's abuse policy dated (YEAR) revealed abuse is the infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain or mental anguish. Potential abusers can be anyone who comes into the facility, including residents. The policy included it is the objective of the facility to provide a safe haven for all residents through preventive measures that protect every resident's right to freedom from abuse.
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, staff interviews, and policy review, the facility failed to ensure services provided met professional standards of quality by failing to ensure one of two sampled residents (#41) was administered a medication as ordered by the physician. The deficient practice could result in adverse medication effects. Findings include: Resident #41 was admitted on (MONTH) 19, (YEAR) with [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. During a medication administration observation conducted on (MONTH) 14, 2019 at 7:36 a.m. with a Licensed Practical Nurse (LPN/staff #87), the LPN was observed administering two 1 milligram (mg) [MEDICATION NAME] tablets and one 10 mg [MEDICATION NAME] tablet to the resident. Review of a nurse progress note dated (MONTH) 14, 2019 revealed the nurse administered the incorrect dose of [MEDICATION NAME]; the resident was administered [MEDICATION NAME] 12 mg instead of [MEDICATION NAME] mg. An interview was conducted with the Director of Nursing (DON/staff #42) on (MONTH) 14, 2019 at 8:30 a.m. After reviewing the electronic record for resident #41, she stated that the current order was for [MEDICATION NAME] 10 mg once daily. A follow up interview was conducted with the DON (staff #42) on (MONTH) 14, 2019 at 8:54 a.m. She stated that the [MEDICATION NAME] medication error was due to the LPN (staff #87) reading the directions from the pharmacy instead of reading the medication order. Another interview was conducted with the DON (staff #42) on (MONTH) 15, 2019 at 3:30 p.m. She stated that she expects the nurse to compares the medication supplied with the order in the electronic Medication Administration Record. Regarding

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F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) resident #41, the DON stated that the nurse should have compared the medication supplied to the [MEDICATION NAME] order instead of comparing the medication supplied to the pharmacy supply notes. She stated that the medication error could put the resident at risk for adverse effects. Review of the facility's policy for Administering Medications revealed medications shall be administered as prescribed and that medications must be administered in accordance with the orders. The policy included 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 (route of administration) before giving the medication.
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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, staff interviews, and policy review, the facility failed to ensure one sampled resident (#23) was provided nail care. The deficient practice could result in poor hygiene, infection, and injury to skin. Findings include: Resident #23 was readmitted to the facility on (MONTH) 28, (YEAR), with [DIAGNOSES REDACTED]. Review of the Activity of Daily Living (ADL) care plan revised (MONTH) 28, (YEAR), revealed the resident had ADL performance deficit related to activity intolerance and limited mobility. Interventions included the resident required total staff participation with personal hygiene care. Review of the clinical record revealed an order dated (MONTH) 28, (YEAR) for the resident to be seen by a podiatrist of choice as needed. Review of the podiatry appointment lists for (MONTH) 23, (YEAR), (MONTH) 9, (YEAR) and (MONTH) 1, 2019, revealed the resident had not been scheduled to see a podiatrist. The quarterly Minimum Data Set (MDS) assessment dated (MONTH) 11, 2019, revealed a Brief Interview for Mental Status score of 11 which indicated the resident had moderate impaired cognition. The assessment included the resident was totally dependent and required two-person assistance with personal hygiene tasks. During an initial interview conducted with the resident on (MONTH) 12, 2019 at 2:04 p.m., the resident's right foot toenails were observed to be long with the big toenail on the right foot extended approximately 1/4 inch above the toe. Another observation was conducted of the resident on (MONTH) 15, 2019 at 9:26 a.m. The resident was observed sleeping with her right foot exposed. The right foot toenails were again observed long and dried blood was observed around the cuticle of the toe next to the big toe. The baby toenail was observed to be curved growing over the toe. An interview was conducted on (MONTH) 15, 2019 at 9:14 a.m. with the Transportation Attendant (staff #8) who stated that the resident has not seen the podiatrist in the last few months. Staff #8 stated that since the resident is a diabetic, only a nurse or specialist can trim the resident's nails. She said that she schedules an appointment when the nurse notifies her that a resident needs to see a podiatrist. During an interview conducted with a Certified Nursing Assistant (CNA/staff #16) on (MONTH) 15, 2019 at 9:32 a.m., the CNA stated that she trims residents' nails but not the nails of residents that are diabetics. She stated that nails that are long could cause discomfort, snagging, and cutting into another toe. While observing resident #23 toenails, she stated that the resident's toenails are thick, too long and need to be trimmed by a specialist. The observation also revealed a small cut in the left toe next to the left big toe and that the left big toenail was jagged. An interview was conducted with a Registered Nurse (RN/staff #44) on (MONTH) 15, 2019 at 9:45 a.m. The RN stated that it is the nurse's responsibility to put the resident on the list for podiatry care. She stated that the nurses do not document the nail care they provide to residents. After observing resident #23 toenails, she stated the nails needed trimming. Review of the facility's policy titled Fingernails/Toenails, Care of, revised (MONTH) (YEAR), revealed the purpose of nail care is to clean the nail bed, trim the nails, and to prevent infections. Trimmed and smooth nails prevent the resident from scratching and or injuring his or her skin. Nail care entails daily cleaning and regular trimming. The policy also included staff are not to provide nail care for residents with diabetes or circulatory impairments.
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 clinical record review, staff interviews, and policy review, the facility failed to ensure one sampled resident (#4) was administered pain medications consistent with professional standards of practice. The deficient practice could result in unrelieved pain. Findings include: Resident #4 was admitted to the facility on (MONTH) 26, 2019, with [DIAGNOSES REDACTED]. Review of the clinical record revealed the following physician orders: -[MEDICATION NAME] HCl 2 milligrams (mg) 1 tablet by mouth every 4 hours as needed for a pain level of 6-10 dated (MONTH) 30, 2019. -[MEDICATION NAME] 325 mg 2 tablets by mouth every 4 hours as needed for a pain level of 1-5 dated (MONTH) 30, 2019. Review of the Medication Administration Record [REDACTED]. Continued review of the (MONTH) MAR indicated [REDACTED]. Review of the MAR for (MONTH) 2019, revealed the resident was administered [MEDICATION NAME] on (MONTH) 17 and 28 for a pain level of 7. Continued review of the (MONTH) MAR indicated [REDACTED]. Review of the MAR for (MONTH) 2019 revealed the resident was administered [MEDICATION NAME] on (MONTH) 5 for a pain level of 10, (MONTH) 13 for a pain level of 7, and (MONTH) 12 for a pain level of 6. Further review of the clinical record revealed no documentation regarding why the resident was administered pain medications outside of the ordered parameters and no documentation that the physician was notified. An interview was conducted on (MONTH) 14, 2019 at 1:17 p.m. with a Registered Nurse (RN/staff #44). The RN stated that when a resident is complaining of pain, she asks the resident to rate the pain on a scale of 1-10 and administers pain medication according to the parameters ordered by the physician. After reviewing the MAR for (MONTH) 2019, the RN stated that [MEDICATION NAME] and [MEDICATION NAME] were not always administered according to the ordered parameters. She also said that resident #4 often asks for the stronger pain medication and does not want the [MEDICATION NAME]. The RN stated that for these instances, the physician should be notified for direction. During an interview conducted on (MONTH) 15, 2019 at 8:48 a.m. with the Director of Nursing (DON, staff #42), the DON stated that she expects nurses to administer as needed pain medications according to the physician order. The DON stated that the nurses are to notify the physician when a resident requests a pain medication outside of the ordered parameters. She stated the process is to fax the S-Bar form to the physician and wait for the physician order. An interview was conducted on (MONTH) 15, 2019 at 12:16 p.m. with a RN (staff #7). She stated that she became aware that she had given the resident pain medications out of the ordered parameters last night when the DON informed her to sign some S-BAR forms that she had completed, but had not signed. She said the S-Bar form is not used to get approval for a change in medication administration, but is to let the physician know that a change has occurred. Review of the facility's policy, Medication Administration, revised (MONTH) 2012, revealed the Director of Nursing will supervise and direct all nursing personnel who administer medications or related functions and that medications must be administered in accordance with the orders. Review of the facility's policy, Administering Pain Medications, revised (MONTH) 2010, revealed that pain management is defined as the process of alleviating the resident's pain to a level that is acceptable to the resident and is based on his and her clinical condition and treatment goals. Pain level is to be assessed using standardized pain assessment tools, such as a pain intensity scale and that pain medication is to be administered as ordered.
F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain**

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F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) **the services of a licensed pharmacist.** **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 controlled medication record for one of eight sampled residents (#333) was accurate. The deficient practice could result in a delay identification of loss or potential diversion. Findings include: Resident #333 was admitted on (MONTH) 8, 2019, with [DIAGNOSES REDACTED]. Review of the clinical record revealed a physician order [REDACTED]. A review of the controlled substance record for Clobazam 10 mg was conducted on (MONTH) 15, 2019 at 11:51 a.m. with a Licensed Practical Nurse (LPN/staff #91). The record revealed documentation Clobazam 10 mg was last administered on (MONTH) 15, 2019 at 8:31 a.m. and that 24 tablets remained. However, review of the medication card containing the Clobazam 10 mg tablets revealed there were 25 tablets remaining. Review of the Medication Administration Record [REDACTED]. An interview was conducted with the LPN (staff #91) on (MONTH) 15, 2019 at 1:02 p.m. The LPN stated that she signed out Clobazam 10 mg on the controlled substance record on (MONTH) 15, 2019 at 8:31 a.m. She stated that she forgot to remove the Clobazam 10 mg tablet from the medication card. The LPN further stated that she did not administer the Clobazam 10 mg tablet that morning. She stated the physician was notified and stated to administer the Clobazam now. During an interview conducted on (MONTH) 15, 2019 at 1:21 p.m. with the Director of Nursing (DON/staff #42), the DON stated that she expects the nurse to document a medication was administered after the medication has been administered. Review of the facility's policy Controlled Substance states The facility shall comply with all laws, regulations and other requirements related to handling, storage, disposal, and documentation of schedule II and other controlled substances . The facility's policy Administering Medication included .The individual administering the medication must initial the resident MAR indicated [REDACTED].
F 0760 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation, staff interviews, and policy review, the facility failed to ensure that one sampled resident (#79) was free from a significant medication error. The deficient practice could result in significant adverse medication side effects. Findings include: Resident #79 was admitted to the facility on (MONTH) 14, 2014 with [DIAGNOSES REDACTED]. Review of the physician's orders [REDACTED]. Review of the pharmacy delivery receipts revealed that [MEDICATION NAME] 25 mcg patches were delivered on (MONTH) 5, 2019. Continued review of the physician's orders [REDACTED]. Review of the Medication Administration Record [REDACTED]. However, the controlled substance record for [MEDICATION NAME] revealed [MEDICATION NAME] 25 mcg patches were signed out from (MONTH) 6 through (MONTH) 30, 2019. Review of the MAR for (MONTH) 2019 revealed a [MEDICATION NAME] 100 mcg patch was applied on (MONTH) 2. However, the controlled substance record for [MEDICATION NAME] revealed a [MEDICATION NAME] 25 mcg patch was signed out on (MONTH) 2, 2019. Continued review the clinical record revealed a prescription for [MEDICATION NAME] 100 mcg patch every 3 days was signed by the physician on (MONTH) 3, 2019. Review of the pharmacy delivery receipts revealed the first box of [MEDICATION NAME] 100 mcg patches were delivered on (MONTH) 5, 2019. The MAR for (MONTH) 2019 revealed the first [MEDICATION NAME] 100 mcg patch was applied on (MONTH) 8, 2019. The controlled substance record for [MEDICATION NAME] revealed a [MEDICATION NAME] 100 mcg patch was signed out on (MONTH) 8, 2019. A nurse progress note dated (MONTH) 9, 2019 revealed the resident was noted with nausea and vomiting and stated that her stomach felt upset. The note included [MEDICATION NAME] (antiemetic) 8 milligrams was given. Review of the physician orders [REDACTED]. The MAR for (MONTH) 2019 revealed the [MEDICATION NAME] 100 mcg patch was removed on (MONTH) 10, 2019. A nurse incident note dated (MONTH) 10, 2019 revealed the resident was noted to have on the wrong dose [MEDICATION NAME] which was immediately removed. The on call physician was notified who stated to remove the patch and monitor the resident. The physician came to the facility and signed a new order for the correct dosage to be placed on (MONTH) 11, 2019. The noted included the resident complained of some nausea but declined a need for nausea medication. Continued review of the clinical record revealed a physician's orders [REDACTED]. The facility incident report dated (MONTH) 10, 2019 revealed that during narcotic count it was noted that the resident's [MEDICATION NAME]es were the wrong dosage. The report included the patch was removed immediately from the resident and the Director of Nursing (DON) and physician were notified. An interview was conducted with a Registered Nurse (RN/staff #88) on (MONTH) 15, 2019 at 9:21 a.m. The RN stated that she had changed the [MEDICATION NAME] order in their electronic system for resident #79 on (MONTH) 6, 2019 because the order was put in their electronic system incorrectly. She stated the order that was put in their electronic system instructed to change the patch every 60 hours instead of every 72 hours. She stated that with their new pharmacy, the order could not be revised, it had to be re-created. The RN stated that when she created the new order on (MONTH) 6, 2019, she accidentally clicked the wrong dose. She stated that she clicked 100 mcg instead of 25 mcg. The RN stated that at some point the script for [MEDICATION NAME] 100 mcg patches was printed out and signed by the doctor. She stated during report on (MONTH) 10, 2019, it was reported to her that resident #79 was experiencing some nausea. She also stated that during the narcotic count, she noticed the [MEDICATION NAME] boxes were bigger than the boxes they had been using. The RN stated that she reviewed the order and realized the order was incorrect, that the [MEDICATION NAME]es should be 25 mcg not 100 mcg. She stated that she removed the patch, called the physician, and that the physician came to the facility and discontinued the [MEDICATION NAME] 100 mcg patches and wrote a new order for [MEDICATION NAME] 25 mcg patches. She stated the resident was told what had happened and why she was feeling bad. The RN stated that she could have prevented the error by double checking the order she created before sending it. An interview was conducted with the DON (staff #42) on (MONTH) 15, 2019 at 10:44 a.m. She stated that when an order is put in the system, medical records runs a daily order listing report and reviews the medications that were discontinued or newly ordered within the last 24 hours. The DON stated that is when they would recognize any discrepancy or red flag. She stated that nurses and medical records enter orders into the system, but if the order is entered by medical records a nurse would review the order for accuracy and sign off on the order. Regarding resident #79, the DON stated that she was notified of the [MEDICATION NAME] error on Saturday (MONTH) 10, 2019. She stated the nurse reported that she inadvertently entered 100 mcg instead of 25 mcg. The DON stated that on (MONTH) 1, 2019, the physician signed a script for the [MEDICATION NAME] 100 mcg patches, but that she does not believe the physician ever gave the order to change the dose from 25 mcg to 100 mcg. An interview was conducted with the primary physician (staff #105) on (MONTH) 15, 2019 at 2:03 p.m. She stated that she did not change the dose for the [MEDICATION NAME] from 25 mcg to 100 mcg on (MONTH) 6, 2019. She stated resident #79's pain is well controlled on the [MEDICATION NAME] 25 mcg patch. The physician stated that it must have been a facility mistake or it may have been discussed with the on call physician. A follow up interview was conducted with the DON (staff #42) on (MONTH) 15, 2019 at 3:20 p.m. The DON stated that she would have expected the nurse to call the physician and clarify how the order should read before changing the order. She stated that the nurse should have double checked the order before changing it in the system. Review of the facility's policy on Administering Medications revealed medications shall be administered in a safe and timely manner, and as prescribed. The policy included that medication must be administered in accordance with the orders. The facility's policy on Medication and Treatment Orders revealed orders for medications and treatments will be consistent

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F 0760 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) with principles of safe and effective order writing. The policy included that medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in this state. Review of the facility's policy on Adverse Consequences and Medication Errors revealed a medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders [REDACTED]. Examples of medication errors included omission, unauthorized drug (a drug is administered without a physician's orders [REDACTED].