STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035094	A. BUILDING _____ B. WING _____	**08/28/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HAVEN OF SEDONA	**505 JACKS CANYON ROAD SEDONA, AZ 86351**

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 3 residents (#2, #53 and #9) were free from physical abuse. The deficient practice could result in further incidents of resident to resident abuse. Findings include: -Resident #2 was admitted on (MONTH) 15, 2013, with [DIAGNOSES REDACTED]. A quarterly MDS (Minimum Data Set) assessment dated (MONTH) 7, 2019, revealed a Brief Interview for Mental Status (BIMS) score of 10 which indicated the resident had moderate impaired cognition. The assessment included the resident did not exhibit physical or verbal behavioral symptoms directed towards others. A care plan with a review date of (MONTH) 2019 revealed the resident has episodes of inappropriate behaviors as evidenced by dementia with behavioral disturbance, anxiety, [MEDICAL CONDITION], anger, combative and agitation. The goal was that the behavioral episodes would be reduced to less than daily. Interventions included monitoring for early warning signs of behavior, removing the resident from unwanted stimuli, and monitoring and charting behaviors every shift and reporting to the provider. Review of a psychiatric consultation/follow up note dated (MONTH) 26, 2019 revealed staff reported an increase in aggressive behaviors. The note included the resident had been striking out at staff, putting her feet on the table at lunch, and was difficult to redirect. A nursing progress note dated (MONTH) 17, 2019 revealed resident #2 was in her wheelchair in the hallway near the dining room when she started kicking another resident (#53) in the right lower leg. The other resident (#53) slapped resident #2 on the left arm. The note included resident #2 was removed from the area by the nurse and kept away from the other resident (#53). A nursing progress note dated (MONTH) 21, 2019 revealed the resident was pushing residents out of her way on the evening shift. Review of the behavioral monitoring flow sheet for (MONTH) 2019 revealed no combative, agitation, and/or crying behaviors were present. Regarding resident #53 -Resident #53 was admitted on (MONTH) 31, (YEAR) with [DIAGNOSES REDACTED]. The quarterly MDS assessment dated (MONTH) 16, 2019 revealed a BIMS score of 9 which indicated the resident had moderate impaired cognition. A nursing progress note dated (MONTH) 17, 2019 at 6:45 p.m. revealed resident #53 was talking with a nurse in the hallway when another resident (#2), who was sitting in the hallway in her wheelchair, started kicking resident #53 on the right lower leg. The note also revealed resident #53 started slapping the other resident (#2) on the left arm. The note included the nurse stepped between the two residents and that the other resident (#2) was removed from the area and kept away from resident #53. The note also included there were no injuries. Review of the facility investigative report dated (MONTH) 19, 2019 revealed that on (MONTH) 17, 2019 at 6:45 p.m. resident #53 was in the hallway by the main dining room speaking with the nurse (staff #6) when resident #2, who was also in the hallway in her wheelchair, kicked resident #53 on the right leg. Resident #53 then slapped resident #2 on the left arm. The note revealed staff #6 intervened after resident #2 landed a second kick to resident #53's right leg, and that resident #2 was removed from the area. There was no injury to either resident. Both residents were interviewed by the Director of Nursing (DON/staff #70) on (MONTH) 19, 2019. The report included resident #2 denied the incident ever took place. An interview was conducted on (MONTH) 25, 2019 at 1:39 p.m. with resident #53. She stated that resident #2 kicked her on her knee. Resident #53 stated that resident #2 should not be around the other residents because she is not safe. She said that her right knee still hurts where resident #2 kicked her. On (MONTH) 25, 2019 at 2:07 p.m., an interview was conducted with resident #2. Resident #2 stated, I didn't do anything. She said that I kicked her, but I didn't. I don't know what the problem is. People keep saying that I do these things, but I don't. An interview was conducted on (MONTH) 25, 2019 at 2:27 p.m. with the Registered Nurse (RN/staff #6). She confirmed that on (MONTH) 17, 2019 she had parked her medication cart outside of the dining room in the hallway. The RN said that as residents were exiting the dining room, resident #2 stopped her wheelchair in the hallway, against the wall opposite to the medication cart. Staff #6 said as resident #53 was leaving the dining room, resident #53 stopped at the medication cart to speak with her. She said at that point, resident #53 was standing in front of resident #2. The RN stated that it was at that time resident #2 kicked resident #53 in the right lower leg, around the knee area. She stated that resident #53 then slapped resident #2 on the left arm. The RN stated resident #2 then kicked resident #53 in the right lower leg a second time as she stepped between them. She stated that resident #2 was quickly removed from the situation, and that the two residents were kept apart for the rest of the evening. During an interview conducted on (MONTH) 27, 2019 at 9:23 a.m. with a Certified Nursing Assistant (CNA/staff #2), the CNA stated that resident #2 does not exhibit any warning signs that she may become combative. She said the resident usually acts out in the dining room. The CNA stated that recently, within the past few weeks, the resident had attempted to stab a CNA with her fork. She also stated that the resident hits others for no reason. On (MONTH) 27, 2019 at 1:33 p.m., an interview was conducted with the DON (staff #70). She stated that her expectation is that staff first intervene to keep the residents safe when there is a resident to resident altercation and then report the incident immediately to her or the administrator. She said she expects the nursing staff to immediately assess the residents, to notify the physician/obtain any new orders, and to notify the residents' families. The DON stated that if the residents are not able to be redirected, her expectation is for staff to call 911. She said that once residents are separated, there are no given timeframes to recheck the residents, but the expectation is to keep an eye on both residents.Regarding resident #9 -Resident #9 was admitted on (MONTH) 14, (YEAR), with [DIAGNOSES REDACTED]. A quarterly MDS assessment dated (MONTH) 18, 2019, included a BIMS score of 4 indicating the resident had severely impaired cognition. A nursing progress note dated (MONTH) 21, 2019 revealed resident #9 was hit by another resident (#2) on the arm while sitting in her chair. The note included a CNA intervened immediately.

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 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) Review of the facility reportable event record revealed that a resident to resident incident occurred on (MONTH) 21, 2019 at approximately 7:30 p.m. in the hallway. Resident #9 was in the hallway in the wheelchair as resident #2 was wheeling towards the dining room. Resident #2 attempted to push resident #9 out of her way. Staff intervened and moved resident #9 out of resident #2 path allowing resident #2 to proceed towards dining room area. Resident #2 was up near the dining room for a few minutes and came back down the hallway. As resident #2 got close to resident #9, resident #2 reached out and slapped resident #9 on the right arm. Staff intervened immediately and separated the residents. The report included resident #9 was assessed to have no injuries. During an interview conducted on at (MONTH) 26, 2019 at 1:21 p.m. with the RN (staff #6), the RN stated that if resident #2 gets too close to someone, she might kick them. She stated that resident #2 gets into an altercation every now and then. An interview was conducted on (MONTH) 26, 2019 at 1:56 p.m. with a CNA (staff #64). Staff #64 stated that on (MONTH) 21, 2019 at about 7:30 p.m., she was sitting at the nurses' station charting when she heard resident #2 shouting at resident #9 using inappropriate language. The CNA stated that she came out of the nurses' station and saw resident #2 slapping resident #9 on her right arm. The CNA stated that she immediately separated the residents and took resident #2 to her room and resident #9 to her room. She stated the nurse who was also at the nurses' station was notified immediately of the incident. The CNA stated that these types of incidents involving resident #2 happens often, 2 - 3 times a week, and that it is usually in the evening. She stated that she does not know what triggers the incidents. The CNA also stated that if she observes that resident #2 is agitated, she will remove resident #2 from the situation. In an interview conducted on (MONTH) 26, 2019 at 2:16 p.m. with a CNA (staff #61), the CNA stated that on (MONTH) 21, 2019 at about 7:30 p.m. she was in the kitchenette in the nurses' station when she heard yelling. She stated that she came out of the kitchenette and observed resident #9 laughing and heard resident #2 tell resident #9 to get out of the way. The CNA stated resident #9 was in the way, but that resident #2 could have gone around resident #9. She stated that she saw resident #2 slap resident #9 a couple of times on her right arm. She stated staff #64 separated the residents. The CNA stated that when she checked on resident #9, resident #9 stated that her arm hurts and that she told resident #9 that she would let the nurse know. She said that resident #2 is usually kind and nice but that night resident #2 was complaining about dinner and had stated that she wouldn't give it to her dog and it was disgusting. An interview was conducted on at (MONTH) 27, 2019 at 2:15 p.m. with a RN (staff #21). Staff #21 stated that she was the nurse taking care of resident #9 and resident #2 when the altercation happened on (MONTH) 21, 2019 at about 7:30 p.m. The RN stated that she did not observe the incident but that a CNA reported the incident to her. She stated that she conducted a skin check and did not observe any bruising or redness. The RN also stated resident #2 was angry that night when she was in the dining room and did not want to eat but that a CNA calmed her down. She further stated that resident #2 is aggressive towards staff and other residents. The RN stated that once they document behavior monitoring at the beginning of their shift, they do not document behavior monitoring again even if there are incidents or behaviors that occur afterwards. Review of the facility's Abuse policy revealed the facility strives to prevent the abuse of all their residents but that due to the proximity of their residents one to another, situations may arise where they are not able to prevent all incidents of abuse. The policy included their objective is to provide a safe haven for their residents through preventative measures that protect every resident's right to be free from abuse. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. The policy also revealed abuse includes verbal abuse, sexual abuse, mental abuse, and physical abuse and potential abusers can be residents.
F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility documentation, clinical record review, staff interviews, and policy review, the facility failed to implement their policy regarding reporting and investigating allegations of abuse for three residents (#2, #53 and #9). The deficient practice could result in further abuse investigations not being thoroughly completed and delays in notifying the State Survey Agency regarding allegations of abuse. Findings include: -Resident #2 was admitted on (MONTH) 15, 2013, with [DIAGNOSES REDACTED]. -Resident #53 was admitted on (MONTH) 31, (YEAR) with [DIAGNOSES REDACTED]. Review of the facility investigative report dated (MONTH) 19, 2019 revealed that on (MONTH) 17, 2019 at 6:45 p.m. resident #53 was in the hallway by the main dining room speaking with the nurse (staff #6) when resident #2, who was also in the hallway in her wheelchair, kicked resident #53 on the right leg. Resident #53 then slapped resident #2 on the left arm. The note revealed staff #6 intervened after resident #2 landed a second kick to resident #53's right leg, and that resident #2 was removed from the area. There was no injury to either resident. Both residents were interviewed by the Director of Nursing (DON/staff #70) on (MONTH) 19, 2019. The report also included a written statement from staff #6. However, review of the State data system revealed the incident was not reported to the State Survey Agency until (MONTH) 19, 2019 at 11:27 a.m. and there was no evidence other residents or staff members were interviewed during the investigation. An interview was conducted on (MONTH) 26, 2019 at 1:21 p.m. with the Registered Nurse (RN/staff #6). The RN stated that she did not view the incident between resident #2 and #53 as dangerous or intentional, so she did not report the incident to administration. During an interview conducted with the DON (staff #70) on (MONTH) 26, 2019 at 2:04 p.m., the DON stated that she interviewed resident #2, resident #53, and staff #6. She stated other residents were not interviewed. The DON said the social worker should have interviewed other individuals, but she did not. The DON also stated that she spoke to staff #6 regarding her failure to report the incident. -Resident #9 was admitted on (MONTH) 14, (YEAR), with [DIAGNOSES REDACTED]. Review of the facility reportable event record revealed that a resident to resident incident occurred on (MONTH) 21, 2019 at approximately 7:30 p.m. in the hallway. Resident #9 was in the hallway in the wheelchair as resident #2 was wheeling towards the dining room. Resident #2 attempted to push resident #9 out of her way. Staff intervened and moved resident #9 out of resident #2 path allowing resident #2 to proceed towards dining room area. Resident #2 was up near the dining room for a few minutes and came back down the hallway. As resident #2 got close to resident #9, resident #2 reached out and slapped resident #9 on the right arm. Staff intervened immediately and separated the residents. Resident #9 was assessed to have no injuries. The report included a statement from two Certified Nursing Assistants (staff #61 and staff #64). However, there was no documented evidence that interviews were conducted with resident #2, resident #9, or other residents. In an interview conducted on (MONTH) 26, 2019 at 11:05 a.m. with the DON (staff #70), the DON stated she did not interview resident #9 because she is cognitively impaired. She stated that since resident #2 refused to admit she hit a resident in an incident that happened on (MONTH) 17, 2019, she did not interview her. She stated that she did not interview any other residents to determine if resident #2 was aggressive towards other residents. The DON also stated that she had not heard about resident #2 being aggressive or mean to other residents so she did not feel it was necessary to interview other residents. Another interview was conducted on (MONTH) 27, 2019 at 1:33 p.m. with the DON (staff #70). The DON stated that they have 2 hours to report an allegation of abuse to the State Agency. She stated the Administrator, DON, or Assistant DON will direct the investigation. The DON stated that during a resident to resident altercation investigation, the residents involved are interviewed as well as other residents to rule out a trend of potential abuse from the aggressor. She stated that any staff that witnessed the incident would be interviewed. She stated she should have interviewed other residents but that she did not. The facility's policy regarding Abuse revealed if abuse is witnessed or suspected, reporting and investigation will take place. The Administrator will be notified and the Administrator and the witness reporting the incident will notify the State Agency. Suspected abuse will be reported in accordance with timeframes and standards required by CMS (Center for Medicare and Medicaid Services). The Administrator will begin investigation immediately. A minimum of three residents will be interviewed in order to determine if there is a trend. The policy included staff members will document their own statements and sign and date the bottom of the statement.
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.**

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F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) Based on facility documentation, staff interviews, and policy review, the facility failed to ensure an allegation of abuse was reported within the required timeframe for two residents (#2 and #53). The deficient practice could result in additional allegations of abuse not being reported timely to the State Survey Agency. Findings include: Review of the facility investigative report dated (MONTH) 19, 2019 revealed that on (MONTH) 17, 2019 at 6:45 p.m. resident #53 was in the hallway by the main dining room speaking with the nurse (staff #6) when resident #2, who was also in the hallway in her wheelchair, kicked resident #53 on the right leg. Resident #53 then slapped resident #2 on the left arm. The note revealed staff #6 intervened after resident #2 landed a second kick to resident #53's right leg, and that resident #2 was removed from the area. There was no injury to either resident. However, review of the State data system revealed the incident was not reported to the State Survey Agency until (MONTH) 19, 2019 at 11:27 a.m. An interview was conducted on (MONTH) 26, 2019 at 1:21 p.m. with the Registered Nurse (RN/staff #6). The RN stated that she did not view the incident between resident #2 and #53 as dangerous or intentional, so she did not report the incident to administration. During an interview conducted with the DON (staff #70) on (MONTH) 26, 2019 at 2:04 p.m., the DON stated that she spoke to staff #6 regarding her failure to report the incident. Another interview was conducted on (MONTH) 27, 2019 at 1:33 p.m. with the DON (staff #70). The DON stated that they have 2 hours to report an allegation of abuse to the State Agency. The facility's policy regarding Abuse revealed if abuse is witnessed or suspected, reporting will take place. The Administrator will be notified and the Administrator and the witness reporting the incident will notify the State Agency. The policy also revealed suspected abuse will be reported in accordance with timeframes and standards required by CMS (Centers for Medicare and Medicaid Services).
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** Based on facility documentation, staff interviews, and facility policy, the facility failed to ensure allegations of abuse were thoroughly investigated for 3 residents (#2, #53, and #9). The deficient practice could result in additional allegations of abuse not being thoroughly completed. Findings include: -Review of the facility investigative report dated (MONTH) 19, 2019 revealed that on (MONTH) 17, 2019 at 6:45 p.m. resident #53 was in the hallway by the main dining room speaking with the nurse (staff #6) when resident #2, who was also in the hallway in her wheelchair, kicked resident #53 on the right leg. Resident #53 then slapped resident #2 on the left arm. The note revealed staff #6 intervened after resident #2 landed a second kick to resident #53's right leg, and that resident #2 was removed from the area. There was no injury to either resident. Both residents were interviewed by the Director of Nursing (DON/staff #70) on (MONTH) 19, 2019. The report also included a written statement from staff #6. However, there was no evidence other residents or staff members were interviewed during the investigation. During an interview conducted with the DON (staff #70) on (MONTH) 26, 2019 at 2:04 p.m., the DON stated that she interviewed resident #2, resident #53, and staff #6. She stated other residents were not interviewed. The DON said the social worker should have interviewed other individuals, but she did not. -Review of the facility reportable event record revealed that a resident to resident incident occurred on (MONTH) 21, 2019 at approximately 7:30 p.m. in the hallway. Resident #9 was in the hallway in the wheelchair as resident #2 was wheeling towards the dining room. Resident #2 attempted to push resident #9 out of her way. Staff intervened and moved resident #9 out of resident #2 path allowing resident #2 to proceed towards dining room area. Resident #2 was up near the dining room for a few minutes and came back down the hallway. As resident #2 got close to resident #9, resident #2 reached out and slapped resident #9 on the right arm. Staff intervened immediately and separated the residents. Resident #9 was assessed to have no injuries. The report included a statement from two Certified Nursing Assistants (staff #61 and staff #64). However, there was no documented evidence that interviews were conducted with resident #2, resident #9, or other residents. In an interview conducted on (MONTH) 26, 2019 at 11:05 a.m. with the DON (staff #70), the DON stated she did not interview resident #9 because she is cognitively impaired. She stated that since resident #2 refused to admit she hit a resident in an incident that happened on (MONTH) 17, 2019, she did not interview her. She stated that she did not interview any other residents to determine if resident #2 was aggressive towards other residents. The DON also stated that she had not heard about resident #2 being aggressive or mean to other residents so she did not feel it was necessary to interview other residents. Another interview was conducted on (MONTH) 27, 2019 at 1:33 p.m. with the DON (staff #70). The DON stated the Administrator, DON, or Assistant DON will direct the investigation. The DON stated that during a resident to resident altercation investigation, the residents involved are interviewed as well as other residents to rule out a trend of potential abuse from the aggressor. She stated that any staff that witnessed the incident would be interviewed. She stated she should have interviewed other residents but that she did not. The facility's policy regarding Abuse revealed if abuse is witnessed or suspected, investigation will take place. The Administrator will begin investigation immediately. A minimum of three residents will be interviewed in order to determine if there is a trend. The policy included staff members will document their own statements and sign and date the bottom of the statement.
F 0640 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.** Based on clinical record review, facility documentation, staff interviews, policy review and the Resident Assessment Instrument (RAI) Manual, the facility failed to ensure Minimum Data Set (MDS) assessments were transmitted to the Centers for Medicare and Medicaid Services (CMS) within 14 days of completion for 6 residents (#1, #2, #3, #4, #5, and #25). The deficient practice could result in delays in receiving resident specific information related to quality measure purposes. Findings include: -Resident #1 was admitted to the facility on (MONTH) 26, (YEAR). Review of the clinical record revealed a quarterly MDS assessment dated (MONTH) 6, 2019 with a completion date of (MONTH) 13, 2019. However, review the facility's CMS Submission Report revealed the assessment was not transmitted to CMS until (MONTH) 27, 2019 and included it was submitted late. -Resident #2 was admitted to the facility on (MONTH) 15, 2013. Review of the quarterly MDS assessment dated (MONTH) 7, 2019 revealed a completion date of (MONTH) 11, 2019. However, review of the facility's CMS Submission Report revealed the assessment was not transmitted to CMS until (MONTH) 27, 2019 and included it was submitted late. -Resident #3 was admitted to the facility on (MONTH) 15, (YEAR). Review of the clinical record revealed a quarterly MDS assessment dated (MONTH) 24, 2019 with a completion date of (MONTH) 1, 2019. Review of the facility's CMS Submission Report revealed the assessment was not transmitted to CMS until (MONTH) 27, 2019 and included it was submitted late. -Resident #4 was admitted to the facility on (MONTH) 12, 2013. Review of the quarterly MDS assessment dated (MONTH) 23, 2019 revealed a completion date of (MONTH) 1, 2019. Review of the facility's CMS Submission Report revealed the assessment was not transmitted to CMS until (MONTH) 27, 2019 and included it was submitted late.

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F 0640 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) -Resident #5 was admitted to the facility on (MONTH) 14, (YEAR). Review of a quarterly MDS assessment dated (MONTH) 22, 2019 revealed a completion date of (MONTH) 28, 2019. Review of the facility's CMS Submission Report revealed the assessment was not transmitted to CMS until (MONTH) 27, 2019 and included the assessment was submitted late. -Resident #25 was admitted to the facility on (MONTH) 26, (YEAR). Review of the clinical record revealed a significant change in status MDS assessment dated (MONTH) 3, 2019. The care plan completion date was (MONTH) 17, 2019. Review of the facility's CMS Submission Report revealed the assessment was not transmitted to CMS until (MONTH) 28, 2019 and included it was submitted late. During an interview conducted with the MDS coordinator on (MONTH) 27, 2019 at 1:00 p.m., she stated that she was unable to find the MDS assessment validation reports for residents #1, #2, #3, #4, #5, and #25. During an interview conducted with the Administrator (staff #86) on (MONTH) 27, 2019 at 1:22 p.m., he provided the facility's submission reports for residents #1, #2, #3, #4, #5, and #25. However, the report did not reveal whether the MDS assessments were transmitted, accepted or rejected by the CMS system. An interview was conducted with the Assistant Director of Nursing (ADON/staff #53) on (MONTH) 28, 2019 at 8:18 a.m. She stated that batches/assessments had been created in the system on (MONTH) 14, 2019 and (MONTH) 1, 2019 for the MDS assessments for residents #1, #2, #3, #4, and #5, but that the batches/assessments had not been transmitted to the CMS system as required. The ADON stated that the assessment for resident #25 was transmitted but had been rejected with a fatal error. She stated that they did not notice the rejection and did not resubmit the assessment. The ADON stated that they did not transmit the assessments with the required time frame. She stated that they follow the RAI manual for direction and clarification when completing the MDS assessments. The facility's policy regarding MDS completion and submission timeframes revealed that the facility will conduct and submit resident assessments in accordance with current Federal and State submission timeframes. The policy included that the assessment coordinator or designee is responsible for ensuring resident assessments are submitted to the CMS system in accordance with current Federal and State guidelines. The policy stated that timeframes for completion and submission of assessments is based on the current requirements published in the RAI Manual. The RAI manual dated (MONTH) (YEAR) revealed a quarterly MDS assessment transmission date is to be no later than the MDS completion date (Z0500B) plus 14 calendar days. The manual also revealed a significant change in status MDS assessment transmission date is to be no later than the care plan completion date (V0200C2) plus 14 calendar days.
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 observations, clinical record review, facility documentation, staff interviews, and policy and procedures, the facility failed to ensure that care and services were provided according to accepted standards of practices for one resident (#26) who sustained a burn. The deficient practice could result in delayed assessment and treatment of [REDACTED]. Findings include: Resident #26 was admitted to the facility on (MONTH) 20, (YEAR), with [DIAGNOSES REDACTED]. A provider's progress note dated (MONTH) 4, (YEAR) revealed the resident was very debilitated from progressive [MEDICAL CONDITION] to the point where he is wheelchair bound and dependent on others for the majority of Activities of Daily Living (ADL), due to severe joint deformities, contractures, weakness, and muscle wasting. The note included the resident had joint pain to bilateral shoulders, elbows, wrists and fingers, had major motor weakness and generalized intermittent muscle spasms. The note also included the resident had decreased ROM to bilateral shoulders, elbows and wrists, and had bilateral upper extremity weakness. A provider's progress note dated (MONTH) 11, 2019 revealed the resident had significant, longstanding [MEDICAL CONDITION] arthritis (RA) and had joint pain to bilateral shoulders, elbows, wrists and fingers, and chronic RA changes about the hands with swan neck deformity of the fingers, and z deformity of the left thumb, wrists, elbows and shoulders. The note further included the resident had swelling of bilateral wrists and had bilateral upper extremity weakness. Review of an Interdisciplinary Team (IDT) note dated (MONTH) 20, 2019 revealed the resident had jerking movements to the upper body at times and had bilateral hand deformities from arthritis. Review of a quarterly Minimum Data Set (MDS) assessment dated (MONTH) 30, 2019, revealed a Brief Interview for Mental Status score of 13, which indicated the resident had intact cognition. The MDS included the resident required extensive assist with eating and drinking, and had functional limitation in ROM to bilateral upper and lower extremities. An observation was conducted on (MONTH) 25, 2019 at 11:58 a.m. of the resident sitting in his wheelchair in the hall near the nurses' station. The resident was observed to have spastic movements bilaterally to the upper and lower extremities and the residents hands were contracted. At this time, a Certified Nursing Assistant (CNA) approached the resident with a cup of coffee (which was in a plastic coffee cup with a single handle and no lid) and placed the cup of coffee on the bedside table next to the resident and stated, Be careful, it's hot. The resident then picked up the cup of coffee and as he brought the cup to his lips, he quickly jerked it away and some of the coffee spilled on the front of his torso/lap area. The resident's hands jerked again and the majority of the coffee spilled on his lap. The resident then made a moaning noise and exhibited uncontrollable, spastic movements of all extremities. The CNA told the resident that she would help him change out of his wet clothes and took him to his room immediately. A nursing progress note dated (MONTH) 25, 2019 a.m. was marked as a late entry, however, the actual date and time that this note was written was not documented. The note included that after lunch, the resident was in the wheelchair near the nurses station begging for coffee, and the CNA gave him coffee with supervision. The CNA placed the coffee on the table beside the resident and he knocked the coffee off the table and onto his leg, making a red mark on his leg. The resident denied pain, but ice was applied to the area immediately. Another nursing progress note dated (MONTH) 25, 2019 eve included the CNA discovered the resident had a blister and assumed that someone had given him hot coffee and had burned himself. Per the note, the resident had a blister which was about 4 centimeters (cm) long and 2 cm wide. The note included that the night nurse cleaned and applied a dressing to ensure the wound stayed clear from contamination and from sudden movements from the resident. Review of the clinical record including the nurses notes for (MONTH) 25, 2019, revealed there was no documentation that the provider was notified regarding the red area on the resident's leg from the hot coffee. A nursing progress note dated (MONTH) 26, 2019 at 1:00 a.m. revealed the resident had a blister, which measured 8 cm by 11 cm, and the area was covered with a 4 x 4 dressing for protection. A nursing progress note dated (MONTH) 26, 2019 at 5:00 a.m. revealed the resident stated that he spilled coffee yesterday morning and had no complaints of pain. A nursing progress note dated (MONTH) 26, 2019 at 7:20 a.m. revealed the Nurse Practitioner (NP) was notified at 7:20 a.m. This was the first documentation that the physician/NP had been notified since the burn occurred on (MONTH) 25 at 11:58 a.m.A nursing progress note dated (MONTH) 26, 2019 at 7:30 a.m. revealed that a call was placed to the hospice provider. A wound observation was conducted on (MONTH) 26, 2019 at 9:22 a.m. with a Registered Nurse (RN/staff #8) and a CNA (staff #51). A dressing was observed to be in place on the resident's left thigh. Staff #51 stated that the dressing was where the resident dropped coffee on himself on (MONTH) 25. Staff #8 removed the dressing and there was a reddened area of irregular shape which measured 10 cm by 9 cm, with two raised fluid filled blisters. The larger blister was draining clear fluid. Staff #8 said the wound was from a burn and that the provider would be coming in pretty soon to assess the burn for treatment. A nursing progress note dated (MONTH) 26, 2019 at 10:20 a.m. revealed the left upper thigh has a pink/red large area with two blisters. The documentation included the resident spilled hot coffee on his thigh yesterday p.m. and would talk to the provider to assess the wound and to write orders for treatment. According to the Weekly Wound Measurement/Condition Report dated (MONTH) 26, 2019, the resident had a left thigh burn that was 11 cm long by 8 cm wide, with a superficial depth. The documentation included there were two draining blisters and that the wound was new. A physician's orders [REDACTED]. The order included for [MEDICATION NAME] cream to the left thigh burn daily until resolved. Review of the incident report dated (MONTH) 26, 2019 revealed that on (MONTH) 25, 2019 at 12:30 p.m., the resident was at

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(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	(continued... from page 4) the nurses station in his wheelchair after lunch begging for coffee. The CNA gave the resident a cup of coffee and put it on the side table near him. When the resident went to get it, he spilled it on his left leg. The report included the resident had a light red area to the left anterior thigh, with no blistering or pain and that an ice pack was applied. The report also documented that the medical doctor was notified in the a.m. A care plan dated (MONTH) 26, 2019 identified the resident had a burn to the left thigh. The goal was for the injury to resolve within 28 days. The approaches included to notify the medical doctor and responsible party of skin injury and report any changes; wound evaluation by medical doctor or nurse practitioner; observe for signs and symptoms of infection or complications to injury area; treatment to area as ordered, monitor for effectiveness of treatment; pain assessment and management as needed; and to provide education to resident/family. A provider progress note dated (MONTH) 27, 2019 included the visit was to evaluate a skin change to the left lateral/upper thigh. The noted included there was no overt signs of infection and to refer to the nursing notes for full measurements. The documentation included the resident had a wound disruption and there was no severe harm. An interview was conducted with a CNA (staff #51) on (MONTH) 26, 2019 at 1:06 p.m. She stated that on (MONTH) 25, 2019 around 12:45 p.m., the resident asked for coffee which she provided. She stated the resident spilled the coffee on himself while she was with him. She stated that she and another CNA (staff #19) took him to his room and cleaned him up and there was no redness noted at that time. She said that staff #19 went in after and noted that the area was getting red, so they notified the nurse (RN/staff #6) and the nurse told staff #19 to put ice on the burn. An interview was conducted with a CNA (staff #19) who stated that on (MONTH) 25, 2019, the resident had called about 15 minutes after she and CNA (staff #51) cleaned him up from spilling the coffee, and asked for the nurse. She stated that she noticed a red area from the coffee spill and reported it to the nurse. She stated the nurse told her to put an ice pack on the area. She stated that around 6:00 p.m. on (MONTH) 25, she noticed that the area had a small blister, so she reported it to the nurse (RN/staff #21). An interview was conducted with a RN (staff #6) on (MONTH) 26, 2019 at 1:59 p.m. She stated that she believed the resident spilled the coffee on himself around 12:30 p.m. on (MONTH) 25, 2019. She stated the CNA's had notified her that the resident had a red area from the coffee spill. She said that she looked at it and it was light red and ice was put on it. She said the resident denied having pain. She stated that she did not think that she documented anything at that time and was going to follow up and see if the redness was still there. She stated that she had planned to start a change of condition form on her shift if the redness continued but she did not. She stated that she believed that she had reported to the oncoming nurse (RN/staff #21) that the resident had spilled coffee on himself and had some redness, but she was not sure if she told the oncoming nurse about the burn in report. She stated that she knew the CNA's were following up on the area and were going to let her know if there were any changes, as well as keep the ice pack on the area. She stated that she worked on the unit with resident #26 until 2:30 p.m. on (MONTH) 25, 2019 and did not notify the physician. An interview was conducted with a RN (staff #21) on (MONTH) 26, 2019 at 2:14 p.m. , who worked the 2pm-10pm shift on (MONTH) 25. She stated that she did not get the information in report on (MONTH) 25, by the previous nurse (staff #6) that the resident had spilled coffee on himself and had a burn. She stated that one of the CNA's told her that the resident had blisters on his skin around 8:30 to 9:00 p.m. on (MONTH) 25, 2019. She stated that she had 30 residents so she was unable to look at the area, until the next nurse came in for change of shift (on the night shift). She stated that she and the oncoming night nurse went together to assess the burn on resident #26. She stated the wound was blistered and she did not know that the burn was at that level until that time. She said it was worse than what she understood it to be. She said that she assumed the burn was caused by hot liquid, because he spills everything. She said the resident was sleepy and did not say what had caused the burn. She stated that she documented what happened but did not make any notifications to the physician/provider, because her shift was over and the oncoming night nurse was going to do the incident report. An interview was conducted with the Assistant Director of Nursing (ADON/staff #53) on (MONTH) 27, 2019 at 11:04 a.m. She stated that when an accident occurs with a resident, the CNA should notify the nurse, the nurse should assess the resident, put the resident on change of condition charting, fill out an incident report, and notify the provider and hospice on that shift, per their policy even if there were no signs or symptoms of an injury. She stated that once the incident report was done and change of condition charting was started, the resident should be assessed and charted on each shift and that the incident should be reported to the oncoming nurse at shift change. She said the aftercare following the incident did not meet her expectations, as the nurse working at the time of the incident did not put the resident on change of condition charting, did not report the incident to the oncoming nurse and did not call the practitioner. She said that when the CNA reported to the nurse that a blister had developed, that nurse should have called the practitioner and obtained orders. She said if the change of condition charting would have been initiated and a treatment put into place, the area may not have developed further injury/blistering. She stated that staff did not follow expectations or facility policy related to change of condition requirements following an accident. Review of the policy for a Change in a Resident's Condition of Status revealed the facility shall promptly notify the resident, his/her attending physician, and resident representative of changes in the resident's medical/mental conditions and/or status. The policy included that the nurse shall notify the resident's attending physician or physician on call, when there has been an accident involving the resident. The policy stated that prior to notifying the physician or health care provider; the nurse will make detailed observations and gather relevant and pertinent information for the provider. Review of the policy for Investigating Injuries revealed the Director of Nursing services or designee will assess all injuries and document clinical findings in the clinical record. The policy included the nursing staff shall discuss the situation with the attending physician or medical director.
F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	**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, facility documentation, staff and resident interviews and policy and procedures, the facility failed to identify individual risks factors and implement interventions and provide assistive devices and adequate staff assistance to prevent an accident for one resident (#26). The deficient practice could result in further accidents and injuries to residents. Findings include: Resident #26 was admitted to the facility on (MONTH) 20, (YEAR), with [DIAGNOSES REDACTED]. A provider's progress note dated (MONTH) 4, (YEAR) revealed the resident was very debilitated from progressive [MEDICAL CONDITION] to the point where he is wheelchair bound and dependent on others for the majority of Activities of Daily Living (ADL), due to severe joint deformities, contractures, weakness, and muscle wasting. The note included the resident had joint pain to bilateral shoulders, elbows, wrists and fingers, had major motor weakness and generalized intermittent muscle spasms. The note also included the resident had decreased ROM to bilateral shoulders, elbows and wrists, and had bilateral upper extremity weakness. Review of an Activities of Daily Living (ADL) care plan revealed the resident required assistance with ADL's related to the following: [MEDICAL CONDITIONS], anxiety, [MEDICAL CONDITION], contractures of extremities, palsy, extensive sarcopenia, chronic contractures, pseudo [MEDICAL CONDITION], spastic and history of encephalitis. An intervention was to assist with ADL's as needed. A provider's progress note dated (MONTH) 11, 2019 revealed the resident had significant, longstanding [MEDICAL CONDITION] arthritis (RA) and had joint pain to bilateral shoulders, elbows, wrists and fingers, and chronic RA changes about the hands with swan neck deformity of the fingers, and z deformity of the left thumb, wrists, elbows and shoulders. The note further included the resident had swelling of bilateral wrists and had bilateral upper extremity weakness. Review of an Interdisciplinary Team (IDT) note dated (MONTH) 20, 2019 revealed the resident had jerking movements to the upper body at times and had bilateral hand deformities from arthritis. A provider's progress note dated (MONTH) 17, 2019 revealed the resident had joint pain, stiffness to fingers bilaterally and had tremors. A provider's progress note dated (MONTH) 25, 2019 revealed the resident had [MEDICAL CONDITION] joint contractures, had

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F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 5) [MEDICAL CONDITION] joint changes and was pseudo-quadriplegic and spastic. Review of a quarterly Minimum Data Set (MDS) assessment dated (MONTH) 30, 2019, revealed a Brief Interview for Mental Status score of 13, which indicated the resident had intact cognition. The MDS included the resident required extensive assist with eating and drinking, and had functional limitation in ROM to bilateral upper and lower extremities. A care plan dated (MONTH) 2019 included the resident was on a therapeutic or altered consistency diet. The care plan also included the resident had motor agitation/restlessness with a goal that the resident would be free of injury. The care plan further included to utilize double handled cups for increased ADL independence. A provider's progress note dated (MONTH) 19, 2019 revealed the resident had severe global muscle wasting/atrophy, as well as abnormal ROM with contractures present to the bilateral shoulders, elbows and wrists. Despite clinical record documentation that the resident had [MEDICAL CONDITION] joint contractures to the hands, pseudo-quadriplegic and spastic movements, motor agitation/restlessness, major motor weakness, generalized intermittent muscle spasms, stiffness to fingers bilaterally and tremors and jerking movements to the upper body at times, there was no documentation that the resident had been assessed for safety risks related to drinking hot liquids. Review of the physician's orders [REDACTED]. Further review of the clinical record revealed no documentation of the resident using a covered sippy cup, nor any documentation that the resident had refused to use a covered sippy cup. An observation was conducted on (MONTH) 25, 2019 at 11:58 a.m. of the resident sitting in his wheelchair in the hall near the nurses' station. The resident was observed to have spastic movements bilaterally to the upper and lower extremities and the residents hands were contracted. At this time, a Certified Nursing Assistant (CNA) approached the resident with a cup of coffee (which was in a plastic coffee cup with a single handle and no lid) and placed the cup of coffee on the bedside table next to the resident and stated, Be careful, it's hot. The CNA was not observed to assist the resident with the cup of coffee. The resident then picked up the cup of coffee and as he brought the cup to his lips, he quickly jerked it away and some of the coffee spilled on the front of his torso/lap area. The resident's hands jerked again and the majority of the coffee spilled on his lap. The resident then made a moaning noise and exhibited uncontrollable, spastic movements of all extremities. The CNA told the resident that she would help him change out of his wet clothes and took him to his room immediately. Review of the nursing progress notes revealed a note dated (MONTH) 25, 2019 a.m. which was marked as a late entry. However, the actual date and time that this progress note was written was not included. The note stated that after lunch the resident was in the wheelchair near the nurses station begging for coffee, and the CNA gave him coffee with supervision. The CNA placed the coffee on the table beside the resident and he knocked the coffee off the table and onto his leg, making a red mark on his leg. The note included the CNA placed the resident into bed and called the nurse to look at his leg and ice was applied to the area immediately. An interview with the resident was conducted on (MONTH) 25, 2019 at 1:08 p.m. Resident #26 stated stated that he spilled coffee on himself and was having some pain to the affected area. At this time, the resident was observed to have bilateral hand malformations/hyperextension especially of the fingers and wrists. The resident was observed to have uncontrolled spastic movements to the upper extremities when using a washcloth to wipe his face, however, there was no [DIAGNOSES REDACTED] at rest. An observation of the resident was conducted on (MONTH) 25, 2019 at 2:03 p.m. The resident was observed independently drinking ice water in the hallway, by holding a cup between his upper palms and maneuvering the cup to his lips. The resident was observed to have [DIAGNOSES REDACTED] movement to the upper extremities on purposeful movement, but not at rest. As the resident drank the water, his hands jerked in a spastic manner and a small amount of water spilled onto the front of his clothing. A nursing progress note dated (MONTH) 26, 2019 at 1:00 a.m. revealed the resident had a blister which measured 8 cm by 11 cm, and the area was covered with a 4 x 4 dressing for protection. A nursing progress note dated (MONTH) 26, 2019 at 5:00 a.m. revealed the resident stated that he spilled coffee yesterday morning and had no complaints of pain. A wound care observation was conducted on (MONTH) 26, 2019 at 9:22 a.m., with a Registered Nurse (wound nurse/staff #8) and a CNA (staff #51). The resident had a dressing in place to the left thigh, which was dated (MONTH) 25, 2019. The CNA (staff #51) stated the dressing was covering the area where the resident dropped coffee on himself. Staff #8 removed the dressing and there was a reddened area of irregular shape which measured 10 cm by 9 cm., with two raised blisters. The larger blister was draining clear fluid. Staff #8 said the wound was from a burn. An observation of the resident was conducted on (MONTH) 26, 2019 at 9:32 a.m. The resident continued to have spastic movements to the upper extremities with purposeful movement, but no [DIAGNOSES REDACTED] was noted at rest. A nursing progress note dated (MONTH) 26, 2019 at 10:20 a.m. revealed documentation that the left upper thigh has pink/red large area with two blisters, larger blister is draining clear water. Per the note, the resident spilled hot coffee on his thigh yesterday p.m., and would talk to the provider to assess the wound and write orders for treatment. Review of the Weekly Wound Measurement/Condition Report dated (MONTH) 26, 2019 revealed the left thigh burn was 11 cm long by 8 cm wide with superficial depth. The documentation included there were two draining blisters and the wound was new. A physician's orders [REDACTED]. The order also included for a sippy cup to be used with any warm beverages, with supervision. According to the incident report dated (MONTH) 26, 2019, the resident was at the nurses station begging for coffee after lunch on (MONTH) 25, 2019. The CNA gave the resident a cup of coffee and put it on the side table near him. When the resident went to get it, he spilled it on his left leg. The report included the resident had a light red area to the left anterior thigh, with no blistering on skin, no pain and an ice pack was applied. An interview was conducted with the wound care nurse (staff #8) on (MONTH) 26, 2019 at 9:55 a.m. She stated the area on the left thigh was a burn and the provider was coming in that day to assess the burn for treatment. She stated that she was not aware of any past burn injuries for this resident. On (MONTH) 26, 2019 at 10:07 a.m., this surveyor was informed by a CNA (staff #51) that the coffee that resulted in the resident's burn on (MONTH) 25, was obtained from the coffee machine on the kitchenette on the East unit nurses station. The surveyor then obtained hot water from this same coffee machine, as the coffee carafe was empty at this time. The temperature reading was 168 degrees Fahrenheit (F). An observation was conducted on (MONTH) 26, 2019 at 11:55 a.m. of staff #87 (clinical support staff)obtaining a temperature of the coffee which was poured from the coffee machine carafe in the East unit nursing station kitchenette. Staff #87 stated the coffee temperature was 174.5 degrees F. Shortly following the observation she was heard to say that the coffee from the East Unit kitchenette was too warm and a CNA was notified not to use the machine. An interview was conducted with a CNA (staff #19) on (MONTH) 26, 2019 at 1:01 p.m. She stated that she has newly been told to use a sippy cup with resident #26. She stated that he spills ice water on himself a lot of the time related to his uncontrollable movements. She stated they tried sippy cups in the past for him, but that he hates them. She said this was the first time that she heard of him spilling coffee. An interview was conducted with a CNA (staff #51) on (MONTH) 26, 2019 at 1:06 p.m. She stated that on (MONTH) 25, 2019, resident #26 asked her for some coffee. She stated that she gave him a cup, but he said it was too cold and wanted fresh coffee. She said that she brewed a fresh pot of coffee and brought it to him approximately 10-15 minutes after it was made. She said that she placed the coffee on the bed side table and knelt to eye level in front of him to tell him to be careful, because the coffee was very hot. She said that as she was standing back up, he spilled the coffee on himself. She stated they had tried sippy cups with lids, but he refused to use them and wanted his coffee in a regular coffee cup. She stated it is rare for him to spill fluids and that she has never known him to spill coffee on himself. She stated that he has altered movements in his hands and arms and would guess them to be uncontrollable movements. An interview was conducted with a registered nurse (staff #21) on (MONTH) 26, 2019 at 2:14 p.m. She stated the resident is always asking for water or coffee and that he spills everything. She stated that she has tried to give him straws, but he just throws them out. She said that he has only spilled cold water when she has cared for him and this is the first time he has gotten burned. She stated that once in a while he has spastic/uncontrolled movements, which improve with [MEDICATION NAME] use. When questioned regarding the resident spilling fluids on himself and the possibility of getting burned, she replied that she did not think about that because she only gives him cold fluids.

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F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 6) An interview with the resident was conducted on (MONTH) 27, 2019 at 8:37 a.m. He stated that he had a big burn on his leg and that it was hurting worse today. During the interview, the resident was observed to have spastic movements to the upper extremities with purposeful movement, but no [DIAGNOSES REDACTED] at rest. Another interview was conducted with resident #26 on (MONTH) 27, 2019 at 10:25 a.m. He stated that sometimes he spills drinks, but has never spilled anything hot on himself before. He stated that staff has tried to serve coffee to him in a cup with a lid, but he did not like it and wanted it in a coffee cup. He stated that staff had not educated him on the risks of burning himself and did not think it would ever happen. He stated that if he were to drink coffee now, he would drink it in a cup with a lid. He said that he will not be drinking coffee anymore, because he is afraid that he will burn himself again. He stated that his leg was burning and that he had a pain level of 8 out of 10, but had not asked for more pain medication yet. An interview was conducted with a registered nurse (staff #6) on (MONTH) 27, 2019 at 10:34 p.m. She stated the resident has multiple contractures of the fingers and has had spastic movements of his arms for some time, and that it's worse when he is agitated. She said that he has spilled drinks, but he is careful with hot drinks and has never spilled them before. She stated that they do not give him anything without a CNA close by, and that a CNA was with the resident at the time of the spill. When questioned regarding the resident's burn risk, she said that she was sure that they had assessed his burn risk and that is probably why they were doing closer supervision. An interview was conducted with the Assistant Director of Nursing (ADON/staff #53) on (MONTH) 27, 2019 at 11:04 a.m. She stated the spastic movements and altered joint status for resident #26 was not new, and that he had a history of [REDACTED]. She said if the resident refused to use the sippy cups, there should be documentation of this and notification to the provider. She stated this resident would be at risk of spills [MEDICAL CONDITION] hot liquids and that they did not do what was needed to prevent the accident and resulting burn to the resident. She stated that as a result of the accident, the resident now has a burn with blisters and associated pain. She said that staff did not follow expectations or facility policy related to accident prevention. An observation of the resident was conducted on (MONTH) 28, 2019 at 9:15 a.m. The resident was supine in bed and was observed to have altered fine movements to the upper extremities. The resident was able to do larger movements (i.e. rub his ear, and wipe his face), however the movements were over exaggerated and were not fully controlled. The resident's head movements were also over exaggerated and his head bounced, when raised up and down from the pillow. An interview with the Executive Director was conducted on (MONTH) 28, 2019 at 1:29 p.m., who stated there was no policy specific for assessing resident's risk for burns. Review of the policy on [MEDICAL CONDITION] hot beverages revealed that hot food and beverages will be served at safe temperatures to prevents burns. The policy included that staff will monitor hot beverages on a regular basis at the point they are served. The policy stated that the optimum temperatures of hot beverages is 160 to 185 degrees Fahrenheit (F), however, to [MEDICAL CONDITION] beverages may be served at no more that 155 degrees F. The policy included that residents who are at risk [MEDICAL CONDITION] choose to drink beverages above 155 degrees F. will be educated on the risks and benefits of hot beverages. Appropriate supervision to obtain hot beverages will be provided to any individual demonstrating decreased safety awareness and/or anyone who is at risk [MEDICAL CONDITION] scalds, based on clinical assessment. The policy further included that lap trays, slip guards or cup holders on wheelchairs may be used to help hot liquids remain upright. A policy on Safety and Supervision of Residents revealed that resident safety and supervision and assistance to prevent accidents are facility-wide priorities. The policy included that safety risks and environmental hazards are identified on an ongoing basis. Employees shall be trained and in-serviced on potential accident hazards, how to identify and report accident hazards, and preventing avoidable accidents. The policy identified resident-oriented approaches to safety which included the following: address the safety and accident hazards for individual residents; staff shall use various sources to identify risk factors for residents including the information obtained from the medical history, physical exam, observations of the resident and the MDS; the interdisciplinary team shall analyze information obtained from assessments and observations to identify any specific accident hazards or risks for the resident and shall target interventions to reduce the potential for accidents; implement interventions to reduce accident risks and monitoring to ensure that interventions are implemented correctly and consistently.
F 0732 **Level of harm -** Potential for minimal harm **Residents Affected -** Some	**Post nurse staffing information every day.** Based on observations, facility documentation, staff interviews and policy review, the facility failed to ensure the daily posted nurse staffing information included the resident census. The deficient practice could result in residents and visitors not being made aware of the current staffing information. Findings include: Observations were conducted on (MONTH) 26 and 27, 2019 of the Posting of Licensed and Unlicensed Direct Care Staff information, which was located at the front desk. The form contained information regarding the daily number and hours worked for Licensed Nurses and Certified Nursing Assistants. However, the postings did not include the resident census. Review of the facility Posting of Licensed and Unlicensed Direct Care Staff forms from (MONTH) 26 to (MONTH) 25, 2019, revealed the resident census was not included on 13 out of 30 days. An interview was conducted with the Staffing Coordinator (staff #69) on (MONTH) 27, 2019 at 8:25 a.m. She stated the forms are prepared daily to make sure the facility has appropriate staffing for the resident census and resident care. She stated that the daily posting form needs to be filled out with the date and the starting resident census for the day. Staff #69 said the forms did not contain the resident census and therefore did not meet the requirements and expectations for completing the posted nurse staffing information. An interview was conducted with the Administrator (staff #86) on (MONTH) 27, 2019 at 8:39 a.m. He stated the staff posting form includes the projected resident census for the day and if the resident census was not on the form, it would not meet the expectations/requirements for completion of the posted nurse staffing information. Review of the facility's policy for Posting Direct Care Daily Staffing Numbers revealed the facility will post on a daily basis for each shift, the number of nursing personnel responsible for providing direct care to residents and will include the resident census at the beginning of each shift.
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 interviews, 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 food borne illnesses. Findings include: During a dining observation conducted on (MONTH) 25, 2019 at 11:57 a.m., a staff member (#4) was observed assisting a resident by spreading butter on the resident's bread. The staff member was observed touching the bread with bare hands. A second dining observation was conducted the same day at 12:03 p.m. Staff #4 was observed assisting another resident by spreading butter on the resident's bread. The staff member was observed touching the bread with bare hands. An interview was conducted with a Certified Nursing Assistant (CNA/staff #55) on (MONTH) 26, 2019 at 10:40 a.m. He stated that when touching residents' food, staff members should wear gloves. He stated that staff did not need to wear gloves when passing out meal trays, only when touching or cutting up food. An interview was conducted with the CNA (staff #4) on (MONTH) 27, 2019 at 10:15 a.m. She stated that staff should wash their hands prior to serving food to residents. The CNA stated that sometimes she touch residents' bread when setting up meals, but that she always washes her hands prior to serving meals. Review of the facility's policy for General Food Preparation and Handling, revealed staff will handle utensils, cups, glasses and dishes in such a way as to avoid touching surfaces that food or drink would come in contact with. The policy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035094	A. BUILDING _____ B. WING _____	**08/28/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HAVEN OF SEDONA	**505 JACKS CANYON ROAD SEDONA, AZ 86351**

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 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 7) included tongs or other serving utensils will be used to serve breads or other items to avoid bare hand contact with food.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on personnel record review, staff interview, and policy review, the facility failed to ensure an employee (staff #18) who has and/or is expected to have direct interaction with a resident for more than 8 hours a week provided evidence of freedom from infectious [MEDICAL CONDITION] (TB). The deficient practice could result in the potential of residents and employees being exposed to TB. Findings include: Review of the personnel record for a Registered Nurse (RN/staff #18) revealed a hire date of (MONTH) 18, (YEAR). The record included a TB testing consent and record form signed by the RN dated (MONTH) 11, 2019 that the RN had been exposed to TB and had a history of [REDACTED]. Continued review of the personnel record revealed a New Hire TB Screen & Annual TB Questionnaire for PPD (purified protein derivative) Converters and Reactors form that the RN exhibited no present symptoms of TB. The form was signed by the infection control nurse, not a medical practitioner, dated (MONTH) 28, 2019. An interview was conducted with the Infection Control Nurse (staff # 53) on (MONTH) 27, 2019 at 9:40 a.m. She stated that employees with a history of a positive TB test complete a yearly questionnaire with the infection control nurse and that if the employee is not exhibiting any signs or symptoms of TB there would be no further action required. Staff #53 stated that she did not realize a medical practitioner is required to sign the questionnaire that an individual is free from infectious TB. Review of the facility's policy for TB testing and chest x-ray requirements for employees revealed that in accordance with state and federal requirements, employees are required to remain free of TB and verify this status through current and yearly TB testing and the conducting of a chest X-ray or TB symptom check. The policy included employees will have their current TB testing status regardless of the form of the testing updated annually either with additional testing, an additional chest x-ray or an additional symptoms check.