STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035175	A. BUILDING _____ B. WING _____	**12/07/2018**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MARAVILLA CARE CENTER	**8825 SOUTH 7TH STREET PHOENIX, AZ 85042**

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, staff interviews, facility documentation, and policy review, the facility failed ensure one resident (#88) was treated with respect and dignity. Findings include: Resident #88 was admitted to the facility on (MONTH) 23, (YEAR), with [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS) assessment dated (MONTH) 17, (YEAR), revealed the resident scored a 5 on the Brief Interview for Mental Status (BIMS) indicating the resident had severe cognitive impairment. Review of the current self-care deficit care plan revealed the resident required supervision with activities of daily living. The goal was for the resident to maintain the highest practical level of independence. Interventions included adjusting the daily routine as needed to promote independence. The facility's documentation dated (MONTH) 29, (YEAR) revealed at 11:40 - 11:45 a.m. two certified nursing assistants (CNA/staff #270 and CNA/staff #62) witnessed a CNA (staff #231) grabbed the resident's arm and tell him No, I don't have time to shave you. Per the documentation, resident #88 was interviewed at 2:20 p.m. and stated that he had asked for a shave during a shower and was told no and that he stated he could shave himself. He stated that when he tried to reach for the supplies, the CNA grabbed his arm and said no. The documentation also included the resident did not sustain any injuries and that the resident was alert and oriented to person, place, and time. An interview was conducted on (MONTH) 4, (YEAR) at 2:25 a.m. with staff #270. She stated that resident #88 requires minimal assistance with activities of daily living and is alert and oriented to person, place, and time with confusion at times. She stated that on (MONTH) 29, (YEAR) a little before 12:00 p.m., she and another CNA (staff #62) witnessed the resident asked staff #231 if she was going to shave him. She stated that the staff #231 replied no and that is when the resident walked over to the cabinet and tried to open the cabinet with the razors. Staff #270 further stated that as the resident reached for the razors, staff #231 grabbed his arm and stated no you are not going to do it (shave) and that the resident started yelling and was mad. She stated that she and the other CNA (staff #62) told the resident they would shave him and that the staff #231 walked out of the shower room. An interview was conducted on (MONTH) 5, (YEAR) at 9:01 a.m. with staff #231. She stated about one and a half months ago the resident got upset with her because she could not shave him and tried to hit her. She stated that she asked the resident if he could wait to be shaved until after lunch. Staff #231 stated the resident got upset and began raising his voice and started walking toward the cabinet with the razors and tried to open it. She stated that she placed her arm out and told the resident that he was not allowed to go into the cabinet. She further stated as he was reaching up she saw his hand and elbow bend with a closed fist and that she grabbed his wrist. The CNA stated that she told the resident that it is not okay for him to hit people. She stated that she was trying to protect herself from the resident by grabbing his arm. She stated the other CNAs in the room then offered to shave the resident. The CNA also stated that she did not handle the situation as well as she should have. An interview was conducted on (MONTH) 5, (YEAR) at 10:36 a.m. with staff #62. She stated that on (MONTH) 29, (YEAR), she and staff #270 went to the shower room to wash their hands. She stated staff #231 was in the shower room with resident #88. Staff #62 stated the resident was asking for staff #231 to shave him. She further stated that the resident then walked to the razor cabinet and as he was reaching for the razors staff #231 stated you better not do that and grab the resident's arm. She stated she and staff #270 then told the resident they would shave him. During a follow up interview conducted on (MONTH) 6, (YEAR) at 12:39 p.m. with staff #231, she stated the expectation is for staff to treat residents with dignity and respect. She stated that even if residents exhibit verbal aggression or rudeness towards staff; staff are expected to know when to walk away and turn the other cheek. During an interview conducted on (MONTH) 7, (YEAR) at 11:21 with the Director of Nursing (DON/staff #263). She stated that the expectation is for all residents to be treated with respect and dignity by staff. The DON stated that it would not be appropriate for staff to raise their voice at residents or deny residents care. Review of the facility's policy titled Resident Rights Standard of Practice revealed residents have the right to be treated with respect and dignity including the right to receive services in the facility with reasonable accommodation of resident needs and preferences.
F 0600 **Level of harm -** 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, resident and staff interviews, facility documentation and policies and procedures, the facility failed to ensure one resident (#15) was free from sexual abuse by another resident (#76), failed to ensure one resident (#23) was free from physical abuse by one resident (#136) and failed to ensure one resident (#52) was free from physical abuse by one resident (#45). Findings include: -Resident #15 was readmitted on (MONTH) 12, 2007, with [DIAGNOSES REDACTED]. A quarterly MDS (Minimum Data Set) assessment dated (MONTH) 8, (YEAR) included the resident had moderate cognitive impairment for decision making. A nurses' note dated (MONTH) 30, (YEAR) at 7:00 p.m. revealed that resident #76 was found in the room of resident #15 and that resident #15's genitals were exposed. The nurse separated the resident's and the two residents would be kept apart and monitored. The note further included that the on-call ADON (Assistant Director of Nursing) and the physician had been notified. -Resident #76 was admitted on (MONTH) 19, (YEAR), with [DIAGNOSES REDACTED]. A care plan for resident #76 identified that resident #76 can be sexually inappropriate. An approach included to redirect the resident if being sexually inappropriate with female staff or peers. A quarterly MDS assessment dated (MONTH) 10, (YEAR) included the resident had moderate cognitive impairment for decision making and had disorganized thinking. The MDS included the resident had other behavioral symptoms not directed towards others such as; hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or

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 -** Actual harm **Residents Affected -** Few	(continued... from page 1) smearing food or bodily wastes, or verbal/vocal symptoms like screaming, and disruptive sounds, which occurred 4-6 days in the last 7 days of the assessment period, but less than daily. Review of a nursing note dated (MONTH) 31, (YEAR) at 4:46 p.m., revealed that resident #76 had numerous redirections, due to his inappropriate sexual behaviors. Per the note, resident #76 had been asking other residents for oral sex. Resident #76 had been redirected back to his room to which the resident responded by asking staff to come to his room and watch him masturbate. The note included that at 1:34 p.m., the nurse was approached by a CNA who reported inappropriate sexual contact between resident #76 and resident #15. The CNA reported that as she was monitoring the hallway, she entered the room of resident #15 and found resident #76 sitting on the bed of resident #15, and resident #15 was on his knees with the penis of resident #76 in his mouth. The resident's were immediately separated. Facility administration, physician, responsible parties, police, Adult Protective Services and the State Agency were notified. Review of the facility's investigation revealed that resident #15 was alert and oriented to person, place and time, ambulates independently and requires supervision with cares. Resident #15 has had no sexually inappropriate behaviors toward staff or other residents. Resident #76 was alert and oriented to person only, and tends to wonder and invade other residents space, by attempting to go in and out of other resident's rooms. Resident #76 has a history of being hypersexual and verbally inappropriate with staff, but has not been with peers. Per the report, staff entered the room of resident #15 and found resident #15 on his knees, performing oral sex on resident #76. According to a statement from resident #76, he had asked resident #15 to perform oral sex on him. An interview was conducted with a Certified Nursing Assistant (staff #291) on (MONTH) 5, (YEAR) at 9:35 a.m. Staff #291 stated that she was monitoring the hallway on (MONTH) 31, when she found resident #76 in the room of resident #15. She said that resident #76 was sitting on the bed of resident #15, and resident #15 was on his knees in front of resident #76, with resident #76's penis in his mouth. Staff #291 stated that there was no monitoring or 1:1 supervision of resident #76, prior to this incident. Staff #291 stated that she had heard from other staff that resident #76 had been wandering the hallways soliciting oral sex from staff. On (MONTH) 5, (YEAR) at 10:12 a.m., an interview was conducted with resident #15. Resident #15 stated that resident #76 had asked him to perform oral sex. Resident #15 stated he didn't want to do it, but he felt afraid. -Resident #136 was admitted to the facility on (MONTH) 26, (YEAR), with [DIAGNOSES REDACTED]. A quarterly MDS assessment dated (MONTH) 15, (YEAR) revealed the resident had long and short term memory problems and had moderate cognitive impairment with decision making. The MDS also included the resident required supervision to limited assistance with activities of daily living. Review of a behavior care plan revealed the resident had behaviors of yelling, screaming and striking out at staff. One of the goals included will receive supportive services to maintain stability of mental/emotional health. Interventions were to approach in a calm manner, when confused or experiencing psychotic disturbances do not attempt to bring to reality, maintain low stimulus environment, remove resident from common areas during times of unacceptable behaviors, if resident refuses care or interventions assure safety and leave immediate area and approach in 5-10 minutes or provide alternate caregiver and to document the resident's response. Review of the nursing notes from (MONTH) and (MONTH) (YEAR) revealed that resident #136 had repeatedly been verbally abusive with attempts of physical abuse toward staff and peers. Review of a CNA note dated (MONTH) 25, (YEAR) at 2:17 p.m., revealed that resident #136 was coming in and out of his room screaming in anger and staff had to redirect him back to his room numerous times. The note included that the resident was monitored by staff for safety. A nursing note dated (MONTH) 25, (YEAR) at 3:29 p.m. revealed resident #136 continued with intermittent behaviors and was currently in bed appearing to be asleep and staff were continuing to monitor him. A nursing note dated (MONTH) 25, (YEAR) at 6:16 p.m. included that resident #136 had possible physical aggression toward a resident (#23). Another resident had reported that resident #136 had choked a resident (#23). Per the note, resident #136 was found on the floor behind the wheelchair of resident #23 and was removed by staff. Resident #136 was verbally aggressive and continued to yell with attempts to strike out. A nursing note dated (MONTH) 29, (YEAR) included that resident #136 had been placed on 1:1 supervision for aggression. -Resident #23 was admitted to the facility on (MONTH) 11, (YEAR), with [DIAGNOSES REDACTED]. Review of a quarterly MDS assessment dated (MONTH) 12, (YEAR) revealed that resident #23 had short and long term memory problems and had moderate cognitive impairment with decision making. Review of a care plan revealed the resident has a self care deficit, but was able to self-propel in a wheelchair for mobility. The resident exhibits alteration in mood/behavior as evidenced by yelling and striking out at others. A goal included that the resident will demonstrate absence of violent or aggressive behaviors. Interventions were to intervene immediately if demonstrates aggressive behaviors toward self or others, educate staff to recognize early signs of agitationand administer medications per order to reduce anxiety. A nursing note dated (MONTH) 25, (YEAR) revealed that at approximately 4:45 p.m., the nurse heard a resident yell He's choking her! Upon reaching the dayroom, a resident (#136) was noted to be on his knees behind the wheelchair of resident #23. The residents were immediately separated. When resident #23 was asked if someone choked her, resident #23 did not respond, but a skin evaluation showed slight redness to the right side of resident #23's neck. Review of the facility's investigation revealed that staff heard another resident yell out, He's choking her! A staff member heard a scream and saw resident #23 sitting in her wheelchair trying to remove resident #136's arm from around her neck. This staff member then assisted resident #23 in removing resident #136's arm from around her neck. Redness was noted to resident #23's neck after the incident. An interview was conducted on (MONTH) 5, (YEAR) at 10:42 a.m. with a LPN (staff #303), who stated that she did not witness the incident between resident #23 and #136, but heard a person whom she believes to be a resident yell out, He is choking her! Staff #303 stated that upon arrival, she saw resident #136 behind the wheelchair of resident #23. Staff #303 stated that she asked both resident's what had happened but neither resident provided a response. Staff #303 said that there was a red mark on resident #23's neck. Staff #303 stated that resident #136 can have very aggressive behaviors at times. Staff #303 said that the incident occurred in the front hallway outside the unit dining room and there are cameras everywhere, so the incident may have been on camera. An interview was conducted on (MONTH) 5, (YEAR) at 2:41 p.m. with the Director of Nursing (DON/staff #263), who stated that once abuse is suspected or identified, the expectation is for staff to immediately report it to the administrator. Staff #263 stated that staff are to immediately ensure resident's safety and then follow the reporting process. Staff #263 stated that staff are educated to look out for resident to resident abuse, as well as other types of abuse. An interview was conducted on (MONTH) 5, (YEAR) at 3:20 p.m. with a Certified Nursing Assistant (CNA/staff #87), who stated that she witnessed the incident which occurred between residents #23 and #136. Staff #87 stated that resident #23 was making loud noises in the hallway outside the dining room, which is located close to the room of resident #136. Staff #87 stated that resident #136 does not like a lot of noise and can be unpredictable when in a rage moment. Staff #87 stated that she saw resident #136 walk up behind resident #23 in her wheelchair, and suddenly grab resident #23 by putting his arm around her neck. She said that resident #23 screamed out and was trying to remove his arm. Staff #87 stated resident #136 is very strong and it took a lot of force to remove his arm and that it required two CNAs to assist in removal of his arm from her neck. Staff #87 stated that multiple staff members came to assist. She said that resident #136 had slid to the floor behind the wheelchair of resident #23, prior to other staff members arriving. Another interview was conducted on (MONTH) 6, (YEAR) at 1:05 p.m. with the DON, who stated that if the incident occurs in the view of a camera such as in the hallway, the camera footage can be reviewed. The DON stated that the incident between resident #23 and #136 happened in the hallway outside of the dining room on the unit. She said the video footage was reviewed by herself and an assistant DON. She said a CNA was watching the residents in the hallway and left the hallway to walk into the dining room. She said resident #136 then reached for resident #23 and possibly fell . She stated that this unit is difficult because it is all about watching the residents and that some residents have triggers and sometimes snap without warning. On (MONTH) 6, (YEAR) at 1:32 p.m., the DON provided a review of the video recording of the incident, which occurred on (MONTH) 25, (YEAR) at approximately 4:34 p.m. in the hallway outside of the Sunset dining room. Per the video, resident #23 was sitting in her wheelchair in the hallway with another resident. No staff were present. Resident #136 walked up behind

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F 0600 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 2) resident #23 and put his left arm around her neck, eventually falling on his buttocks and continued to have his arm around her neck, causing resident #23 to tip backwards in her wheelchair, with the arm of resident #136 still around her neck. Resident #136 finally let go of her neck and resident #23's wheelchair went back to an upright position, without staff intervention. Per the video recording, staff then started to approach both residents. -Resident #45 was admitted to the facility on (MONTH) 25, (YEAR), with [DIAGNOSES REDACTED]. A quarterly MDS assessment dated (MONTH) 26, (YEAR) revealed the resident had moderate cognitive impairment with decision making and had short and long term memory problems. Review of a care plan revealed the resident had behaviors of striking, hitting and punching at staff and peers. The interventions included the following: -Monitor whereabouts when wandering and redirect as needed. -Approach in a calm manner. -When confused or experiencing psychotic disturbances, do not attempt to bring to reality. -If the resident refuses care, assure safety and leave the immediate area. Re-approach in 5-10 minutes or provide an alternate caregiver and document the response. -Avoid confrontation when the resident is agitated. -Refer to psych services as needed with exacerbation or inability to effectively redirect behaviors. A nursing note dated (MONTH) 29, (YEAR) revealed that when resident #45 was in the dining room, he became agitated when asked to get cleaned up and he kicked another resident. Review of the nursing notes from (MONTH) (YEAR) - (MONTH) (YEAR) revealed the resident had repeatedly been verbally and physically abusive towards staff and residents. A nursing note dated (MONTH) 23, (YEAR) included that resident #45 was in the dining room with other residents, when resident #52 reached out toward resident #45, and resident #45 then punched resident #52 on the left side of the face. -Resident #52 was admitted to the facility on (MONTH) 9, (YEAR), with [DIAGNOSES REDACTED]. Review of an annual MDS assessment dated (MONTH) 26, (YEAR) revealed the resident had severe cognitive impairment and had short and long term memory problems. Review of the facility's investigation revealed that on (MONTH) 23, (YEAR) at 9:30 p.m., several residents were sitting in the dining room watching television. Resident #45 and resident #52 were sitting at the same table. Resident #52 is diagnosed with [REDACTED]. At this time, resident #52 thrust out his arms toward resident #45 without hitting him and then resident #45 raised his arm and hit resident #52 on the left side of his face. A CNA (staff #130) witnessed the altercation and both residents were separated. No injuries were sustained by either resident. On (MONTH) 5, (YEAR) at 11:10 a.m., an interview was conducted with a CNA (staff #241). She stated that resident #52 has [MEDICAL CONDITION]'s disease and the disease causes him to spastically thrust his arms involuntarily. She also stated that resident #45 has a history of hitting, punching and kicking other residents on the unit. An interview was conducted on (MONTH) 6, (YEAR) at 1:32 p.m. with the nurse practitioner (staff #311). She stated that resident #45 has a history of striking out at other residents and is more aggressive in the evening. She stated he will strike out if someone is in his way or if it's noisy on the unit. She stated that he is unpredictable, has poor impulse control and staff have difficulty trying to keep him from striking out at other residents. An interview was conducted on (MONTH) 6, (YEAR) at 2:39 p.m., with staff #130. She stated that both residents were sitting next to each other watching television in the dining room. She stated that resident #52 does not have a history of being physically aggressive towards staff or other residents. She said that resident #52 started thrusting his arms out towards resident #45 and then resident #45 punched resident #52 in the face. She stated resident #45 has a history of being physically abusive towards staff and other residents. Review of the facility's Abuse Prohibition Standards of Practice policy revealed that each resident has the right to be free from verbal, sexual, physical and mental abuse, corporal punishment and involuntary seclusion. The policy stated that residents will not be subject to abuse by anyone, including but not limited to facility staff, other residents, consultants and volunteers. Per the policy, tips for the prevention of abuse included to observe resident behavior and reactions to other residents and to assess, monitor and develop appropriate plans of care for residents with inappropriate sexual behaviors towards staff or other residents. The policy defined abuse as: any willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish.
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 clinical record review, interviews, facility documentation, and policy review, the facility failed to implement their policy regarding an allegation of abuse involving two residents (#4 and #5). Findings include: -Resident #5 was admitted (MONTH) 29, (YEAR) with [DIAGNOSES REDACTED]. A Certified Nursing Assistant (CNA/staff #54) psych note dated (MONTH) 5, 2019 revealed the resident's roommate (#4) was yelling at him you muthef r get out of here, you f n nigger, I hate you. The note included resident #4 started moving toward resident #5 as he continued yelling and that resident #5 started yelling I'm going to kill you muthef r, I'm tired of you. The note also included resident #5 was taken to the dining room and that once in the dining continued saying I'm going to kill that muthef r, get him over here. -Resident #4 was admitted (MONTH) 13, (YEAR) with [DIAGNOSES REDACTED]. Review of the clinical record revealed a CNA (staff #82) psych note dated (MONTH) 5, 2019 that resident #4 was yelling at his roommate (#5) you stupid motherf r, I'm going to kick your ass, get your f .g ass out of here. The note included the roommate (#5) replied get him the f k out of here before I kick his stupid nasty ass. Review of the State Agency data base revealed the allegation of abuse was not reported to the State Agency. The facility's Unusual Occurrence Report revealed that on (MONTH) 5, 2019, resident #4 was yelling and cursing at resident #5 and that resident #4 stated get him (#5) the f k out of here and that it occurred in the room that they shared. The report also revealed notifications were made but did not include notification to the State Agency or APS. Further review of the report did not reveal a thorough investigation had been conducted. The report included interviews with staff but did not include interviews with resident #4 and resident #5. An interview was conducted with the Assistant Director of Nursing (ADON/staff #3) on (MONTH) 12, 2019 at 3:47 p.m., who stated that the incident was not reported to the State Agency because there was no physical contact. The ADON also stated that they completed their Unusual Occurrence Report which included interviews with staff but, they did not interview the residents involved. During an interview conducted with the Director of Nursing (DON/staff #1) on (MONTH) 12, 2019 at 4:20 p.m., the DON acknowledged that the verbal altercation which included a threat should have been reported to the State Agency. The DON stated that abuse investigations would include interviewing the residents involved. The facility's policy regarding Abuse Prohibition Standard of Practice revealed verbal abuse is any oral, written, or gestured language that includes disparaging or derogatory terms to a resident or within the resident's hearing distance, regardless of the resident's age, ability to comprehend, or disability. The policy included incidents of alleged abuse must be reported to the appropriate local, state, and federal agencies. The policy also included the facility must notify the State Agency and APS of incidents of alleged abuse within two hours after the allegation is made. The Abuse policy also included interviewing the involved resident if possible and documenting all responses. The policy further included that if the resident is cognitively impaired; interview the resident several times to compare responses.
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, staff interviews, facility documentation and policies and procedures, the facility failed

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F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) to report an allegation of abuse for one resident (#88) and injuries of unknown source for one resident (#107) to the State Survey Agency, within the required timeframe. Findings include: -Resident #88 was admitted to the facility on (MONTH) 23, (YEAR), with [DIAGNOSES REDACTED]. Review of the facility's investigative documentation revealed that on (MONTH) 29, (YEAR) at 11:40 -11:45 a.m., two certified nursing assistants (CNA's) reported suspicion of abuse. They reported that a CNA grabbed resident #88's arm and told him No, I don't have time to shave you. However, the allegation of abuse was not reported to the State Survey Agency until (MONTH) 29, (YEAR) at 4:28 p.m., which was more than two hours after the allegation was made. An interview was conducted on (MONTH) 5, (YEAR) at 2:41 p.m., with the Director of Nursing (DON/staff #263). She stated that once abuse is suspected, the expectation is for staff to immediately report it to the administrator or herself. She stated the State Agency is to be notified within two hours. -Resident #107 was readmitted on (MONTH) 10, (YEAR), with [DIAGNOSES REDACTED]. Review of a behavior care plan dated (MONTH) 16, (YEAR), revealed the resident was totally dependent on staff, required one-to-one staffing ratio at all times and required 2-3 staff to provide care. A wound assessment dated (MONTH) 11, (YEAR) included the resident had a raised bump on the sacrum with a round bruise that measured 4.0 cm by 4.0 cm. The assessment included that the cause of the injury was unknown. According to the facility's investigation, a CNA (staff #87) reported that on (MONTH) 11, (YEAR) staff changed the resident's brief and noticed a bump on the resident's sacrum which was the size of a baseball. The facility was unable to determine how the injury occurred. A wound assessment dated (MONTH) 12, (YEAR) included that the resident had a dark purple blue bruise on the left side of the bridge of her nose, along with a small bruise on the left interior crack of her eye. The assessment included that the cause of the injuries were unknown. Review of the facility's investigative documentation revealed that on (MONTH) 12, (YEAR), the resident had a bruise on the left side of the bridge of her nose and a bruise on the inner crack of her left eye. The report included that the bruise on the bridge of the resident's nose may have been caused by a prior fall. The facility was unable to provide any documentation that the above injuries of unknown source were reported to the State Survey Agency. Review of another investigative report dated (MONTH) 24, (YEAR), revealed the resident was found to have a bruise to her right upper eyelid. The documentation included that the bruise was of an unknown origin. A wound assessment dated (MONTH) 25, (YEAR) included the resident had a dark purple blue bruise to her right eye and that it was an injury of an unknown origin. The facility was unable to provide any documentation that the injury of unknown origin from (MONTH) 24, was reported to the State Survey Agency. An interview was conducted with the Director of Nursing (DON/staff #263) on (MONTH) 5, (YEAR) at 7:24 a.m. Staff #263 confirmed that the injuries of an unknown source were not reported to the State Survey Agency. An interview was conducted on (MONTH) 5, (YEAR) at 1:14 p.m. with a registered nurse (staff #288), who stated that she was aware of the laceration to the resident's eye, a hematoma to the resident's head and other injuries of unknown origin. She said when a resident has an injury, an incident report is completed by nursing staff and that the station nurse calls the State Agency. She said the incident report is given to the Assistant Director of Nursing (ADON). Another interview was conducted with staff #263 on (MONTH) 6, (YEAR) at 8:45 a.m. Staff #263 stated that there is a process for reporting injuries, which begins with the CNA reporting the injury to the charge nurse and the charge nurse writes the incident report. She stated that the charge nurse then calls the ADON, DON, or the Administrator to report it and the charge nurse is instructed as to whether to report the incident to the State Agency. Staff #263 said that all employees have been trained and know that an injury of unknown origin is a possible incident of abuse. Review of the facility's policy regarding Abuse Prohibition Standards of Practice revealed that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source are reported immediately to the administrator of the facility and to other officials (including the State Survey Agency), no later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury.
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, staff interviews, facility documentation and policies and procedures, the facility failed to thoroughly investigate an allegation of sexual assault involving two residents (#25 and #76). Findings include: -Resident #25 was admitted on (MONTH) 10, (YEAR), with [DIAGNOSES REDACTED]. An annual MDS (Minimum Data Set) assessment dated (MONTH) 28, (YEAR) documented the resident had severe cognitive impairment with skills for decision making and needed extensive assistance of two persons with bed mobility and transfers. A nurses' note dated (MONTH) 26, (YEAR) at 9:36 a.m., revealed resident #25 was yelling that his roommate (resident #76) had tried to rape him and steal his wrist watch. Another nurses' note dated (MONTH) 26, (YEAR) at 6:17 p.m. revealed documentation of the incident and that the nurse completed a head to toe assessment, which did not provide any evidence of the claim of rape. -Resident #76 was admitted on (MONTH) 19, (YEAR), with [DIAGNOSES REDACTED]. Review of the care plans for resident #76 revealed the resident can be sexually inappropriate with female staff. Interventions were to offer activity programs which were directed toward specific interests of the resident and to redirect if being sexually inappropriate with female staff members or peers. Review of facility's investigative documentation revealed that this allegation was reported to the State Agency on (MONTH) 26, (YEAR), within the required timeframe. Further review the facility's investigative report revealed there was no documentation of the nurses' head to toe assessment of resident #25, as documented in the nurses note from (MONTH) 26. On (MONTH) 7, (YEAR) at 11:30 a.m., a telephone interview was attempted with the LPN (Licensed Practical Nurse/staff #185), who had documented in the nurse's note on (MONTH) 26, that a head to toe assessment of resident #25 had been completed. However, staff #185 was unable to be reached. An interview was conducted on (MONTH) 7, (YEAR), with the Director of Nursing (DON/staff #263). Staff #263 stated that a head to toe assessment of resident #25 could not be located anywhere, and that staff should have completed the assessment to rule out or to provide supportive evidence as to whether a sexual assault or any other physical injury had occurred. Review of the facility's Abuse policy regarding investigating allegations of abuse revealed that all allegations of abuse should be thoroughly investigated and include documentation of the physical examination of the resident alleging the abuse.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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 observation, clinical record review, facility documentation and staff interviews, the facility failed to ensure that adequate supervision was provided to one resident (#107) to prevent injuries. Findings include: Resident #107 was readmitted on (MONTH) 10, (YEAR), with [DIAGNOSES REDACTED]. An annual MDS (Minimum Data Set) assessment dated (MONTH) 31, (YEAR) revealed the resident had severe cognitive impairment with daily decision making. Review of a care plan revealed the resident had a visual deficit and was at risk for falls. The care plan was updated on (MONTH) 15, (YEAR) to reflect that the resident had a small bruise to the left eyelid. One of the interventions was for one-to-one care at all times for safety.

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	035175	A. BUILDING _____ B. WING _____	12/07/2018

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) A behavior care plan dated (MONTH) 16, (YEAR) included that the resident was totally dependent on staff, required one-to-one staffing ratio at all times and for 2-3 staff to provide care. Review of a wound assessment dated (MONTH) 11, (YEAR), revealed that the resident had a round bruise which measured 4.0 cm by 4.0 cm on her sacrum. The cause of the injury was unknown. According to the facility's investigative report, a CNA reported that when staff changed the resident's brief, they noticed a bump on the sacrum, which was the size of a baseball. The report further included that the area had a round raised bruised area on the sacrum. A wound assessment was completed on (MONTH) 12, (YEAR), which documented that the resident had a dark purple blue bruise on the left side of the bridge of her nose, along with a small bruise on the left interior crack of her eye. The cause of the injuries were unknown. Further review of the care plan revealed the resident continued to be at risk for falls. The care plan was updated on (MONTH) 12, (YEAR) to reflect that the resident had a bruise on the left side of the bridge of her nose. One of the interventions was to provide one-to-one care to ensure the resident's safety. Review of a wound assessment dated (MONTH) 20, (YEAR) revealed the resident had a firm nodule at the lower posterior side of her head, with an open center. Review of the facility's investigative report revealed that the lead CNA was conducting rounds at 8:00 a.m. on (MONTH) 20, (YEAR), and found the night CNA (staff #310) who was assigned to the resident sitting at the edge of the resident's bed sleeping, with his arm laid across the upper back of the resident and the resident was also sleeping. The incident was reported to a licensed practical nurse (LPN/staff #70) who came into the resident's room and witnessed staff #310 sleeping. Per the report, staff #310 apologized for sleeping and left the facility. Within minutes of staff #310 leaving, a CNA checked on the resident and discovered blood on the resident's blanket (the resident was wearing a soft helmet which was only supposed to be worn when the resident was not in bed). Staff removed the helmet and saw a wound (4 cm by 3 cm with an open area which was 2 cm by 1 cm) to the back of the resident's head that was bleeding. A LPN (staff #288) was not able to safely control the bleeding, so the resident was sent to the hospital. Review of the hospital documentation revealed the resident had a 3 cm scalp laceration with mild underlying hematoma. CT scan showed no fractures or hemorrhage. The laceration was closed with two staples. A nursing note dated (MONTH) 20, (YEAR) at 10:09 p.m. revealed the resident had returned from the hospital, due to an unknown injury to the back of the resident's head. The note included that the resident was on 1:1 for safety and wellness. Review of a wound assessment dated (MONTH) 25, (YEAR), revealed the resident had a dark purple blue bruise to her right eye and that the injury was of an unknown origin. Despite documentation of ongoing one-to-one supervision, the resident continued to sustain multiple injuries. An interview was conducted with the Director of Nursing (DON/staff #263) on (MONTH) 5, (YEAR) at 7:24 a.m. Staff #263 stated that the resident is supposed to wear a soft helmet whenever she is not in bed, and that the helmet is padded enough around the resident's forehead area, so they did not see how the resident would have injured the bridge of her nose by falling. She said that if the resident had fallen, the end of the resident's nose would have hit the ground. Staff #263 was unable to explain how the resident could have sustained multiple injuries of unknown origin, when the resident had 1:1 supervision at all times. An interview was conducted with a CNA (staff #150) on (MONTH) 5, (YEAR) at 10:09 a.m. Staff #150 stated that the resident continuously rolls around in bed with her eyes closed, and when the resident wakes up she gets up very fast, so a CNA must sit next to the bed at all times to keep the resident from rolling off the bed or falling. She stated that she does have to leave the resident in bed and go to the bedroom door, in order to ask for someone to supervise the resident, so she can take a break. At this time, the resident's curtain was observed pulled shut and the resident was not visible from the doorway. Staff #150 said that the curtain was usually closed, because the resident's roommate preferred it closed for privacy. She acknowledged that you could not see the resident from the bedroom door, because the curtain blocked the view of the resident. She also stated that there was no call light in the resident's room, so she had to go to the resident's bedroom door to get help, when she needed to go on a break. An interview was conducted with a CNA (staff #291) on (MONTH) 5, (YEAR) at 11:00 a.m. Staff #291 stated that the resident rolls around in bed and when she wants to get up if the staff person is not next to bed, the resident will fall on the floor. Staff #291 stated that the curtain in the resident's room is often closed, so she is not able to see the resident when she has to go to the door. She said that she has gone to the door with the curtain closed to ask staff to relieve her, so she can take a break. An interview was conducted with a registered nurse (staff #288) on (MONTH) 5, (YEAR) at 1:14 p.m., who stated that a CNA is assigned to the resident. Staff #288 said there is a primary CNA and a secondary CNA who covers for the primary CNA, if the primary CNA needs a break. She said the primary CNA assigned to the resident can come out of the resident's room, if the CNA needs assistance. She also acknowledged that the resident does not have a call light in her room, so the CNA's cannot use the call light when they need assistance. Staff #288 also stated that the CNA needs to sit close to the resident's bed, because it is normal behavior for the resident to roll out of bed. An observation was conducted on (MONTH) 6, (YEAR) of the resident's room and there was no call light by her bed, and there was no call light cord for the resident's roommate. Another interview was conducted with the DON on (MONTH) 6, (YEAR) at 8:45 a.m. The DON stated that on (MONTH) 20, (YEAR) when the injury to the back of the resident's head was found by the morning staff, the night CNA (staff #310) had been found sleeping.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, and policy review, the facility failed to ensure that expired medications were not available for resident use and failed to ensure a controlled medication was not returned to the broken seal card and secured with tape. Findings include: -During a medication room observation conducted on the Sunset unit with a licensed practical nurse (LPN/staff #300) on (MONTH) 5, (YEAR) at 8:10 a.m., one vial of [MEDICATION NAME] 23 (vaccine) was observed with an expiration date of (MONTH) 8, (YEAR) and two IV (intravenous) extension sets were observed with an expiration date of (MONTH) (YEAR). Following the observation, an interview was conducted with staff #300. She stated that the nurses on the unit are supposed to check for expired items in the carts and in the medication room. The LPN stated that expired items should be discarded. During an interview conducted with the Director of Nursing (DON/staff #263) on (MONTH) 5, (YEAR) at 1:24 p.m., she stated that she is ultimately responsible for ensuring that there are no expired drugs or items in the medication rooms and carts. She stated that the assistant director of nursing is delegated to check weekly for expired items/medications in the medication rooms and carts. The DON also stated that the night nurses are supposed to check the medication rooms at least once or twice a week for expired items and that the nurses should check the expiration date of medications before administering them. The facility's policy regarding Storage of Medication included, Outdated, contaminated, discontinued or deteriorated medications are immediately removed from stock and disposed of according to procedures for medication disposal. -During a medication cart observation conducted on the Sunset unit with a registered nurse (RN/staff #288) on (MONTH) 5, (YEAR) at 10:21 a.m., a review of a [MEDICATION NAME] (antianxiety) controlled medication sheet revealed that there were 23 tablets remaining. However, review of the medication card revealed there were 24 tablets left. Continued reviewed of the medication card revealed the medication slot 24 was opened and a piece of tape had been used to seal the tablet into the medication card. Following this observation, an interview was conducted with staff #228. She stated that she had removed a [MEDICATION NAME]

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F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 5) to administer to a resident and had signed out for the medication on the medication sheet when she realized that it was not time for the medication. The RN stated that she placed the [MEDICATION NAME] back into the hole and sealed it with a piece of tape. When asked about the entry on the medication sheet, the RN stated that it was a mistake and crossed out her entry. She then stated that the medication could have easily popped out by accident and that she had sealed the medication with tape so that she can administer the medication later. The RN stated that she will not waste the medication. During an interview conducted with a licensed practical nurse (LPN/staff #79) on (MONTH) 5, (YEAR) at 10:29 a.m., she stated that when the medication card seal is opened by accident or by mistake, she will waste the medication and inform her supervisor. The LPN stated that when this happens, you cannot put the medication back and secure it with tape. An interview was conducted with the Director of Nursing (DON/staff #263) on (MONTH) 5, (YEAR) at 1:24 p.m. She that stated that if for some reason the nurse made a mistake in punching the medication out of the card and was not going to administer the medication to the resident, the nurse would have to waste the medication. The DON also stated that the nurse would have to write a reason on the back of the medication sheet why the medication was wasted and that two nurses will have to sign the sheet. She stated that it is standard of practice that medications removed from the medication card by mistake are not to be placed back into the card and sealed with tape. The facility's policy on Controlled Medication Storage included that .controlled substances are subject to special handling, storage, disposal, and record keeping in the nursing care center in accordance with Federal, State, and other applicable laws and regulations.
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 observation, staff interview, and review of policy and procedures, the facility failed to ensure two large metal containers of strawberry jello with fruit were covered when stored in the refrigerator. Findings include: During the initial tour of the kitchen conducted on (MONTH) 3, (YEAR) at 8:35 a.m., two large metal containers of solidified strawberry jello with fruit was observed in the walk-in refrigerator not covered. Following this observation, an interview was conducted with the kitchen manager (staff #313). He stated that the jello is always left uncovered during the cooling off process. Staff #313 stated that the jello was still in the cooling process although the two containers of jello may look solidified and that the cooling process can take 3-4 hours. However, he was unable to say how long the jello had been in the refrigerator uncovered and was unable to state how cross contamination was being prevented. Review of the facility's policy regarding Cooling of Cooked Foods and the Cooling Food Temperature Log revealed that food should be put into the cooler when it has reached 135 degrees Fahrenheit (F) and to leave the food loosely covered until the temperature reaches 41 degrees F, then cover, label, and date.
F 0867 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.** Based on concerns identified during the follow-up survey, facility documentation, staff interviews, and policies and procedures, the facility's Quality Assurance (QA) committee failed to identify quality concerns and implement effective plans of action to correct the deficiencies related to abuse. Findings include: During the facility's recertification survey, resident to resident sexual and physical abuse was identified and cited for 3 residents. During the follow-up survey, concerns were also identified regarding ongoing resident to resident altercations of verbal and physical abuse, involving 3 residents. Review of the facility's QA documentation for (MONTH) and (MONTH) 2019 revealed that the facility interviewed residents using a questionnaire to determine if any abuse occurred and to create an environment of freedom to report any potential abuse. The results were submitted to QA for review and further discussion. However, there was no evidence that the QA committee identified ongoing concerns regarding resident to resident abuse and developed and implemented a corrective action plan. An interview was conducted with the administrator (staff #273) and the Director of Nursing (DON/staff #1) at 4:20 p.m. on 3/12/19. The administrator said that the QA committee is taking resident to resident altercations to QA and discussing them even though this does not appear in the documentation provided for the QA committee. He said that they are tracking them and looking for trends. He said that they have created many different interventions to prevent the resident to resident altercations including a unit expectation list that was implemented in (MONTH) 2019 which details different expectations of each secured behavioral unit. He said that this has helped reduce the occurrence of altercations. The DON said that one of the biggest issues they have is space. The residents could use their own rooms and more space to keep them calm. Both the DON and the administrator said that the QA is ongoing for the resident to resident altercations and that they are working on it, but that they have not resolved the resident to resident altercations at this time. Review of the facility's QA policy revealed that the purpose is to ensure an interdisciplinary approach to all resident's needs and to provide the highest level of care possible. The policy noted that all changes will be communicated with the interdisciplinary team, responsible party, and physician. Nursing administration will review the 24 hour report each day and report all problems to the DON or designee and the QA committee during the QA daily meeting. The QA committee will follow up daily but no less than weekly, to review outcomes and ensure the highest level of care possible in all areas of the facility.