STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **035139**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **11/07/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HAVEN OF SHOW LOW	**2401 EAST HUNT STREET SHOW LOW, AZ 85901**

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 0550 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident and staff interviews, and policy review, the facility failed to ensure one resident (#8) was treated with dignity by failing to respond timely to the resident's requests for toileting assistance. The deficient practice could result in residents not being treated with dignity. Findings include: Resident #8 was readmitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. Review of the care plan initiated (MONTH) 29, 2019 revealed the resident had an ADL (activities of daily living) self-care performance deficit related to activity intolerance. The goal was that the resident would maintain the current level of function in transfers and toilet use. Interventions included the resident required 2 staff participation with transfers and 1-2 staff participation to use the toilet. The admission Minimum Data Set assessment dated [DATE] revealed a score of 15 on the Brief Interview for Mental Status which indicated the resident had no cognitive impairment. The assessment included the resident required extensive assistance of two+ staff for transfer and toilet use. The assessment also included the resident was frequently incontinent of urine and occasionally incontinent of bowel. An interview was conducted with the resident on 11/4/2019 at 12:19 PM. The resident stated that she feels the staff have purposely ignored her when she needs help to go to the toilet. She stated that on at least two separate occasions she has urinated and soiled herself waiting for assistance. She stated that she has notified the nursing staff and social services of the issue. During an observation conducted on 11/05/19 at 11:19 AM, the resident was placed at the nursing station to wait to use the bathroom. The nurse informed the resident that she would take the resident to the bathroom after she finished her charting. The resident was observed to wait 7 minutes before being assisted to the bathroom. An interview was conducted on 11/05/19 at 1:02 p.m. with a Certified Nursing Assistant (CNA/staff #43), who stated that there has been times that she has been the only CNA working providing care for approximately 35 residents. She said the residents have complained to her about the time it takes for her to respond to their requests and that the residents have had to wait up to 30 minutes because she is helping other residents. Another interview was conducted with the resident on 11/05/19 at 1:23 PM. She stated she notified the nurse that the staff did not want to help her. She stated that she has been at the nurses' station asking for help. She stated that she urinates in her brief because of the wait time and has to wait 30 minutes to two hours to be changed. The resident stated that one night she called her family and asked them to call the facility to have someone help her. An interview was conducted with a CNA/Restorative Nursing Assistant (RNA/staff #35) on 11/05/19 at 2:05 PM. She stated that it normally takes about 5 minutes to answer a call light. She stated that there are times when there is only one CNA in the building for at least 32 residents. An interview was conducted with the social worker (staff #14) on 11/6/2019 at 10:50 AM. She stated the resident has discussed with her the issues with staff not helping her to the bathroom. She stated that she knows that there are times there is only one CNA on the floor which makes it difficult to get the residents up. An interview was conducted on 11/07/19 at 8:26 a.m. with the Director of Nursing (DON/staff #12), who stated that she is aware that there are times when there is only one CNA providing care during a shift. Review of the facility's policy Quality of Life - Dignity revealed demeaning practices and standards of care that compromise dignity are prohibited. The policy included staff shall promote dignity and assist residents as needed by promptly responding to the resident's request for toileting assistance.
F 0561 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interviews, clinical record review, and policies, the facility failed to ensure one sampled resident's (#8) choice regarding meals was supported and accommodated. The deficient practice could result in residents not having the choice about aspects of their life that are significant to them. Findings include: Resident #8 was readmitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. Review of the care plan initiated (MONTH) 30, 2019 revealed the resident was at risk for nutritional problems related to variable oral intake. The goal was to for the resident to remain hydrated and not experience a significant weight change. Interventions included assisting the resident with meals as needed and encouraging fluid and by mouth intake. An admission Minimum Data Set (MDS) assessment dated [DATE] revealed a score of 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident had no cognitive impairment. The assessment included the resident required setup help with meals and supervision with eating. An interview was conducted with the resident on 11/4/2019 at 12:19 PM. She stated that she is at the mercy of the staff because she needs help with setting up her meals. She stated she used to go to the dining room for meals but that now she wants to eat in her room. The resident stated the problem with eating in her room is that she needs someone to set up her tray and help prepare food items (like cutting her meat) so she can eat. The resident stated staff have told her that they are too busy to help her. The resident further stated she has reported it to the social worker and to the nursing staff but nothing has changed. A review of the clinical record revealed no documentation related to concerns with assisting the resident with meals. During a lunch observation conducted on 11/4/2019 at 12:39 PM, the resident's lunch tray was delivered to her room and placed on the bedside table approximately 6 feet away from resident. Seven minutes later, a staff member entered the room, moved the bedside table over to the resident, set up the tray and left without asking the resident if she needed assistance with her meal. An interview was conducted with a Certified Nursing Assistant/Restorative Nurse Assistant (CNA/RNA/staff #35) on 11/5/2019 at 1:20 PM. She stated her goal for every resident is for the residents to do for themselves as long as they can. The CNA stated that resident #8 cannot lift her arms at times to feed herself because of the pain. The CNA also stated she told

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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 0561 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) resident #8 that there is not enough staff to assist her when she eats in her room so she needs to eat in the dining room if she needs assistance. An interview was conducted with a Registered Nurse (RN/staff #15) on 11/5/2019 at 2:01 PM. She stated resident #8 has the right to eat wherever she wants. The RN stated that if the resident wants to eat in her room, staff should assist her with meals as needed in her room. She stated the resident does have difficulty raising her arms to eat but that she is not aware the resident needs any special help with her meals. An interview was conducted with the social worker (staff #14) on 11/6/2019 at 10:50 AM. She stated the resident did discuss with her the concerns she has regarding eating in her room. She stated that the resident, to her knowledge, does not need help with eating. The social worker also stated that she told the administrator and the Director of Nursing (DON) about the resident's concerns. During an interview conducted with the DON (staff #12) on 11/6/2019 at 11:28 AM, she stated that she was not aware of any issues regarding resident #8's choice to eat in her room. The DON stated the resident has the right to eat in the dining or in her room and that the staff would support her choice. A facility's policy titled Quality of Life - Self Determination and Participation revealed the facility respects and promotes the right of each resident to exercise his or her autonomy regarding what the resident considers to be important facets of his or her life. Each resident shall be allowed to choose activities including eating that are consistent with his or her interest. The policy included residents shall be provided assistance as needed to engage in their preferred activities on a routine basis. Review of the facility's policy Resident Rights revealed the facility promotes and protects the rights of residents regarding the right to self-determination which included choice of activities.
F 0623 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policy review, the facility failed to notify two residents (#4 and #180) and/or the resident's representative in writing of the transfers/discharges and failed to send a copy of the notice to the Ombudsman. The deficient practice could result in residents not being provided a written notice of transfer and the Ombudsman not receiving a copy of the notice. Findings include: -Resident #180 was admitted to the facility on (MONTH) 27, 2019, with [DIAGNOSES REDACTED]. Review of the admission Minimum Data Set (MDS) assessment dated (MONTH) 3, 2019, revealed a Brief Interview Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact. The face sheet revealed the resident was her own responsible party and included a family member was the Power of Attorney (POA) for care. Review of a progress note dated (MONTH) 3, 2019, revealed that the resident was transferred to the hospital for a change in condition. However, further review of the clinical record revealed no evidence the resident and/or the resident's representative was notified in writing of the transfer or that the Ombudsman was sent a copy of the notice of transfer to the hospital. An interview was conducted with the Resident Relations Manager (staff #14) on (MONTH) 7, 2019 at 1:48 p.m. Staff #14 stated that she does not notify the resident and/or the resident's representative in writing of the transfer to the hospital. She also stated that she does not send a copy of the notice of the transfer to the hospital to the Ombudsman. She said that she and her supervisor are currently working on a process to ensure all residents are notified in writing about their transfers. She said that once a process is developed, she will be the person responsible for providing the written transfer notice and maintaining documentation. -Resident #4 was admitted on (MONTH) 26, 2019 with [DIAGNOSES REDACTED]. The admission MDS assessment dated (MONTH) 2, 2019 revealed a score of 8 on the BIMS which indicated the resident had moderate cognitive impairment. Review of the face sheet revealed the resident was her own responsible party and that a family member was the responsible party. A nursing progress note dated (MONTH) 10, 2019, revealed the resident was sent to the hospital for a change in condition. However, further review of the clinical record did not reveal evidence the resident and/or the resident's representative were notified in writing of the transfer or that the ombudsman was sent a copy of the transfer to the hospital. On (MONTH) 6, 2019 at 9:12 a.m., an interview was conducted with the Resident Relations Manager (staff #14). She stated she had no knowledge regarding notifying the resident and/or their representative in writing of the transfer/discharge to the hospital. She stated that she does not send a notice of the transfer to the ombudsman. An interview was conducted with the Director of Nursing (DON/staff #12) on (MONTH) 6, 2019 at 9:55 a.m. The DON stated that she does not notify the resident or the resident's representative in writing of the transfer. The DON further stated that she only notifies the ombudsman if a resident has been in an accident and/or has an injury. The facility's policy titled Transfer or Discharge Notice revised (MONTH) 2012, revealed a resident and/or the resident's representative will be provided with a thirty (30) day written notice of an impending transfer or discharge except if an immediate transfer or discharge was required by the resident's urgent medical needs. The policy did not include notifying the resident and/or the resident's representative in writing of the immediate transfer or discharge required for the resident's urgent medical needs or sending a copy of the notice to the ombudsman.
F 0625 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.** **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 two residents (#4 and #180) and/or the resident's representative were notified in writing of the facility's bed-hold policy upon transfer to the hospital. The deficient practice could result in residents not being informed of the facility's bed-hold policy in writing.Findings include: Resident #180 was admitted to the facility on (MONTH) 27, 2019, with [DIAGNOSES REDACTED]. Review of a nursing progress note dated (MONTH) 3, 2019, revealed the resident was transferred to the hospital for a change in condition. Review of the discharge assessment dated (MONTH) 3, 2019 revealed the facility bed-hold policy had been explained but did not include the resident and/or the resident's representative was notified in writing of the facility's bed-hold policy. Additional review of the clinical record revealed no evidence the resident and/or the resident's representative were notified in writing of the facility's bed-hold policy. An interview was conducted on (MONTH) 7, 2019 at 1:48 p.m. with the Resident Relations Manager (staff #14), who stated that she does not notify a resident or the resident's representative in writing of the facility's bed-hold policy upon transfer to the hospital. She stated that she gives a copy of the bed-hold policy to the insurance case manager when a resident is transferred to the hospital. Staff #14 stated that she thinks residents are given a bed-hold policy when they are admitted to the facility. -Resident #4 was admitted on (MONTH) 26, 2019, with [DIAGNOSES REDACTED]. A nursing progress note dated (MONTH) 10, 2019 revealed the resident was sent to the hospital for a change in condition. However, further review of the clinical record did not reveal evidence the resident and/or the resident's representative were notified in writing of the facility's bed-hold policy. On (MONTH) 6, 2019 at 9:12 a.m., an interview was conducted with the Resident Relations Manager (staff #14). She stated that when a resident is transferred to the hospital, either she or the Business Office Manager (staff #8) will complete a Notice

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F 0625 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) of Bed Hold Request and fax it to the resident's case manager. She stated that she did not know anything about notifying the resident and/or the resident's representative in writing of the facility's bed-hold policy. During an interview conducted on (MONTH) 6, 2019 at 9:48 a.m. with the Business Office Manager (staff #8), staff #8 stated that it has not been part of her process to notify the resident and/or the resident's representative about the facility's bed-hold policy in writing. On (MONTH) 6, 2019 at 9:55 a.m., an interview was conducted with the Director of Nursing (DON/staff #12). She stated her expectation is that in emergent situations, the nurse will educate the resident and/or the resident's family about the bed-hold policy verbally. The DON stated they did not have a bed-hold policy that addressed notifying the resident and/or the resident's representative in writing about the facility's bed-hold policy upon transfer to hospital. Review of the facility's policy regarding bed holds dated (YEAR), did not include a resident and/or the resident's representative will be provided written information about the facility's bed hold policy upon transfer to a hospital.
F 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident and staff interviews, and policy review, the facility failed to ensure services provided or arranged by the facility met professional standards of quality for three residents (#181, #331, and #8). The deficient practice could result in residents having missed appointments and medication errors. Findings include: -Resident #181 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The resident was discharged to the hospital on (MONTH) 31, 2019. Review of the hospital discharge orders dated 5/22/19 revealed orders for [MEDICATION NAME] (antibiotic) 2 grams IV (intravenously) every 12 hours through 7/12/19, a follow up appointment with ID (Infectious Disease) prior to discontinuing the antibiotic treatment, and an EGD (esophagogastroduodenoscopy) and colonoscopy in 4 to 5 weeks. Review of the Medication Administration Records revealed [MEDICATION NAME] was administered every 12 hours from 5/23/19 through 7/12/19. However, review of the clinical record revealed no evidence the resident had a follow up appointment with ID prior to discontinuing the antibiotic treatment or that the resident had an EGD and colonoscopy. Further review of the clinical record, revealed the order was transcribed for a follow up appointment with ID (Infectious Disease) but did not include prior to discontinuing the antibiotic treatment. An interview was conducted with the medical records clerk (staff #4) on 11/07/19 at 09:08 AM. Staff #4 stated that she verifies admission orders [REDACTED]. She stated that after the review, she transcribes the orders as directed onto the MAR and sends the appointment orders to the scheduler to schedule the appointments. Staff #4 also stated that she did not understand the part of the ID appointment order that the appointment was to be scheduled before discontinuing the antibiotic, because discontinuing was scribbled d/c. The clerk stated that she contacted the Director of Nursing for clarification but was not given clarification, so she did not transcribe the part of the order regarding prior to discontinuing the antibiotic treatment. Staff #4 stated that she did send the order to the scheduler to schedule the ID and EGD/colonoscopy appointments. An interview was conducted with the Director of Nursing (DON/staff #12) on 11/07/19 at 11:56 AM. The DON stated that she was not the DON at the time the resident was admitted . She stated the proper procedure should have been to call the hospital physician for clarification of the order regarding the ID appointment. An interview was conducted with the scheduler (staff #51) on 11/07/19 on 12:22 PM. Staff #51 stated that even though she has no documentation of it, she does remember scheduling the resident for an ID appointment. She stated there was no time frame on the order and that the resident was discharged before the appointment date. Staff #51 also stated that she did receive the order to schedule the EGD/colonoscopy appointment, but that she forgot to schedule it. During an interview conducted with the administrator (staff #40) on 11/07/19 at 01:32 PM, the administrator stated transcribing order and scheduling appointments should be should be done correctly for every resident. -Resident #331 was admitted to the facility on (MONTH) 22, 2019, with [DIAGNOSES REDACTED]. Review of the care plan initiated (MONTH) 25, 2019 revealed the resident was receiving antidepressant medications. The goal was that the resident would be free from adverse reactions related to antidepressant therapy. Interventions included monitoring for antidepressant side effects which included constipation. A physician's orders [REDACTED]. During a medication pass observation conducted with a Registered Nurse (RN/staff #15) on (MONTH) 6, 2019 at 08:41 a.m., the nurse was observed to put three spoonful of [MEDICATION NAME] husk (bulk-forming laxative) into a cup of water and mix it. She then administered this mixture to the resident. Immediately following this observation an interview was conducted with the RN. The RN stated the facility was out of [MEDICATION NAME] powder so she gave the [MEDICATION NAME] husk. Staff #15 said that she had spoken with the Nurse Practitioner (NP) about being out of [MEDICATION NAME] and that the NP stated she could substitute [MEDICATION NAME] husk for [MEDICATION NAME]. The RN stated that she had administered [MEDICATION NAME] husk to the resident last night and today. She also stated that she had not written the order to substitute [MEDICATION NAME] husk for [MEDICATION NAME]. In an interview conducted on (MONTH) 7, 2019 at 10:10 a.m. with a Licensed Practical Nurse (LPN/staff #25), the LPN said it is definitely not ok to substitute a medication with another medication without a physician order. In an interview conducted with the NP on (MONTH) 7, 2019 at 10:11 a.m., the NP stated he was not aware that [MEDICATION NAME] husk was being substituted for [MEDICATION NAME] powder. The NP stated that he had not received any messages that he was aware of about medication substitutions for resident #331. He said the nurses should obtain an order for [REDACTED]. An interview was conducted with the Director of Nursing (DON/staff #12) on (MONTH) 7, 2019 at 10:43 a.m. The DON stated that if an over the counter medication is not available, they can purchase the medication from a store. She stated the pharmacy should be contacted to expedite sending the medication. The DON stated her expectation is that the nurse would contact the physician that a medication is not available and let the physician decide what to do. The DON also stated that the nurse should not have administered [MEDICATION NAME] husk to resident #331. -Resident #8 was readmitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. Review of the care plan initiated 8/30/2019 revealed the resident was on diuretic therapy related to [MEDICAL CONDITION] and [MEDICAL CONDITION]. Interventions included administering medication as ordered. The admission Minimum Data Set (MDS) assessment dated [DATE] revealed a score of 15 on the Brief Interview for Mental Status (BIMS), indicating the resident had no cognitive impairment. Review of the clinical record revealed a physician order [REDACTED]. Review of the Medication Administration Record for (MONTH) revealed the resident was administered the renal multivitamin from 11/2/2019 through 11/5/2019. An interview was conducted with the resident on 11/4/2019 at 12:19 PM. She stated she was started on new medications that she was not made aware of. She stated all medication changes needed to go through her kidney physician. The resident stated a staff member told her the renal multivitamin was ordered by someone in-house. She also stated that she felt she was made to take the medications. In an interview conducted with a Registered Nurse (RN/staff #15) on 11/5/2019 at 2:01 PM, the RN stated a renal multivitamin was ordered for the resident but that the facility did not have the renal multivitamin. Staff #15 stated the facility could not afford the ordered medication so she had to create a substitute. The RN stated she administered a total of 4 medications in place of the renal multivitamin: a regular multivitamin, zinc, folic acid and vitamin C. She stated she did not notify anyone of the substitution because it was handled. She stated that when the resident saw 4 new pills in her medicine cup, the resident became very upset. The RN stated that she was able to educate the resident about the change in medications. She stated she was able to convince the resident to take the medications and that the resident took the 4 medications. An interview was conducted with the Director of Nursing (DON/staff #12) on 11/06/19 at 02:19 PM. She stated if a physician orders [REDACTED]. The DON stated that she was not aware of any staff members substituting medications. The DON stated that the resident should have been administered the medication as prescribed by the physician. The facility's policy titled Medication and Treatment Orders revealed medications shall be administered only upon the

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F 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 3) written order of a person duly licensed and authorized to prescribe such medications.
F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **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 two residents (#12 and #26) received treatment and care in accordance with professional standards of practice. The deficient practice could result in residents' changes in condition not being addressed timely. Findings include: -Resident #12 was admitted on (MONTH) 12, 2019, with [DIAGNOSES REDACTED]. Review of the clinical record revealed a physician's orders [REDACTED]. Review of the care plan revealed the resident had liver disease related to alcohol [MEDICAL CONDITION] and was prescribed [MEDICATION NAME] for treatment. The goal was the resident would be free from signs and symptoms of liver complications including cognitive decline or mental status changes. Interventions included administering the medication as ordered. The Nurse Practitioner Note (NP) note dated (MONTH) 14, 2019 revealed no reports of any abusive patterns and staff did not report any incidents or events. The note included the NP had ordered labs which included checking the resident's ammonia level. A physician's orders [REDACTED]. Review of the admission MDS assessment dated (MONTH) 19, 2019, did not reveal the Brief Interview for Mental Status (BIMS) or the Staff Assessment for Mental Status was conducted. The assessment included - for the behavioral symptoms and no documentation for wandering. An admission Social Service assessment dated (MONTH) 19, 2019 revealed the resident had no behavioral concerns, no history of psychiatric treatment, and that no referrals were needed. Review of the Medication Administration Record [REDACTED]. Review of the MAR for (MONTH) 2019 revealed the resident refused [MEDICATION NAME] twice on (MONTH) 1, 2, 9, 15, 16, 19, and 30, and once on (MONTH) 3, 4, 5, 7, 8, 10, 17, 28, 29, and 31. Review of a nursing alert charting note dated (MONTH) 25, 2019 revealed a change of condition summary. The resident was found outside the building for a second time that day, was out at the far driveway, and was very combative towards the Certified Nursing Assistant (CNA). The note included the resident was brought back into the building and a wander guard was applied to the resident's right ankle. A nursing alert charting note dated (MONTH) 30, 2019 revealed another change of condition summary that the resident was upset because the roommate was yelling at her and being mean. The note included the resident was so upset she pulled the fire alarm in the hallway near the dining room. The note also included the resident calmed down when she was moved to another room and that she was adjusting well to the room and the new roommate. However, review of the clinical record revealed no evidence the practitioner was notified the resident was refusing the [MEDICATION NAME] and that the resident had a change in behavior. A NP note dated (MONTH) 1, 2019 revealed the staff had not reported any incidents or events. Review of the MAR for (MONTH) 2019 revealed the resident refused [MEDICATION NAME] twice on (MONTH) 4 and 7, and once on (MONTH) 1, 2, 6, 8, 12, 13, 15, 20, and 30. A nursing alert charting note dated (MONTH) 30, 2019 revealed the resident was adjusting well to the room change, was still angry and refusing medications, and was making angry remarks to the staff. A nursing medication administration note dated (MONTH) 30, 2019 revealed the resident was ignoring staff and that the NP was aware of the behavioral issues. However, the NP note dated (MONTH) 3, 2019 revealed the resident slept well over the weekend without difficulties or problems per staff and that staff did not report any incidents or events. The note included the resident continues to do well in the facility and appears happy. Review of the MAR for (MONTH) 2019 revealed the resident refused [MEDICATION NAME] once on (MONTH) 3, 4, 27, and 30. Review of the care plan dated (MONTH) 10, 2019 revealed the resident exhibited exit-seeking behavior as evidence by trying to exit secure facility exits and wandering. The goal was the exit-seeking behaviors will be reduced to less than daily. Interventions included monitoring the resident for tailgating when staff or visitors come and go from the facility and referring to Social Services as needed. A quarterly Social Service Review dated (MONTH) 12, 2019 revealed the resident's cognitive status, behavioral symptoms, and mental health was the same as the prior assessment on (MONTH) 16, 2019. Review of the laboratory report dated (MONTH) 17, 2019 revealed the resident's ammonia level was 255 ug/dL (micrograms/deciliter). Normal reference interval is 19 - 87 ug/dL. The report also included a handwritten note that the NP was notified on (MONTH) 20, 2019 at 8:35 a.m. Review of a nursing alert charting note dated (MONTH) 18, 2019 revealed a change of condition summary. The resident started cussing at a CNA and kicked the CNA in the jaw while the CNA was trying to provide incontinent care to the resident. The note included the CNA left the room so that the resident could calm down. The quarterly MDS assessment dated (MONTH) 19, 2019 revealed a score of 6 on the BIMS which indicated the resident had severely impaired cognition. The assessment include the resident exhibited wandering behavior 1 to 3 days out of the 7 day look-back period but did not exhibit any physical or verbal behaviors. A nursing alert charting note dated (MONTH) 20, 2019 revealed nursing sent a message to the NP regarding the elevated ammonia level of 255. The NP progress note dated (MONTH) 20, 2019 revealed the resident was not overly lethargic, no reports of fever/chills/nausea/vomiting/diarrhea, and that staff had not reported any incidents or events. The note included the ammonia level is elevated, the resident is asymptomatic and will be watched for now. The note also included the labs would be rechecked next week to ensure this was normal for the resident. However, further review of the clinical record did not reveal follow up labs were ordered or that the resident's behaviors had been reported to the practitioner. Review of a NP progress note dated (MONTH) 1, 2019 revealed the resident frequently refused [MEDICATION NAME] and complained of diarrhea. The note included the [MEDICATION NAME] is needed to keep the ammonia level as low as it is which is high compared to the normal population. The note also included the staff did not report any incidents or events. An alert nursing note dated (MONTH) 10, 2019 revealed resident #12 went into another resident's room and was messing with the bed controls. The note included resident #12 had also thrown all of her bedding (which was not wet) into the hall and purposely run over a CNA's leg with her wheelchair. An alert nursing note dated (MONTH) 23, 2019 revealed the resident had hit and cussed at a CN[NAME] The note included the resident had been violent and verbally abusive with this CNA on one other occasion. Review of the MAR for (MONTH) 2019 revealed the resident refused [MEDICATION NAME] once on (MONTH) 4, 6, 7, 8, 9, 11, 12, 26, 28, and 30 and twice on (MONTH) 10, 13, 14, 15, 16, 17, 18, 21, 22, 23, 24, 27, 29, and 31. A NP progress note dated (MONTH) 1, 2019 revealed the resident has a little bit of an attitude about her medications and refuses to take them but that she does fairly well. The note included staff does not report any significant incidents or events. The note also included no recommendation to change the medications. Review of an Incident Note dated (MONTH) 6, 2019 revealed the resident was in her room with her back to the door sitting in her wheelchair talking to another woman. The resident was visibly upset. The resident was observed holding a butter knife and motioning to cut her wrist. Staff approached the resident cautiously and gently took her hand. The resident then stuck the butter knife under her leg. After 10 minutes of calming the resident and getting the resident to say what was upsetting her, staff were able to take the butter knife from the resident. Review of an alert nursing note dated (MONTH) 6, 2019 revealed the resident had been found with a butter knife and was threatening to cut her wrists. The note included the resident was distraught over family issues and was being sent to the hospital for evaluation of suicidal ideation.

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NAME OF PROVIDER OF SUPPLIER **HAVEN OF SHOW LOW**		STREET ADDRESS, CITY, STATE, ZIP **2401 EAST HUNT STREET SHOW LOW, AZ 85901**	

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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 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 4) Review of the hospital lab report dated (MONTH) 6, 2019 revealed the ammonia level was 36. The normal reference interval is 9 - 30 umol/L (micromole/liter). During an interview conducted with the Medical Records Manager (staff #4) on (MONTH) 7, 2019 at 8:40 a.m., staff #4 stated that other than the laboratory report dated (MONTH) 20, 2019; there were no other laboratory reports for resident #12. An interview was conducted with a Registered Nurse (RN/staff #5) on (MONTH) 7, 2019 at 8:46 a.m. The RN stated that when a resident refuses a medication frequently, the process would be to document an alert progress note and contact the practitioner. The RN also stated that he had not reported resident #12 refusing [MEDICATION NAME] to the practitioner. He said the resident is usually in good spirits, but when she's not feeling well you can tell by her behavior. On (MONTH) 7, 2019 at 9:24 a.m., an interview was conducted with the Nurse Practitioner (NP/staff #49). The NP stated that it was not reported to him that the resident refused [MEDICATION NAME] on a regular basis. He stated it was reported the resident refuses [MEDICATION NAME] sometimes. The NP also stated that he was not aware the resident had assaulted staff. He stated that he would expect staff to notify him of a change in condition and if a resident was frequently refusing medications. He said symptoms of high ammonia levels would include lethargy and increased confusion. The NP stated he ordered the laboratory test to recheck the ammonia level but that he does not remember seeing the laboratory report. On (MONTH) 7, 2019 at 11:00 a.m., an interview was conducted with the DON (staff #12). She stated her expectation is for nursing to notify the practitioner if a resident is refusing medications and if a resident has a change of condition related to behaviors. The DON stated a practitioner writing about an order in the progress note is not the same as writing the order. The DON also stated that the practitioner can write the order or alert staff to write the order. The facility's policy titled Change in a Resident's Condition or Status revised (MONTH) (YEAR), revealed staff shall promptly notify the resident's attending physician of changes in the resident's medical/mental status. The nurse will notify the resident's attending physician when there has been a significant change in the resident's physical/emotional/mental condition and refusal of medications two (2) or more consecutive times. The policy stated that a significant change of condition is a major decline in the resident's status that requires interdisciplinary review and/or revision of the care plan and will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions. The policy also revealed that except in medical emergencies, notifications will be made within 24 hours of a change occurring in the resident's medical mental condition or status. The facility's policy regarding Lab and Diagnostic Test Results - Clinical Protocol revised (MONTH) 2012, revealed the physician will identify and order lab testing based on diagnostic and monitoring needs. The staff will process test requisitions and arrange for tests. Nursing staff shall promptly notify the physician if the result is something that should be conveyed to a physician regardless of other circumstances (that is, the abnormal result is problematic regardless of any other factors). -Resident #26 was admitted to the facility on (MONTH) 13, 2019, with [DIAGNOSES REDACTED]. Review of the weights summary report for 2019 revealed weights were obtained monthly from (MONTH) to August. Review of a physician progress notes [REDACTED]. The note included they will continue to monitor the resident's weight loss. However, further review of the weights summary for 2019 revealed no weight was obtained for (MONTH) and October. Review of the clinical record revealed no documentation that the resident had refused to be weighed in (MONTH) or October. A monthly Nursing Summary dated (MONTH) 22, 2019 revealed the resident's most recent weight was on (MONTH) 22, 2019. Review of the dietary WINS (weight intervention nutrition skin) list dated (MONTH) 6, 2019 revealed no weight since (MONTH) and that a new weight was needed. Further review of the clinical record revealed a weight was obtained on (MONTH) 6, 2019. An interview was conducted on (MONTH) 6, 2019 at 1:01 p.m. with the Dietary Manager (staff #32), who stated that the only reason a resident would not be on monthly weights is if the resident was on hospice or was too fragile to move. The dietary manager stated that they have been requesting weights for this resident from nursing. During an interview conducted with the Registered Dietician on (MONTH) 6, 2019 at 1:06 p.m., she stated that at the WINS meeting she makes a list of all the residents who have nutritional concerns. She stated resident #26 is on this list and that they requested a weight be obtained for this resident on September18 and (MONTH) 8, 2019. In an interview conducted with a Restorative Nursing Aide (RNA/staff #35) on (MONTH) 6, 2019 at 1:57 p.m., staff #35 stated that the RNAs and the CNAs are the ones that weigh residents. Staff #35 also stated that she did not know why resident 26 was not weighed monthly. An interview was conducted with the Director of Nursing (DON/Staff #12) on (MONTH) 7, 2019 at 10:43 a.m. The DON stated that her expectations for weights are a resident is weighed when admitted , once for 4 weeks following admission, and then weighed monthly. She stated that this resident refuses care and that if the resident had refused to be weighed, it would be documented. A review of the facility's policy for Nutrition Management Program dated (YEAR), revealed all residents are weighed within 24 hours of admission and for the following four weeks or until stable. Residents that demonstrate a significant weight loss will be placed on weekly weights until weight is stabilized. The policy also revealed all other residents will be weighed monthly.
F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed clinical record review, staff interviews, and policy review, the facility failed to ensure one (#180) of four sampled residents was provided care and services to prevent the development of pressure sores. The deficient practice could result in residents developing pressure sores. Findings include: Resident #180 was admitted to the facility on (MONTH) 27, 2019, with [DIAGNOSES REDACTED]. Review of the care plan initiated (MONTH) 27, 2019 revealed the resident had impairment to skin integrity related to the right hip surgical incision. The goal was that the resident would have no complications related to skin injury. Interventions included pressure relieving/reducing mattress, pillows, sheepskin padding etc. to protect the skin while in bed. The care plan did not include skin concerns to the heels. Review of the clinical record revealed a physician order [REDACTED]. A care plan initiated on (MONTH) 27, 2019 revealed the resident had activities of daily living self-care performance deficit related to activity intolerance. Interventions included the resident required the assistance of one staff for repositioning and turning in bed, and transfers. Review of the Braden Scale for Predicting Pressure Sore Risk dated (MONTH) 27, 2019, revealed a score of 16, indicating the resident was at low risk for developing pressure sores. Review of a nursing wound progress note dated (MONTH) 28, 2019 revealed the resident's heels were blanching with bogginess. The note included the resident was encouraged and educated about frequent activity/repositioning while in bed and in the wheelchair. The note also included the resident was repositioned using a pillow and that heel boots were placed on the resident's feet. The note did not include any description or other assessment of the heels. Additional review of the care plan revealed the care plan was not revised to reflect the heels with bogginess nor was there an intervention for heel boots on the care plan. The Certified Nursing Assistant (CNA) documentation for turning, repositioning, floating the heels when in bed, and wearing heel protective boots consisted of a Yes to indicate it was completed but did not include if some or all of the interventions were completed and how often. Per the documentation on the form from (MONTH) 28 through (MONTH) 2, 2019, Yes was documented three times on (MONTH) 28 and (MONTH) 2, two times on (MONTH) 29 through 31, and one time on (MONTH) 1. Further review of the clinical record revealed no additional documentation to indicate preventative measures were consistently implemented from (MONTH) 28 through (MONTH) 2, 2019. Review of the Braden Scale for Predicting Pressure Sore Risk dated (MONTH) 3, 2019, revealed a score of 18, indicating the resident was at low risk for developing pressure sores despite skin issues being identified to the resident's heels on (MONTH) 27, 2019. Review of the weekly skin check dated (MONTH) 3, 2019, now revealed the resident had pressure sores to the right and left heel and included a recommendation for foam booties to prevent further breakdown. The admission Minimum Data Set (MDS) assessment dated (MONTH) 3, 2019 revealed a score of 15 on the Brief Interview Mental

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HAVEN OF SHOW LOW	**2401 EAST HUNT STREET SHOW LOW, AZ 85901**

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F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 5) Status which indicated the resident had intact cognition. The assessment included the resident had two unstageable pressure sores with suspected deep tissue injury (DTI) in evolution that were not present at the time of admission. The assessment also included a pressure reducing device was in place for the chair and bed but did not include a turning/repositioning program had been implemented. The assessment also revealed the resident required extensive assistance of two+ staff for bed mobility and transfers, and did not use a wheelchair as a mobility device. Review of the wound physician's note dated (MONTH) 3, 2019, revealed the resident had DTI to the mid-lateral right heel and to the medial left heel. The right heel measured 3.5 centimeters (cm) x 4.5 cm with an area of 12.37 square cm. The left heel measured 2 cm x 3 cm with an area of 4.712 square cm. The right and left heel wound bed had 76-100% [MEDICATION NAME] and the peri-wound skin did not exhibit signs or symptoms of infection. Apply skin prep to the right and left heel and cover with a dry protective dressing daily. Recommendations included floating the heels when in bed, offloading the wound, offloading mattress, and repositioning per facility protocol. Physician orders [REDACTED]. Review of the Pressure Ulcer Documentation and Assessment form dated (MONTH) 3, 2019, revealed the onset of the DTI to the mid-lateral right heel and to the medial left heel was on (MONTH) 3, 2019. The right DTI measured 3.5 cm x 4.5 cm. x 0 and the left DTI measured 3.2 cm x 3.3 cm x 0. Both heels were non-blanchable, deep red and purple in discoloration with epithelization with no drainage or induration noted. Skin prep was applied to the heels and the heels were covered with a dry protective dressing. Interventions included floating the heels while in bed and offloading the wound. The documentation also included the resident was encouraged and educated about frequent activity/repositioning while in the bed and wheelchair and that the resident was repositioned and heel boots were placed on the resident's feet. The care plan regarding skin integrity was revised on (MONTH) 4, 2019, to include the deep tissue injuries to the right and left heel. Further review of the clinical record revealed skin and wound assessments, and pressure sore treatments were provided. The discharge MDS assessment dated (MONTH) 3, 2019, revealed the resident was discharged to the hospital on (MONTH) 3, 2019 with two unstageable DTI sores. An interview was conducted on (MONTH) 6, 2019 at 12:23 p.m. with the wound nurse (staff #17), who said their policy states that residents are to be repositioned every two hours or more. Staff #17 stated that the CNAs are responsible for repositioning residents. She stated the CNAs document the repositioning in the data system every shift and that there is no place for the CNAs to document how often a resident was repositioned each shift. She said there have been times when there was only one CNA on the day shift and that the CNAs have told her that they did not have time to reposition residents every two hours. She also stated that the size and shape of the pressure sores on the resident's heels, is the type of pressure sores a resident gets when the resident uses a wheelchair. Review of the facility's wound management policy dated 2013, revealed the goal of their comprehensive wound management program is to promote the highest level of functioning and well-being of their residents and to minimize the number of residents that develop in-house acquired pressure sores. A thorough head to toe assessment of each resident's skin will be completed on admission and at least weekly thereafter. The skin check will be completed by the wound care team which consists of the wound care nurse and the wound care assistant. A pressure ulcer risk assessment (Braden) will be completed upon admission, the following 4 weeks and quarterly thereafter. Residents with a Braden score less than 12 will have interventions placed to prevent pressure sore development. Skin impairment care plan and goals will be initiated, updated, and reviewed as applicable by the Interdisciplinary team. This is to include all residents at risk as well as those with actual skin impairments.
F 0725 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** Based on resident and staff interviews, facility assessment, and policy review, the facility failed to ensure there was sufficient nursing staff to meet the needs of residents. The deficient practice resulted in residents' needs not being met. The census was 37. Findings include: During the initial phase of the survey, 5 out of 15 residents reported concerns of not having enough staff. Residents reported that they have waited up to 3 hours for staff to answer their call light. They stated staff have turned off the call light, said they would be back and not come back for a long time. They stated they have had incontinent episodes due to the wait time and have not received showers due to the lack of staffing. They also stated residents have helped other residents who needed help because staff did not help the residents. Review of the facility assessment revealed the purpose is to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. Ensure each resident is provided care that allows the resident to maintain or attain their highest practicable physical, mental, and psychosocial well-being. The assessment included a ratio of 1:12-17(residents) or less on the day shift and a ratio of 1:1-15 or less on the night shift for Certified Nursing Assistants (CNAs). The assessment also included the average census range is 34 - 48 residents. An interview was conducted on (MONTH) 5, 2019 at 1:02 p.m. with a CNA (staff #43), who stated that there has been times that she has been the only CNA working providing care for approximately 35 residents. She said the residents have complained to her about the time it takes for her to respond to their requests and that the residents have had to wait up to 30 minutes because she is helping other residents. She said she feels like they are very short staffed. She stated that there is no CNA available to help the residents during mealtimes because she is serving meal trays to the residents' rooms and the other CNA is in the dining room. The CNA also stated that the second CNA takes some of the residents for a smoke break, several times day, and it is difficult for her to answer all the call lights during these breaks. During an observation conducted on 11/05/19 at 01:16 PM, one CNA was observed out with residents that were on a smoke break. The other CNA assigned to the floor was in a meeting. The social worker (staff #14) stated she was a CNA, and that she was the CNA for the residents in the facility. An interview was conducted on (MONTH) 5, 2019 at 2:05 p.m. with another CNA (staff #35), who said that she is in the dining room during mealtimes because she is the Restorative Nursing Assistant (RNA). She stated that she is responsible for assisting residents with eating. She also said she supervises the residents that smoke and that there is only one CNA in the building to help the other residents when smoking breaks occur. She said there have been times when she was the only CNA working a shift and that it was very difficult to help 35 residents. An interview was conducted on (MONTH) 7, 2019 at 8:26 a.m. with the Director of Nursing (DON/staff #12), who stated that she determines the number of staff required to provide care to the residents. The DON stated that she is aware that there are times when there is only one CNA providing care during a shift and agreed that they are short staffed. She said that she would like to have three CNAs for each shift. Review of the facility's policy regarding staffing revised (MONTH) 2007, revealed adequate staffing is provided to meet needed care and services for the resident population. Adequate staffing on each shift is maintained to ensure residents' needs and services are met. The policy included Certified Nursing Assistants/Nursing Assistants are available on each shift to provide the needed care and services of each resident as outlined on the resident's comprehensive care plan.
F 0732 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Post nurse staffing information every day.** Based on staff interviews, facility documentation, and policy and procedure, the facility failed to ensure nurse staffing data information was posted and maintained for a minimum of 18 months. Findings include: Review of the facility's Daily Staff Posting from (MONTH) 4, 2019 through (MONTH) 4, 2019, revealed no nurse staffing data for (MONTH) 5, 6, 12, 13, 19, 20, 26, 27, and (MONTH) 2 and 3, 2019, which are Saturday and Sunday dates. An interview was conducted on (MONTH) 7, 2019 at 8:26 a.m. with the Director of Nursing (DON/staff #12), who stated that the Central Supply Manager (staff #37) was responsible for posting the Daily Staff Posting. She stated staff #37 works during

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F 0732 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 6) the week and that she did not know who was posting the staffing schedule on the weekends. Staff #37 joined the interview and said that there is no one posting the staffing schedule on the weekend. Review of the facility's Posting Direct Care Daily Staffing Numbers policy revised (MONTH) 2006, revealed the facility will post, on a daily basis for each shift, the number of nursing personnel responsible for providing direct care to residents. The policy included records of staffing information for each shift will be kept for a minimum of 18 months or as required by state law (whichever is greater).
F 0775 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Keep complete, dated laboratory records in the resident's record.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policy review, the facility failed to ensure a laboratory report was filed in one resident's (#2) clinical record. The deficient practice could result in laboratory reports not being filed in residents' clinical records. Findings include: Resident #2 was admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. Review of the clinical record revealed a physician order [REDACTED]. Further review of the clinical record revealed no laboratory report for the urinalysis but revealed the order was pending. During an interview conducted with the Director of Nursing (staff #12) on 11/7/2019 at 11:30 AM, she stated that she would have to go to the nursing station to locate the urinalysis result because the laboratory reports are not scanned into the electronic clinical record. An interview was conducted with the Regional Educator (staff #46) on 11/7/2019 at 12:20 PM. She stated that she had the laboratory fax over the results. She stated that she did not know why there was a delay in receiving the laboratory report. Staff #46 stated that there was a culture indicated on the urinalysis and that the culture came back negative for any growth. The facility policy titled Lab and Diagnostic Test Results - Clinical Protocol revealed the laboratory will report test results to the facility and a nurse will review all results for reporting and documenting the results and their implications. The policy did not include filing laboratory reports.