| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **035140** | A. BUILDING _____ B. WING _____ | **08/29/2019** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **LIFE CARE CENTER OF TUCSON** | **6211 NORTH LA CHOLLA BOULEVARD TUCSON, AZ 85741** |

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 0602<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **Protect each resident from the wrongful use of the resident's belongings or money.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on clinical record review, staff interviews, facility documentation, and policy review, the facility failed to ensure one resident (#190) was free from misappropriation of property by failing to ensure the resident's funds were temporarily placed in a safe place upon request of the resident. The deficient practice could result in other residents' property being misappropriated.<br>Findings include:<br>Resident #190 was admitted to the facility on (MONTH) 28, 2019 with [DIAGNOSES REDACTED].<br>A review of the Medicare 14 day MDS (Minimum Data Set) assessment dated (MONTH) 12, 2019 revealed the resident's BIMS (Brief Interview for Mental Status) score was a 15 indicating the resident had intact cognition.<br>Review of the facility's Reportable Event Record/Report dated (MONTH) 12, 2019 revealed On (MONTH) 28, 2019 (resident #190) was admitted to (name of facility). He is alert and oriented and does not need assistance with decision making. (Resident #190) gave the nurse upon admission his wallet with $145 cash. The nurse placed the wallet and money on the inventory sheet and locked it in the medication cart. The nurse told the Executive Director on (MONTH) 30, 2019 that money was locked in the medication cart. The Assistant Director of Nursing with the floor nurse verified that the wallet and $145 was there. The Assistant Director of Nursing and the Executive Director spoke with the Social Worker who stated the family will be coming in for the money and stated he would keep it in the safe in his office. On (MONTH) 8, 2019 (resident #190) told the Social Worker that his son will be coming for the money today. At 8:15 a.m. on (MONTH) 8, 2019 the Social Worker removed the wallet from the safe and the $145 was missing from the wallet. The Social Worker reported it to the Executive Director. The Executive Director asked the Social Worker if the safe was locked. The Social Worker said the safe does not lock. The Social Worker said his office is open during the day so anyone can go in and out of his office when he is not there. I told him we will no longer use the safe that money needs to be taken home or deposited into a trust account at the business office .<br>Further review of the facility's Reportable Event Record/Report dated (MONTH) 12, 2019 revealed the facility reimbursed the resident $145.<br>An interview was conducted with the Social Services Director (staff #119) on (MONTH) 27, 2019 at 2:04 p.m. Staff #119 stated that the Executive Director and the Assistant Director of Nursing gave him the resident's wallet with $145 and asked him to put it in the safe in his office. Staff #119 stated that the safe has not been able to be locked for six months. Staff #119 stated that when he was asked to put the resident's wallet in the safe he did not mention that the safe was unable to be locked. Staff #119 stated that he did not realize that the Executive Director did not know that the safe in his office was unable to be locked.<br>An interview was conducted with the Executive Director (staff #163) on (MONTH) 28, 2019 at 8:33 a.m. Staff #163 stated that the Social Services Director stated that the safe was not locked and that someone walked into his office and helped themselves. Staff #163 stated that the Social Services Director never reported to him that the safe was unable to be locked. Staff #163 stated that the resident was reimbursed $145 and the Social Services Director no longer keeps money or valuables in his office.<br>Review of the facility's policy Protection of Residents: Reducing the Threat of Abuse and Neglect, dated (MONTH) (YEAR) revealed .Each resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation of any type by anyone . |
| F 0641<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **Ensure each resident receives an accurate assessment.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on clinical record review, staff interviews, and the Resident Assessment Instrument (RAI) manual, the facility failed to ensure that a Minimum Data Set (MDS) assessment was accurate for 1 of 3 sampled residents (#91). The deficient practice could result in inaccurate discharge tracking information.<br>Findings include:<br>Resident #91 was admitted to the facility on (MONTH) 28, 2019, with [DIAGNOSES REDACTED].<br>Review of the Discharge Summer note dated (MONTH) 9, 2019 revealed the resident was discharged to home at approximately 5:00 p.m.<br>However, review of the discharge MDS assessment dated (MONTH) 9, 2019, revealed the resident was discharged to an acute hospital.<br>During an interview conducted at 9:45 a.m. on (MONTH) 28, 2019, the MDS Coordinator (staff #10) stated that the resident was discharged home and that the discharge MDS assessment should have been coded the resident was discharged home.<br>In an interview conducted with the Director of Nursing (DON/staff #81) on (MONTH) 28, 2019 at 12:43 p.m., the DON stated that it is her expectation that MDS assessments contain accurate information.<br>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 included .the importance of accurately completing and submitting the MDS cannot be over-emphasized . The manual also included Federal regulations require the assessment accurately reflects the resident's status. |

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.