STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035085	A. BUILDING _____ B. WING _____	09/25/2019

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HAVEN OF SAGUARO VALLEY	6651 EAST CARONDELET DRIVE TUCSON, AZ 85710

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 0742 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, staff interviews and policy reviews, the facility failed to provide the appropriate behavioral health treatment and services for one resident (#295). The deficient practice could result in residents not receiving individualized person-centered care and treatment, in order to reach their highest practicable well-being. Findings include: Resident #295 was admitted on (MONTH) 8, 2019, with [DIAGNOSES REDACTED]. A physician's orders [REDACTED]., wound care consultant, psychiatrist and audiologist of choice as needed. A physician's orders [REDACTED]. A [MEDICAL CONDITION] medication informed consent for dated (MONTH) 10, 2019 for [MEDICATION NAME] included that the resident did not consent to the medication. Further review of the physician orders [REDACTED]. A health status note dated (MONTH) 10, 2019 included that the Nurse Practitioner recommended [MEDICATION NAME] for a [DIAGNOSES REDACTED]. The consent with the risks and benefits were reviewed with the resident, but the resident declined it's use. A signed declination was on file. A social services progress note written by the social services manager (staff #3) dated (MONTH) 10, 2019 at 9:47 a.m., included that social services spoke with the resident about a request for in house psychiatric services. This note stated the resident was informed that the facility did not currently have in-house psychiatric services, but that outpatient services were available. Per the note, the resident declined out-patient services. Another social services progress note written by staff #3 dated (MONTH) 10, 2019 at 1:04 p.m., included that social services and the Director of Nursing (DON) spoke with the resident about her yelling and disrupting the care of the other residents. The resident was educated on acceptable noise levels and if she needs assistance she can use the call light for assistance. The note included that the resident understood and was also educated on possible consequences of continued behavior. A care plan dated (MONTH) 10, 2019 identified the resident has the potential to demonstrate verbal outburst behaviors, related to ineffective coping skills and the refusal of ordered medication. The goal was the resident will verbalize understanding of the need to control verbal outburst behaviors. Interventions were to evaluate for side effects of refusing to take psychoactive medications, provide psychiatric/psychogeriatric consult as needed, assessing the resident's coping skills and anticipating the residents needs with food, thirst, toileting needs, comfort level, body positioning and pain. A physician's note dated (MONTH) 11, 2019 revealed that social services and the DON spoke with the resident yesterday letting her know that her screaming and outbursts were not acceptable. The note stated that for some reason this was enough to change her behaviors. An alert charting Change of Condition Summary dated (MONTH) 13, 2019 included the resident was wakeful and weepy through the night and that one on one time was spent with patient, with little effect. An alert charting note dated (MONTH) 15, 2019 stated the resident continues to be noisy and weepy and reassurance is given repeatedly. Per the note, the resident continues to call for assistance every ten to fifteen minutes. Review of a Minimum Data Set assessment dated (MONTH) 15, 2019 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS identified the resident had verbal behaviors directed towards others and rejected care 1-3 days of the 6 day look back period. Review of the behavioral monitoring documentation from (MONTH) 8 through 25, 2019 revealed the following: -Verbal symptoms such as screaming or disruptive sounds not directed at others was noted on (MONTH) 9, 12, 13, 14, 15, 16, 17, 18, 19, 21, 23 and 24. - Frequent crying was noted on (MONTH) 8, 9, 10, 13, 14, 15, 16, 17, 18, 19, 21, 23 and 24. - Yelling or screaming was noted on (MONTH) 12, 13, 14, 15, 16, 18, 19, 20, 21, 22, 23 and 24. - Behavioral symptoms directed at others including threatening, screaming or cursing at others were noted on (MONTH) 16, 18, 19, 20, 21, 22, 23 and 24. Per the documentation, the charge nurse was notified of the resident's behaviors on (MONTH) 8, 9, 10, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23 and 24. Despite the resident's ongoing behaviors, there were no additional treatments, services or interventions which were implemented to assist the resident in maintaining their highest practicable well-being. In an interview conducted with the resident on (MONTH) 23, 2019 at 1:58 p.m., the resident stated that a CNA told her that the number of times that CNA's go into her room is documented, and if she screams then the CNA will report her to the social worker and the social worker will get rid of her. An observation was conducted on (MONTH) 23, 2019 at 2:35 p.m. of the resident in her room. When asked if she wanted the door open or closed, the resident started crying loudly and putting her hands to her face. At this time, a CNA entered the room and attempted to console the resident that the door would not be closed. Another interview was conducted on (MONTH) 24, 2019 at 12:24 p.m., with a certified nursing assistant (CNA/staff #61). He stated that he hears the resident cry almost every day. Staff #61 said when the resident cries, he attempts to calm her down. He said that usually it is a pretty simple problem, but not always. In an interview conducted on (MONTH) 24, 2019 at 12:36 p.m. with a licensed practical nurse (LPN/ staff #5), he stated that he talks to this resident all the time and that she will cry on a daily basis. He said that she gets easily upset and if something doesn't go her way, she cries. He said that he tries to redirect her and explain what's going on. He said it helps to keep an upbeat attitude, but sometimes it works and sometimes it doesn't. He stated that he doesn't know if she's seen a psychiatrist, as he is not that familiar with this hall. In an interview conducted on (MONTH) 24, 2019 at 12:41 p.m. with the social services manager (staff #3), he stated that he did tell the resident that if the yelling continued they would have to consider alternate arrangements. He said the resident used to yell out when she needed something, but he was told that she's much better at pressing the call light now, since he and the DON talked to her about it. Regarding the social services note dated (MONTH) 10, which documented that the facility did not have in-house psychiatric services, staff #3 stated the facility does have an in house psychiatrist and has had an in house psychiatrist since the new owner (August 2019). He said the psychiatrist will be here in (MONTH) and he

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 0742 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) is the person who puts residents on the list. He stated this resident is not on the list to see the psychiatrist and that he is not sure if she needs to be on the list or not. He stated that he would know about patient outburst from the tasks that have flagged from the night before at daily meetings. He stated that all of the management team including the DON, the Executive Director, and the managers go over what triggered every meeting. In an interview conducted on (MONTH) 24, 2019 at 12:56 p.m., the DON (staff #22) stated that the resident was seen in the hospital by a psychiatrist prior to admission, and the psychiatrist did not diagnose her with a psychiatric diagnosis. She stated the Nurse Practioner who was following this resident tried to prescribe a psychiatric medication for her, but the resident didn't want it. The DON said they do have in house psychiatric services at this time and that they have had psychiatric services since August, 2019. The DON said there is a list of patients to see the psychiatrist in (MONTH) and the social services director manages that list. In a later interview at 2:35 p.m., the DON confirmed that in patient psychiatric services have been available since (MONTH) 19, 2019. A social services progress note dated (MONTH) 24, 2019 now included that the resident is requesting private personal counseling services. Per the note, the resident was informed that the facility does not have private counseling, but can be referred to in-house psychiatric services for an evaluation. The note included the resident is in agreement and will be seen at the next evaluation. In a follow up interview with the LPN (staff #5) conducted on (MONTH) 25, 2019 at 10:14 a.m., staff #5 stated that when a resident refuses a medication, he documents the refusal, updates the doctor and re-approaches the resident three times and documents on the Medication Administration Record [REDACTED] Another interview was conducted with the DON on (MONTH) 25, 2019 at 10:18 a.m., who stated that when a patient refuses a new medication, the expectation is to notify the doctor who wrote the order and document the refusals and the order may be continued. She stated that for a medication that needs a consent like a [MEDICAL CONDITION], a re-approach is expected to be done multiple times. She stated that if the resident continues refusing, then they inform the doctor and this is usually documented in the progress notes. She stated that she informed the nurse practitioner the day the order was given (regarding the [MEDICATION NAME]) and the nurse practitioner stated to discontinue the order as she would re-approach the resident personally. When asked for documentation of this, the DON was unable to provide any. An observation was conducted on (MONTH) 25, 2019 at 10:54 a.m. in the hallway where resident # 295 resided. The resident was observed in her room crying and a CNA (staff #61) was also in the room and was reassuring the resident. Review of a policy regarding Advance Directives revealed that if the resident refuses treatment, the facility and the care providers will reassess the resident for significant change of condition related to the refusal, determine the decision-making capacity of the resident, document specifically what the resident/representative is refusing, assess and document the stated reason for the refusal, advise the resident of the consequences of refusal, offer pertinent alternative treatments, modify the care plan as appropriate, providing all other appropriate services (i.e. those that will allow him or her to maintain the highest practicable physical, mental and psychosocial well-being.)
F 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observations, staff interview and policy review, the facility failed to serve food in accordance with professional standards for food service safety. The deficient practice could place residents at risk for foodborne illnesses. Findings include: During a dining observation conducted on (MONTH) 23, 2019 at 11:27 a.m., a Certified Nursing Assistant (staff #47) was observed assisting a resident with eating lunch. At this time, the resident dropped a piece of chicken on his clothing protector, and staff #47 picked the chicken up with bare hands and handed it to the resident. During the observation, the resident continued to drop food onto his clothing protector, and the CNA repeatedly used bare hands to pick the food up and give it back to the resident to eat. The resident was also observed trying to give food to staff #47 and staff #47 would then grasp the food with bare hands and give it back to the resident to eat. Staff #47 was also observed placing her bare thumb directly on the rim of a cup, as she guided the cup to the resident's mouth. An interview was conducted with the kitchen manager (staff #45) on (MONTH) 24, 2019 at 2:14 p.m. He said food should be served so that bare hands do not come in contact with food or the eating surfaces of plates and utensils. He stated staff should use utensils when assisting residents to eat, and should not touch food with bare hands. Review of the facility's Food Handling policy revealed that some of the critical factors implicated in foodborne illness were poor personal hygiene of food service employees and contaminated equipment. The policy stated that all employees who handle, prepare or serve food will be trained in the practices of safe food handling and preventing foodborne illness. Employees will demonstrate knowledge and competency in these practices prior to serving food to residents.