STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035086	A. BUILDING _____ B. WING _____	**03/14/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HAVEN OF SIERRA VISTA, LLC	**660 SOUTH CORONADO DRIVE SIERRA VISTA, AZ 85635**

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F 0552 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that residents are fully informed and understand their health status, care and treatments.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed clinical record review, staff interviews and policy and procedures, the facility failed to have evidence that one (#267) of six sampled residents/representative was informed of the risks and benefits of a [MEDICAL CONDITION] medication prior to administration. The deficient practice could result in the resident's representative not being aware of the benefits and the potential adverse side effects of taking psychoactive medications. Findings include: Resident #267 was admitted to the facility on (MONTH) 9, (YEAR), with [DIAGNOSES REDACTED]. The resident was discharged on (MONTH) 21, (YEAR). Review of the care plan dated (MONTH) 10, (YEAR), revealed the resident had impaired cognitive function/impaired thought processes related to dementia. Interventions included keeping the resident's routine consistent and providing consistent care givers as much as possible in order to decrease confusion. The admission Minimum Data Set assessment dated (MONTH) 16, (YEAR), revealed a Brief Interview for Mental Status (BIMS) score of 7 which indicated the resident had severe cognitive impairment. An interdisciplinary team note dated (MONTH) 25, (YEAR), included the resident had become more confused. A nurse's note dated (MONTH) 1, (YEAR), revealed the resident was alert and oriented to self and had poor appetite. The note included orders were obtained for [MEDICATION NAME] to stimulate the resident's appetite and for an urinalysis. The note also included the resident's spouse was at the bedside and was notified of the new orders. Review of the clinical record revealed a physician's orders [REDACTED]. Review of the Medication Administration Record [REDACTED]. However, review of the [MEDICAL CONDITION] medication informed consent for [MEDICATION NAME] revealed the consent was signed by the resident who was cognitively impaired. The consent did not contain a date and the boxes for yes I consent and no I do not consent were blank. An interview was conducted on (MONTH) 13, 2019 at 1:18 p.m. with the Director of Nursing (DON/staff #76). She stated that it was not normal for the resident to sign his own medication consent. She stated that if a resident was alert and oriented to self, she would expect the nurse to obtained informed consent from a family member or responsible party. The DON also stated that they had identified an issue with obtaining informed consents for medications. She said that in (MONTH) 2019, it was identified through an audit that was conducted that there were medication consents that had not been completed or were not in the residents' charts. She said that since then weekly audits had been performed to ensure consents were collected, completed, and uploaded into the clinical record. However, review of the facility's audit documentation revealed the facility had not identified the issue of residents with severe cognitive impairment signing informed consents for [MEDICAL CONDITION] medications. The facility's policy for behavior management revealed the Assistant Director of Nursing is to ensure the required informed consent is obtained from the resident and/or responsible party for all [MEDICAL CONDITION] medications.
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 reviews, staff interviews, facility documentation and policy review, the failed to ensure one resident (#59) was free from abuse by another resident (#3). The sampled residents for abuse were four. The resident census was 77. This deficient practice could potentially allow for further abuse. Findings include: -Resident #59 was admitted on (MONTH) 6, (YEAR) with [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS) assessment dated (MONTH) 1, (YEAR) revealed a score of 4 on the Brief Interview for Mental Status (BIMS) which indicated the resident had severe cognitive impairment. Review of a nursing progress note dated (MONTH) 25, (YEAR), revealed a resident (#3) struck resident #59 on the right forearm with a brush which caused immediate swelling. The note revealed there were no open areas or bleeding observed and that resident #59 denied pain. -Resident #3 was admitted on (MONTH) 3, (YEAR) with [DIAGNOSES REDACTED]. A care plan initiated (MONTH) 3, (YEAR) revealed the resident had the potential to demonstrate physical and/or verbal aggression. The goal was that the resident would not harm others. Interventions included intervening as needed to protect the rights and safety of others, approaching the resident in a calm manner, diverting the resident's attention, and removing the resident from the situation. The quarterly MDS assessment dated (MONTH) 23, (YEAR) revealed a score of 7 on the BIMS which indicated the resident had severe cognitive impairment. A nursing progress note dated (MONTH) 25, (YEAR) revealed an off duty Certified Nursing Assistant (CNA) witnessed resident #3 strike resident #59 with a hairbrush. The note also included the writer observed resident #3 standing with a hairbrush in her hand near another resident who was seated at a dining room table. Review of the facility's documentation revealed that on (MONTH) 25, (YEAR) at 11:35 a.m., resident #3 struck resident #59 with a hair brush on the right wrist causing a bruise. The incident occurred in the dining room and was witnessed by a CNA (staff #68). The documentation included a written statement by staff #68 that revealed resident #3 was attempting to take a chair that resident #59 was saving for her spouse. Resident #3 became angry when resident #59 would not let go of the chair and hit resident #59 with a brush. The facility's documentation included the residents were redirected and separated immediately. The Director of Nursing (DON/staff #76) conducted an initial interview with resident #3 who stated resident #59 had gotten too close to her. The DON conducted an initial interview with resident #59 who stated that resident #3 had struck her. An interview was conducted with the CNA (staff #68) on (MONTH) 13, 2019 at 12:47 PM. She stated that resident #59 was seated at the dining table and was saving a chair for her family member. She stated that resident #3 walked up to the table and attempted to grab the chair that resident #59 had been saving. The CNA stated that as resident #3 began pulling the chair away, resident #59 grabbed resident #3's hand. She said resident #3 said, Let go! Staff #68 stated that resident #59 would

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) not let go of the chair and that is when resident #3 hit resident #59 with the hair brush she was holding in her other hand. The CNA stated that she intervened and separated the residents. During an interview conducted with the Registered Nurse (RN/#66) on (MONTH) 13, 2019 at 1:01 PM, she stated that she heard a commotion, stood up from her desk, and saw resident #3 hit at resident #59. The RN stated that she did not realize contact had been made until she saw the hematoma. On (MONTH) 13, 2019 at 1:06 PM, an interview was conducted with the DON (staff #76). She stated that her first priority regarding resident-to-resident abuse is to make sure the residents are ok, and separated. The DON stated that she obtains statements from staff and if possible, from the residents involved, to identify the cause of the incident. The facility's policy on abuse, dated (YEAR), revealed the facility's objective is to provide a safe haven for residents through preventative measures that protect every resident's right to freedom from abuse. The policy also included .Instances of abuse of all resident, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, neglect, and mental abuse including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm . The policy further included that due to the proximity of our residents one to another and an individual's freedom of choice, that situations may arise where it is not possible to completely prevent all incidents of abuse.
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.** Based on clinical record review, staff interviews, facility documentation and policy review, the facility failed to report an allegation of misappropriation of resident funds to the State Agency within the required timeframe for one of four sampled residents (#217). The resident census was 77. Findings include: Resident #217 was admitted on (MONTH) 31, (YEAR) with diagnoses, which included fractured right clavicle, dementia, and repeated falls. The admission Minimum Data Set assessment dated (MONTH) 5, (YEAR) revealed a score of 15 on the Brief Interview for Mental Status which indicated the resident had intact cognition. Review of a hand written note revealed on (MONTH) 3, (YEAR), the resident (#217) stated that he was missing money. The note also included the State Agency was notified on (MONTH) 6, (YEAR) at 2:00 p.m. Review of the facility's investigation report revealed the resident notified a Certified Nursing Assistant (CNA) on (MONTH) 4, (YEAR), that he was missing money. The report included the CNA had seen money under the resident's pillow. The CNA reported the missing money to the resident relations manager (staff #1). On (MONTH) 5, 2019, staff #1 confirmed with the resident's emergency contact, that the resident was missing $300.00. The report did not include notification of this allegation to the State Agency. However, review of the State Agency data base revealed the facility's first notification to the State Agency regarding this allegation was on (MONTH) 12, (YEAR) when they submitted their investigation report. During an interview conducted with the Director of Nursing (DON/staff #76) on (MONTH) 13, 2019, the DON stated that she reported the allegation to the State Agency on (MONTH) 6, (YEAR) at 2:00 p.m. The DON was aware that allegations of misappropriation of resident property are to be reported to the State Agency within 24 hours. An interview was conducted with the Resident Relations Manager (staff #1) on (MONTH) 13, 2019 at 12:10 p.m. Staff #1 stated that she notified Adult Protective Services and the Ombudsman of the allegation, but did not recall notifying the State Agency. The facility's policy titled Abuse Investigation and Reporting, (Revised July, (YEAR)), revealed an alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown sources and misappropriation of resident property) will be reported immediately, but not later than: a. Two (2) hours if the alleged violation involves abuse or has resulted in serious bodily injury; or Twenty-four (24) hours if the alleged violation does not involve abuse and has not resulted in serious bodily injury.
F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview and the Resident Assessment Instrument (RAI) manual, the facility failed to ensure a Minimum Data Set (MDS) assessment for one resident (#68) was accurate. The resident census was 77. This deficient practice has the potential to affect continuity of care. Findings include: Resident #68 was admitted to the facility on (MONTH) 9, 2019 with [DIAGNOSES REDACTED]. Review of the clinical record revealed a physician's orders [REDACTED]. A Health Status note dated (MONTH) 7, 2019 revealed the resident was discharged home at 1:30 p.m. However, review of the discharge MDS assessment dated (MONTH) 7, 2019 revealed the resident was discharged to an acute care hospital. During an interview conducted with the MDS coordinator (staff #95) on (MONTH) 14, 2019 at 9:52 a.m., staff #95 stated that if a resident is discharged home, it would be coded on the discharge MDS assessment as discharged to the community. After reviewing resident #68 discharge MDS assessment, she stated that the assessment was coded incorrectly because the resident was discharged home. The RAI manual instructs to review the clinical record including the discharge plan and discharge orders for documentation of a resident's discharge location. The manual also included .the importance of accurately completing and submitting the MDS cannot be over-emphasized . and that Federal regulations require the assessment accurately reflects the resident's status.
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, staff interviews and policy review, the facility failed to ensure that oxygen was administered per the physician's orders [REDACTED].#15). This deficient practice could result in respiratory complications. Findings include: Resident #15 was readmitted on (MONTH) 4, 2019, with [DIAGNOSES REDACTED]. Review of the clinical record revealed physician's orders [REDACTED]. The 5-day Minimum Data Set assessment dated (MONTH) 11, 2019 revealed a Brief Interview for Mental Status score of 2, which indicated that the resident had severe cognitive impaired. The assessment also included the resident was receiving oxygen therapy. Review of the oxygen saturation report for (MONTH) 2019 revealed the resident's oxygen saturations were between 92 - 99% on 5 LPM of oxygen. During an observation conducted of the resident on (MONTH) 11, 2019 at 1:37 p.m., the resident was observed sitting in a wheelchair in the dining room with oxygen via nasal cannula at 5 LPM. Further observation of the portable oxygen tank revealed the oxygen tank pounds per square inch (PSI) level was reading in the red, which indicated the tank was empty or OFF. Another observation was conducted of the resident with the nasal cannula in place on (MONTH) 11, 2019 at 2:10 p.m. The portable oxygen tank was observed with the oxygen tank PSI level in the red. The resident was observed moving about restlessly and appeared to have difficulty breathing. Immediately following this observation, an interview was conducted with the Registered Nurse (RN/staff #66). The RN stated

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F 0695 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) that the resident is receiving oxygen continuously at 5 LPM and that the resident's heavy breathing pattern was normal because it was behavioral. When the RN checked the resident's oxygen saturation, the oxygen saturation was 87 - 88%. The RN then instructed the resident to take some deep breaths. After being alerted to the fact that the oxygen tank needle was in the red area, the RN used a key to turn the oxygen tank on. Once the oxygen tank was turned on, the resident's oxygen saturation went up to 98%. The RN then stated that a Certified Nursing Assistant (CNA) had changed the portable oxygen tank and must have forgotten to turn the oxygen back on. During an interview conducted with a CNA (staff# 68) on (MONTH) 14 at 10:21 a.m., she stated that for a resident who is receiving oxygen via a portable oxygen tank, she checks the tank every time she walks by the resident to ensure the tank is turned on and is full. The CNA stated that the CNAs are responsible for changing the oxygen tank. She further stated the nurses are responsible for turning on the oxygen and setting the rate. An interview was conducted with the Director of Nursing (DON/staff# 76) on (MONTH) 14, 2019 at 1:15 p.m. The DON stated that CNAs can set up oxygen but cannot turn the oxygen on. The DON stated that the nurses are responsible for turning on a resident's oxygen. She stated that the staff are encouraged to monitor oxygen tanks as they walk by to ensure the tanks are full and working. She also stated that if a resident is having difficulty breathing, the nurse is supposed to assess the resident and check the oxygen and titrate the oxygen accordingly. Review of the facility's policy regarding Oxygen Administration (revised (MONTH) 2010) revealed the purpose is to provide guidelines for safe oxygen administration. The policy instructs to review the physician's orders [REDACTED]. The policy included checking the oxygen tank to ensure that it is in good working order.
F 0757 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews and policy review, the facility failed to ensure that one residents (#36) drug regimen was free from unnecessary drugs, by failing to administer pain medication according to the physician ordered parameters. Findings include: Resident #36 was admitted to the facility on (MONTH) 30, (YEAR), with [DIAGNOSES REDACTED]. The admission Minimum Data Set (MDS) assessment dated (MONTH) 11, (YEAR), revealed the resident scored a 14 on the Brief Interview for Mental Status (BIMS) assessment, indicating intact cognition. The MDS included that the resident frequently experienced severe pain. A physician's orders [REDACTED]. This order was discontinued on (MONTH) 23, 2019. Review of the medication administration record (MAR) for (MONTH) 2019 revealed the resident received [MEDICATION NAME]-[MEDICATION NAME] 5-325 mg outside of the physician ordered parameters as follows: (MONTH) 3 for a pain level of 3, (MONTH) 4 for a pain level of 1, (MONTH) 10 for a pain level of 2, twice on (MONTH) 11 for a pain level of 2, and twice on (MONTH) 17 for a pain level of 2. A physician's orders [REDACTED]. The (MONTH) 2019 MAR included documentation that the resident was administered [MEDICATION NAME] HCl concentrate outside of the physician ordered parameters as follows: twice on (MONTH) 25 for pain levels of 2 and 3, and twice on (MONTH) 31 for a pain level of 2. Review of a pain care plan dated (MONTH) 27, 2019 revealed the use of [MEDICATION NAME]-[MEDICATION NAME], and [MEDICATION NAME] HCl concentrate for chronic pai[DIAGNOSES REDACTED], [MEDICAL CONDITIONS] and restless leg syndrome. A goal included the resident would verbalize adequate pain relief and would not have problems related to side effects of opioid [MEDICATION NAME]. Interventions included for the administration of pain medications as ordered, anticipation of the resident's need for pain relief and responding as soon as possible to any complaint of pain, evaluation of the effectiveness of pain interventions, monitoring and documenting side effects of pain medication and informing the resident of the risks and benefits of pain medication. Review of the MAR for (MONTH) 2019 revealed the resident was administered [MEDICATION NAME] HCl concentrate below the physician ordered parameters of 6-10, over 20 times. An interview was conducted on (MONTH) 14, 2019 at 9:35 AM with a Licensed Practical Nurse (LPN/staff #73). She acknowledged her initials on resident #36's MAR and stated she guessed she hasn't been paying attention to the pain scale on the physician's orders [REDACTED]. On (MONTH) 14, 2019 at 10:07 AM an interview was conducted with a Registered Nurse (RN/staff #90). She said she would assess the resident's pain prior to administering a pain medication. She said she would then check the physician's orders [REDACTED]. On (MONTH) 14, 2019 at 10:11 AM an interview was conducted with the Director of Nursing (DON/staff #76). She stated that her expectation for nurses administering pain medications was for the nurse to assess the resident's pain level and to follow the ordered parameters. The medication administration policy dated (MONTH) 2012 stated medications must be administered in accordance with the orders, including any required timeframe. Additionally, the policy states the individual administering the medication must check the label three (3) times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication.
F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview and policy review, the facility failed to ensure that the protected health information for one resident (#27) was kept confidential and failed to ensure that one resident's (#267) medical record accurately reflected their status. The deficient practice resulted in private medical information being exposed to the public, and the deficient practice had the potential for inaccurate care and treatment being provided. The sample size was 20 and the resident census was 77. Findings include: -Resident #267 was admitted to the facility on (MONTH) 9, (YEAR), with [DIAGNOSES REDACTED]. Review of a care plan dated (MONTH) 10, (YEAR) revealed a potential for skin integrity impairment, related to having a cast to the left lower extremity (instead of the right lower extremity) for a right tibia fracture (instead of a right fibula fracture). A care plan dated (MONTH) 10, (YEAR), included the resident was at risk for experiencing pain, related to a left tibia fracture (instead of a right fibula fracture). Another care plan dated (MONTH) 10, (YEAR) for Activities of Daily Living (ADL) included the resident had self care performance deficits, related to a left tibia fracture (instead of a right fibula fracture). According to a physician's progress note dated (MONTH) 12, (YEAR), the resident's right leg was in a short cast. However, review of the nurse's notes dated (MONTH) 11, 12 and 13, (YEAR), revealed documentation that the resident had a cast in place to his left lower extremity (instead of the right lower extremity). -Resident #27 was admitted to the facility on (MONTH) 11, 2012, with [DIAGNOSES REDACTED]. The State Agency received information that another resident's representative had requested copies of that resident's medical record. Included in the copies that they received was a copy of the laboratory results, which belonged to resident #27. Review of the clinical record for resident #27 revealed diagnostic laboratory results dated (MONTH) 6, (YEAR). The resident's name, date and laboratory values were identical to the copy that the other resident's representative had received. An interview was conducted on (MONTH) 12, 2019 at 9:25 a.m., with the Medical Records Director (staff #12). She stated that the request for medical records had been handled by the legal department. She stated she was not aware that the laboratory results for resident #27 were included in the copies for another resident's records. Review of the facility's policy on Confidentiality of Information revealed the facility would treat all resident information

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F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) confidentially and would access protected health information only as necessary. Access to resident medical records would be limited to authorized staff and business associates. Release of resident information would be handled in accordance with resident rights and privacy policies.