STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **035096**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **12/20/2018**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HAVEN OF SANDPOINTE, LLC	**2222 SOUTH AVENUE A** **YUMA, AZ 85364**

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 0602 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Protect each resident from the wrongful use of the resident's belongings or money.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview, facility documentation and policy review, the facility failed to ensure one resident (#173) was free from misappropriation of property. Findings include: Resident #173 was admitted to the facility on (MONTH) 12, (YEAR), with [DIAGNOSES REDACTED]. The resident was discharged on (MONTH) 8, (YEAR). Review of a facility's investigative report revealed that the nursing home administrator (staff #131) received a call on (MONTH) 30, (YEAR) from prison officials, who reported that one of their employees (Licensed Practical Nurse/LPN/staff #156) who also works part time at the nursing home facility, was involved in a prison drug diversion investigation. Per the report, one of the prescription medication bottles in the possession of staff #156 had a resident's name on it (resident #173), along with other information. The report included that resident #173 had previously been a resident at the nursing home facility. The report further included that on the evening of (MONTH) 29, (YEAR), staff #131, the Chief Nursing Officer and the police, met with staff #156. A search of staff #156's vehicle was conducted at this time and revealed additional medications belonging to resident #173. Staff #156's explanation was that he did not realize there were medications in the bottle. The report included that staff #156 was suspended pending the investigation and that staff #156 resigned on 12/1/18.On (MONTH) 19, (YEAR), former staff #156 was contacted by phone for an interview. He stated that he would return the call within two hours, however, no returned calls were received. An interview was conducted with a Corporate Registered Nurse (staff #152) on (MONTH) 19, (YEAR) at 1:05 p.m. She stated they were notified by prison officials on (MONTH) 30, (YEAR) of a prescription bottle which was full of medications that had been located in the vehicle of staff #156. Staff #152 said that the bottle of medications listed the name of resident #173, who the police had identified as being a prior resident in the facility back in (MONTH) (YEAR). Staff #152 stated that staff #156 was immediately suspended and an investigation was initiated. She stated that when a resident is admitted , all medications brought with the resident are sent home. She said that for whatever reason, the medication for resident #173 remained in the facility in the secured medication room. She confirmed that staff #156 had worked in the facility on (MONTH) 22, (YEAR), when the resident resided at the facility. Review of the policy regarding Misappropriation of Personal Property revealed the facility recognizes and respects that each resident has the right to be free from misappropriation of resident's property. The facility is committed to developing and operationalizing policies and procedures for screening and training employees regarding misappropriation of resident personal property. Misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful use of a resident's belongings without the resident's consent.
F 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview, facility documentation and policy and procedures, the facility failed to prevent the potential for further abuse while an investigation was in progress for one resident (#373). Findings include: Resident #373 was admitted on [DATE], with [DIAGNOSES REDACTED]. Review of an admission MDS (Minimum Data Set) assessment dated [DATE], revealed a BIMS (Brief Interview for Mental Status) score of 4, which indicated the resident had severe cognitive impairment. Review of the facility's abuse investigation revealed that the resident reported to a registered nurse (RN) on 8/9/18 during the night shift that a CNA had hit her and dragged her out of bed that same night. The report included a statement from the accused CNA who stated that a second CNA was helping her provide care for the resident that night. Per the statement from the accused CNA, the nurse told them that the resident had accused both of them of hitting her. A statement from the second CNA also included the nurse had told them that the resident had alleged that both of them had hit her. Further review of the investigative report revealed that the nurse advised the accused CNA to not care for the resident and to keep a distance from the resident and have the second CNA take care of anything that the resident needed for the remainder of the shift. The facility was unable to provide any documentation that at the time of the allegation, both CNA's were removed from providing care to the resident's in the facility, while the investigation was in progress. An interview was conducted with the Chief Nursing Officer (staff #152) on 12/19/18 at 12:58 p.m. Staff #152 stated that when there is an allegation of abuse or neglect, the person who receives the report calls either the Director of Nursing or her immediately. She stated that if it happens at night, they are to call and keep calling until they reach her or the DON to receive further direction. She stated that if the person accused is an employee, it is her expectation and the facility's policy to immediately suspend the employee and begin a full investigation. She said that both CNA's should have been suspended and sent home after the allegation was made. Review of the facility's Abuse policy revealed that In the event of an allegation of abuse, the facility will immediately assess the resident, notify the physician and resident representative, and protect the resident and other residents from further harm. The policy also included When a specific staff is identified as being allegedly involved in the abuse allegation, the staff may be re-assigned or suspended during the investigation.
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 review, staff interviews, review of the Resident Assessment Instrument (RAI) manual and policy and procedures, the facility failed to ensure that the Minimum Data Set (MDS) assessment accurately reflected one resident's (#58) status. Findings include: Resident #58 was admitted on (MONTH) 14, (YEAR), with [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. Review of a care plan dated (MONTH) 15, (YEAR) revealed the resident had a history of [REDACTED]. Review of the Behavior Monitoring record for (MONTH) 16, 18, and 19, (YEAR) revealed the resident displayed behaviors of striking out. Review of the nurse progress notes from (MONTH) 15 through (MONTH) 21, (YEAR) revealed the resident exhibited the following behaviors: -November 15: the resident was aggressive, agitated and hitting the Certified Nursing Assistant (CNA).

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 0641 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) -November 16: the resident was resisting care, was verbally and physically abusive, was cursing in Spanish and called staff bad words, was trying to hit staff and was combative with care. -November 17: the resident cursed at staff on several occasions and made dirty sign language using her finger at another resident this p.m. -November 18: the resident became aggressive and combative with the RN and CN[NAME] She scratched the arm of the RN and hit the CNA in the chest and was combative with care. -November 19: the resident is very combative during Activities of Daily Living (ADL) and medication pass and strikes out at other residents. -November 20: Attempted to slap the Licensed Practical Nurse (LPN) and a CNA on the arms. According to the admission MDS assessment dated (MONTH) 21, (YEAR), the resident was assessed to have short and long term memory problems and was severely impaired with decision making. However, the MDS did not include that the resident had any physical or verbal behaviors directed toward others. An interview was conducted with a MDS nurse (LPN/staff #150) on (MONTH) 20, (YEAR) at 1:05 p.m. She stated that they use the RAI manual for directions on completing the MDS and that they have an imbedded link within the program to the section of the RAI manual that coincides with the section they are working on. She stated that it is important that the MDS be accurate, as it documents the overall status of the resident and how we take care of the resident. She stated that the Care Area Assessments (CAA) section triggers areas which prompts for a deeper investigation and leads to the development of care plans. Staff #150 said that the care plan is important to show others how to take care of the resident. She stated that an inaccurate MDS could result in an incomplete care plan. At this time, the clinical record and MDS were reviewed with staff #150, who stated that the assessment was not accurate for this resident. She stated that she did not follow the RAI manual or their policy for accuracy of the MDS, which could put the resident at risk of not receiving the appropriate care. An interview was conducted with the MDS corporate nurse (RN/staff #155) on (MONTH) 20, (YEAR) at 1:20 p.m. She stated that they use the RAI manual for the MDS/RAI process. She stated that the MDS is expected to be accurate, per the RAI manual instructions. She stated that if the MDS is inaccurate it could lead to not identifying the appropriate risks, problems, or preferences of a resident. At this time, staff #155 reviewed the clinical record documentation and the MDS and stated that staff did not fulfill her expectations for accuracy of the MDS. Review of the facility's policy regarding the MDS revealed that the MDS is completed by following the Centers for Medicare and Medicaid (CMS) RAI manual. The MDS coordinator is to follow the RAI manual instructions when completing all MDS assessments. Review of the RAI manual revealed that the items in section [NAME] identify behavioral symptoms in the last seven days which may cause distress to the resident, or may be distressing or disruptive to facility residents, staff members or the care environment. These behaviors may place the resident at risk for injury, isolation, and inactivity and may also indicate unrecognized needs, preferences, or illness. Direction for coding of physical behavioral symptoms directed toward others, verbal behavioral symptoms directed toward others and other behavioral symptoms not directed toward others includes to code based on whether the symptoms occurred.
F 0758 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **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 that a that a physician's order for a PRN (as needed) antianxiety medication included an end date or that there was documentation of the rationale for its continued use for one resident (#10). Findings Include: Resident #10 was admitted on (MONTH) 15, (YEAR), with [DIAGNOSES REDACTED]. Review of a quarterly Minimum Data Set assessment dated (MONTH) 21, (YEAR) revealed the resident had short and long term memory problems and was severely impaired with daily decision making. A physician's order dated (MONTH) 9, (YEAR) included for [MEDICATION NAME] (antianxiety) 1 mg tablet by mouth every 4 hours PRN for anxiety. The order did not include an end date, but listed the medication as indefinite. A care plan identified that the resident was at risk for adverse effects related to [MEDICAL CONDITION] medication. The goal was that the resident would have no adverse effects related to [MEDICAL CONDITION] medications. Interventions included for medical doctor review for appropriateness and pharmacy review for medical necessity. According to the (MONTH) and (MONTH) (YEAR) Medication Administration Records, the resident received the PRN [MEDICATION NAME] daily from (MONTH) 26-30, from (MONTH) 3-12, on (MONTH) 14 and from (MONTH) 17-19. Further review of the clinical record revealed there was no documentation from the provider regarding the rationale for the continued use of the medication. An interview was conducted with a Licensed Practical Nurse (LPN/staff #117) on (MONTH) 20, (YEAR) at 9:58 a.m. She stated that an as needed (PRN) antianxiety medication can be given for 14 days and then the resident has to have a face to face with the provider to decide whether to discontinue or extend the medication. Staff #117 said that if the provider decides to continue the medication, it can be ordered in 14 day increments. At this time, staff #117 reviewed the clinical record and stated that they did not follow their policy, as there was no documentation of a face to face with the provider within 14 days and there was no documentation of a decision to extend or discontinue the medication. An interview was conducted with the Corporate Director of MDS (RN/staff #155) on (MONTH) 20, (YEAR) at 11:30 a.m. She stated that PRN [MEDICAL CONDITION] medications cannot be given more than 14 days, without an in person visit by the provider to renew the order. She stated the PRN [MEDICATION NAME] should not have been given to this resident for more than 14 days, without documentation from the provider. Review of the policy regarding Psychopharmacological Medication Use revealed the facility should comply with the State Operations Manual and all other applicable laws relating to the use of psychopharmacological medications. When a physician/prescriber orders a psychopharmacologic medication for a resident, the facility should ensure that the physician/prescriber has conducted a comprehensive assessment of the resident and has documented in the clinical record that the psychopharmacologic medication is necessary.
F 0761 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** Based on observation, staff interviews and policy review, the facility failed to store narcotic drugs in a permanently affixed compartment and securely locked. Findings include: An observation of the facility's medication room was conducted on (MONTH) 20, (YEAR) at 3:35 p.m. In the medication room, there was an unsecured pharmacy emergency narcotic medication box, which was in an unlocked partially opened cabinet. The narcotic box was approximately 8 inches by 16 inches by 3 inches and was held closed by numbered breakaway plastic locks. The narcotic box was not permanently affixed and could be easily removed from the cabinet. The narcotic box was also not being stored using a double lock system. An interview was conducted with a Registered Nurse (Interim Director of Nursing (DON/staff #13) on (MONTH) 20, (YEAR) at

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F 0761 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) 3:37 p.m. He stated that narcotic medications require two locks. He stated that their policy and the regulatory requirements were not followed, as there is only one lock on the box and the box is not secured. An interview was conducted with the Corporate RN (staff #152) on (MONTH) 20, (YEAR) at 3:40 p.m. She stated that the narcotic box was not under lock and key and it should be, therefore; the facility did not follow the regulations. Review of the policy on the Storage of Medications revealed that after receiving controlled substances and adding to inventory, the facility should ensure that schedule II-V controlled substances are immediately placed into a secured storage area (i.e. safe, self-locked cabinet or locked room, in accordance with applicable law).
F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **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 medical records were complete for one resident (#10). Findings include: Resident #10 was admitted on (MONTH) 15, (YEAR), with [DIAGNOSES REDACTED]. Review of a care plan revealed the resident was at risk for adverse effects related to [MEDICAL CONDITION] medications. The approaches included to monitor behaviors related to [MEDICAL CONDITION] medication and to observe for adverse effects. Review of the (MONTH) (YEAR) Behavioral Monitoring Record revealed the following: -To monitor and document behaviors related to psychoactive medications for [MEDICATION NAME] and [MEDICATION NAME] every shift. However, there was no documentation that the resident was monitored for behaviors on (MONTH) 1, (MONTH) 4-15, (MONTH) 17, (MONTH) 19-21, and on (MONTH) 31 during the day shift, and on (MONTH) 6, 12, 17 and 22 on the night shift. -Has the resident been free from any side effects related to antipsychotic medication each shift? There was no documentation that the resident was monitored for any side effects on (MONTH) 4-15, (MONTH) 17, (MONTH) 19-21, and on (MONTH) 31 on day shift, and on (MONTH) 6, 12, 17 and 22 on the night shift. -Has the resident been free from any side effects related to antidepressant medication each shift? There was no documentation that the resident was monitored for side effects related to antidepressant medication on (MONTH) 4-15, (MONTH) 17, (MONTH) 19-21, and on (MONTH) 31 on the day shift, and on (MONTH) 6, 12, 17 and 22 on the night shift. -Has the resident been free from any side effects related to antianxiety medication each shift? There was no documentation that the resident was monitored for side effects on (MONTH) 4-15, (MONTH) 17, (MONTH) 19-21 and on (MONTH) 31 on the day shift, and on (MONTH) 6, 12, 17 and on (MONTH) 22 on the night shift. Review of the Treatment Administration Record (TAR) for (MONTH) (YEAR) revealed to monitor for the following care and treatment: -Leg abductor cushion for wheelchair every day shift for weakness. There was no documentation on (MONTH) 5 or 8. -Monitor left front hand bruise every shift. There was no documentation on the day shift for (MONTH) 5 and 8 or on the night shift on (MONTH) 7. -Monitor wound sites every shift. There was no documentation on (MONTH) 5 and 8 or on the night shift on (MONTH) 7. -Pain assessment every shift. There was no documentation on the day shift on (MONTH) 5 and 8. Review of the (MONTH) (YEAR) Behavioral Monitoring Record revealed the following: -To monitor and document behaviors related to psychoactive medication for [MEDICATION NAME], and [MEDICATION NAME] every shift. However, there was no documentation the resident was monitored on (MONTH) 1, 5, and 15 on the day and night shift. -Has the resident been free from side effects related to antipsychotic medication each shift? There was no documentation on (MONTH) 1 and 5 on the day shift. -Has the resident been free from any side effects related to antidepressant medication each shift? There was no documentation on (MONTH) 1 and 5 on the day shift. -Has the resident been free from any side effects from antianxiety medication each shift? There was no documentation on (MONTH) 1, 5 and 15 on the day shift. Review of the TAR for (MONTH) (YEAR) revealed to monitor for the following care and treatment: -Leg abductor cushion for wheelchair every day shift for weakness. There was no documentation on (MONTH) 5. -Pain assessment every shift. There was no documentation on the day shift on (MONTH) 5. Review of the (MONTH) (YEAR) Behavioral Monitoring Record revealed the following: -To monitor and document behaviors related to the psychoactive medication for [MEDICATION NAME], and [MEDICATION NAME] every shift. There was no documentation on (MONTH) 3 and 13 on the day shift. -Has the resident been free from any side effects related to antianxiety medication each shift? There was no documentation on (MONTH) 3 on the day shift. An interview was conducted with a Licensed Practical Nurse (LPN/staff #117) on (MONTH) 20, (YEAR) at 1:56 p.m. She stated that she is expected to document on the behavior monitoring record and document any treatments which are done by her during her shift. She stated that there should not be any blanks on the behavior monitoring records or on the medication and treatment records, because if there are blanks, then there is no documentation that the work was done. In reviewing the medication and treatment records and the behavior monitoring records, staff #117 stated that the blank boxes should have initials in them and that their policy was not being followed in regards to documentation. An interview was conducted with the interim Director of Nursing (DON/staff #13) on (MONTH) 20, (YEAR) at 2:12 p.m. He stated that he expects staff to document medications given and side effects, treatments done and monitoring of behaviors. He stated that holes in the medication and treatment records and on the behavioral monitoring records would mean there is no documentation that the item was assessed, or that the medication was given, or the treatment was done. He stated that incomplete documentation does not follow facility policy or his expectations. Review of the facility's policy on Charting and Documentation revealed the purpose is to provide a complete account of the resident's care, treatment and response to care, as well as the progress of the resident's care, and to provide guidance to the physician in prescribing appropriate medications and treatments and to provide a tool for measuring the quality of care provided to the resident. The policy included to document daily treatments and medications on the medication and treatment records.