STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035232	A. BUILDING _____ B. WING _____	**11/15/2018**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MOUNTAIN VIEW CARE CENTER	**1313 WEST MAGEE ROAD TUCSON, AZ 85704**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0600 **Level of harm -** 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 observations, clinical record reviews, staff interviews, facility documentation and policies and procedures, the facility failed to ensure that one resident (#4) was free from neglect which resulted in a severe sunburn, and failed to ensure that two residents (#'s 31 and 32) were free from resident to resident abuse. Findings include: -Resident #4 was readmitted to the facility on (MONTH) 7, (YEAR), with [DIAGNOSES REDACTED]. A review of the quarterly MDS (Minimum Data Set) assessment dated (MONTH) 3, (YEAR) revealed the resident had severe cognitive impairment with skills for daily decision making and required extensive assistance for locomotion off the unit. A care plan included that the resident prefers to initiate activities of choice independently. A goal was to participate in his preferred leisure activities daily. Interventions included that it was somewhat important for the resident to go outside for fresh air when the weather was good, for staff to encourage the resident to go outside when weather was good and to assist outside for fresh air. A care plan for the potential to demonstrate verbally abusive behaviors related to ineffective coping skills included to give the resident as many choices as possible about care and activities. A Nursing Note dated (MONTH) 10, (YEAR) at 11:38 a.m. included that the Nurse practitioner was in to see the resident related to being found outside. Orders given to start IV (intravenous) fluids and [MEDICATION NAME] was administered for pain. Will continue to monitor. A Nursing Note dated (MONTH) 10, (YEAR) at 2:35 p.m. revealed Checked on patient related to being found outside this morning. Thighs were noted to be red and starting to get blisters. Nurse practitioner .called and orders were given to apply Aloe [NAME] Gel to thighs every shift and as needed and to finish the liter of fluids .Denies pain at this time but states that his legs hurt if you touch them . Another Nursing Note dated (MONTH) 10, (YEAR) at 3:00 p.m. revealed Resident was found outside the patio by CNA (certified nursing assistant), warm to touch, observed with altered cognition. Offered fluids as tolerated, cool compress applied. Nurse practitioner present, evaluated resident. Assisted to bed, kept comfortable and continue offering fluids, and cool compress. Observed slight redness lower abdomen and reddened area on both front of thighs and feet .Resident alert, oriented and able to verbalize needs at this time, but unaware of him being outside . An IDT (Interdisciplinary Team) Note dated (MONTH) 11, (YEAR) documented Investigation started to how long resident was outside. He frequently goes outside by himself. Will get policy for residents going outside. MD (medical doctor) in facility to see resident. A Skin Ulcer Non-Pressure Weekly note dated (MONTH) 11, (YEAR) documented .Top of head only very light pink and appears to be quickly resolving. Arms and hands light pink. Left great toe with intact pink blister. Left thigh is most affected area with redness along entire thigh and intact blister along anterior lateral thigh. Right thigh has redness, anterior thigh, shoulder redness intact . A Nursing Note dated (MONTH) 12, (YEAR) at 2:57 p.m. included .skin care rendered to reddened and superficial open areas . A nursing note dated (MONTH) 14, (YEAR) at 3:16 p.m. included the resident had a bath this morning and most of the closed blistered areas had opened to left thigh, superficial open areas noted, wound care nurse informed. A Skin Ulcer Non-Pressure Weekly note dated (MONTH) 18, (YEAR) documented .All areas resolved except for thighs and left knee. There are still areas covering thighs with redness and notable intact stable scabs over left thigh and left knee. All areas may remain open to air at this time . A Nursing Note dated (MONTH) 21, (YEAR) at 1:17 p.m. revealed Dr .in and updated resident's condition and concerns on skin alteration on his thigh, no new order received . A Skin Ulcer Non-Pressure Weekly note dated (MONTH) 21, (YEAR) revealed .Right thigh has disperse scabbing surrounded by redness that appear to be healing as expected. No drainage or signs and symptoms of infection. The scabbing on right thigh appears thin not involving deeper tissue. Left thigh with extensive scabbing/eschar dispersed over most of surface area of the anterior and lateral thigh. Left knee has eschar that has unknown depth of tissue involvement of approximately 10 x 3 centimeters surface area . Review of a physician progress notes [REDACTED].Earlier this month the patient went outside, quite atypically for him and sat in the sunshine during the day. He was later found, and with the polyester pants that he had on collecting the sunlight, he sustained sunburns from his knees to his hips on the dorsum of his thighs that are almost coalescent in places. While originally just [DIAGNOSES REDACTED] and blisters, as they have evolved some of these are undoubtedly full-thickness and covered with eschar. These are currently left uncovered and cleaned daily. He also has a one centimeter area on his medial aspect of his left great toe that occurred on the same day .I requested today that they be updated, having been asked to see the 'sunburn' for the first time today. Some of these wounds on this particular patient will take the better part of 6 months to heal .He unfortunately sustained significant solar injury to his thighs that will take time to heal . A Skin Ulcer Non-Pressure Weekly note dated (MONTH) 24, (YEAR) included .Right thigh has disperse scabs on anterior surface of skin. All scabs appear stable and surrounding redness has faded showing improvement from last assessment .There are several very small fluid filled blisters on medial surface of upper thigh. Left thigh has scabs over anterior and lateral surface of skin. The scabs/eschar are significant and remain thickened with unknown tissue involvement beneath particularly over patients left knee. No signs/symptoms of infection . A Nursing Note dated (MONTH) 25, (YEAR) at 11:36 a.m. revealed .the patient's wounds are showing improvement in the sense that the surrounding skin around the scabs are less pink and there continues to be no signs and symptoms of infection. Review of the facility's investigative report dated (MONTH) 28, (YEAR) revealed .to the best of our knowledge we are able to identify that (resident's name) was in his room at approximately 10:05 a.m. and (name of CNA) checked on (name of resident) in the courtyard at approximately 10:45 a.m. Thus, it is believed that (name of resident) was outside for approximately 30 to 40 minutes .Review of the weather temperatures on Monday (MONTH) 10, (YEAR) identify that at 6:00 a.m. the temperature was 90 degrees and at 12:00 p.m. temperatures were recorded at 99 degrees .Prior to this incident it was the custom and practice of CNA's performing rounds to check the courtyard as part of their rounds. However, there was no documentation evidencing the courtyard was checked . Review of a Skin Ulcer Non-Pressure Weekly note dated (MONTH) 2, (YEAR) revealed .Right and left thighs continue with dispersed intact scabs on anterior surface of skin. All scabs appear stable and surrounding tissue is pink intact scar

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035232	A. BUILDING _____ B. WING _____	11/15/2018

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MOUNTAIN VIEW CARE CENTER	1313 WEST MAGEE ROAD TUCSON, AZ 85704

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0600 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) tissue. Wounds are showing improvement . A physician's orders [REDACTED]. A physician's orders [REDACTED]. A nurse practitioner note dated (MONTH) 4, (YEAR) revealed the following: The resident had an episode in which he was self-propelling his wheelchair and was found after being stuck in a sun-exposed area of the courtyard for unknown period of time, but felt to be 25-45 minutes based on courtyard rounds. He was lethargic and very warm. His heavier clothes were removed and he was given ice water and cool towels, and as a precaution was given IV fluids of 500 milliliters .It was noted later that the pants he had on at the time had retained a significant amount of heat, causing blistering wounds to the anterior of both thighs. He has been followed by the wound care team very closely since then and his thighs appear to be healing very well. No apparent infections or concerns . A physician note dated (MONTH) 5, (YEAR) included I am seeing the patient in follow-up of [MEDICAL CONDITION] the bilateral legs from thighs to knees. These are narrowing to a strip of eschar on each side that are clearly improving. He is reporting no complaints of pain except when dressing changes are done he will simply ask that care be exercised .Since our last visit the patient has been doing considerably better. He fortunately seems to be not uncomfortable with his wounds. The scabs will start to clear fairly soon. [MEDICATION NAME] treatment is obviously being used .Full thickness burn of thigh . A physician's orders [REDACTED]. Change daily . Review of a Skin/Wound Note dated (MONTH) 23, (YEAR) revealed Right and left thighs continue with dispersed eschar on anterior surface of skin. Most eschar presents with lifting from wound bed. Eschar to left knee continues to be stable. Surrounding tissue is pink intact scar tissue. Wounds are showing improvement. Patient will complain of mild pain .pain subsides when treatment is done .Provider updated, continue current treatment of [REDACTED]. A Skin/Wound Note dated (MONTH) 30, (YEAR) included Eschar to left shoulder was unstable and was separated from wound bed, wound bed presents with pink [MEDICATION NAME] tissue. Surrounding tissue is intact scar tissue. Bilateral anterior thighs continue with stable eschar, surrounding tissue is showing pink intact scar tissue. Intact scar tissue present to areas of where eschar has separated from wound bed and sloughed off. No indication of infection . A Nursing Note dated (MONTH) 9, (YEAR) included .Treatments to bilateral thigh areas and left shoulder continue., per wound nurse .the scabbed area over the left knee has begun to lift, each site is free from signs and symptoms of infection and are showing positive progression . An interview was conducted with a LPN (licensed practical nurse/staff #59) on (MONTH) 14, (YEAR) at 9:05 a.m. Staff #59 stated that they did not know how long the resident was outside when he got sunburned. Staff #59 stated that staff used to check the courtyard maybe every two hours to ensure residents were safe, but did not document when this was done. Staff #59 further stated that since the incident, 30 minute checks of the courtyard are done and are documented. An interview was conducted on (MONTH) 14, (YEAR) at 9:15 a.m., with the CNA (certified nursing assistant/staff #20) who found the resident outside. Staff #20 stated that she had just returned from lunch when she looked out the window of another resident's room across the hall from resident #4, and she saw resident #4 outside. Staff #20 stated that the resident was unresponsive, so she quickly brought the resident back into the facility and called a nurse. Staff #20 stated that when she found the resident, the wheel of his wheelchair was off of the path in the courtyard, as the ground was unlevel and the resident's wheelchair was stuck. Staff #20 stated that she did not know how long the resident had been in the courtyard. Staff #20 stated that staff check the courtyard all the time, but do not document when it's done. Staff #20 stated that there was no set time when the courtyard was to be checked. During the interview with staff #20, it was observed that when the door was opened at the end of the hall near resident #4's room, the door alarmed. Observations further revealed that if the door was shut after someone exited the unit, the alarm automatically shut off. When asked who had the responsibility to respond when the alarm sounded in order to determine who exited the building, staff #20 stated that it was everyone's responsibility and those who hear the alarm. An interview was conducted with another CNA (staff #14) on (MONTH) 14, (YEAR) at 9:25 a.m. Staff #14 stated that it was everyone's responsibility to check the alarm at the end of the hall to determine who exited the unit, but there was no specific person who was assigned to this task. Staff #14 further stated that if she was busy, someone else would check the door. An interview was conducted with the Administrator (staff #121) on (MONTH) 14, (YEAR) at 11:15 a.m. Staff #121 stated that when the incident occurred, staff were checking the courtyard every 30 minutes to ensure resident safety, but it was not documented that it was done. Review of the facility's policy regarding Resident Safety revealed, It is the policy of this facility to create a safe environment for the resident .Make routine visits to check on the resident's condition and comfort . Review of the facility's Abuse policy revealed that it is the policy of this facility that each resident has the right to be free from neglect. Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm and pain. -Resident #31 was admitted to the facility on (MONTH) 14, (YEAR), with [DIAGNOSES REDACTED]. Review of the admission MDS assessment dated (MONTH) 21, (YEAR), revealed a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. The MDS included that the resident exhibited verbal behaviors toward others on 1-3 days of the lookback period. -Resident #32 was admitted to the facility on (MONTH) 14, (YEAR), with [DIAGNOSES REDACTED]. Review of the admission MDS assessment dated (MONTH) 21, (YEAR), revealed a BIMS score of 10, which indicated the resident had moderate cognitive impairment. The MDS included the resident exhibited physical and verbal behaviors toward others on 1-3 days of the lookback period. Review of the facility's investigative documentation revealed that on (MONTH) 25, (YEAR), resident #31 and resident #32 were witnessed yelling at each other. The report included that resident #32 had resident #31 by the arm near his left elbow and pinched him, and then resident #31 hit her on the bottom with a cane. Resident #31 sustained a skin tear to the left arm. An interview was conducted with resident #31 on (MONTH) 13, (YEAR) at 12:49 p.m. He stated that resident #32 scraped the skin off of his arm when she got mad at him. An interview was conducted with resident #32, however she was unable to recount the details of the incident. An interview was conducted with a CNA (staff #65) on (MONTH) 14, (YEAR) at 1:37 p.m. She stated that in the event of abuse, she would make sure the resident is removed from the situation and is safe. An interview was conducted with a LPN (staff # 25) on (MONTH) 14, (YEAR) at 1:51 p.m. She stated that in the case of abuse she would remove the resident and make sure they are okay, and then notify the Administrator immediately. An interview was conducted with a CNA (staff #114) on (MONTH) 15, (YEAR) at 10:02 a.m. She stated that resident #32 uses mean words and a mean tone with resident #31. She stated that resident #32 will get angry at resident #31. She stated that she checks on them every 15-30 minutes, but the checks are not at a scheduled time and she does not document the checks. An interview was conducted with a LPN (staff #31) on (MONTH) 15, (YEAR) at 10:14 a.m. She stated that she could recall the incident between resident #31 and resident #32 on (MONTH) 25, (YEAR), as she was the nurse on that hall at the time. She stated that she was at her medication cart and heard someone talking loudly. She stated that resident #31 and resident #32 were walking side by side and resident #32 grabbed resident #31 by the arm. She stated that she had the CNA (staff #119) wait with the residents until she could get there. She said that resident #32 told her that she was not trying to hurt resident #31 and that she grabbed his arm to get his attention because he was a little in front of her, and her nails got caught in his skin. She stated that resident #31 told her that he was startled and that is why he hit resident #32 on the bottom with the cane to get her to stop. She said that if she observed physical or verbal outbursts between residents, she would separate them and report the issue. She stated that staff keep a close eye on resident #31 and resident #32 and watch for any agitation or behaviors. An interview was conducted with the Administrator (staff #121) on (MONTH) 15, (YEAR) at 10:44 a.m. He stated that in the case of a resident to resident altercation, they first make sure the residents are safe by separating the residents, and then try and determine what triggered the event. He stated that these residents had behaviors before entering the facility. He said that they set up as many interventions as possible to minimize any abusive situation, as residents have the right to be free from abuse. An interview was conducted with a LPN (staff #79) on (MONTH) 15, (YEAR) at 12:06 p.m. He stated that it is well known that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035232	A. BUILDING _____ B. WING _____	11/15/2018

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MOUNTAIN VIEW CARE CENTER	1313 WEST MAGEE ROAD TUCSON, AZ 85704

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0600 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 2) resident #32 scratches and pinches resident #31, and that they are constantly bickering. He stated that he has seen resident #32 scratch or pinch resident #31, at which point resident #31 yells out and then resident #32 has said I will get you with the cane next time. He stated that they need to look out for the residents and uphold resident rights and do all they can to protect the residents. An interview was conducted with a CNA (staff #119) on (MONTH) 15, (YEAR) at 3:05 p.m. She stated that she was working the hall during the event between resident #31 and resident #32. She stated that she witnessed resident #32 trying to pull resident #31 into their room by holding his right arm above the elbow. She said that she witnessed resident #31 get the cane and smacked resident #32, but she was too far away to stop him. She said that resident #31 told her that it caused a skin tear and it hurt him. Review of the Abuse policy revealed that each resident had the right to be free from abuse. The policy included the facility will take action to protect and prevent abuse and neglect from occurring within the facility by; identifying, correcting and intervening in situations in which abuse is more likely to occur; and identifying, assessing, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect such as: Verbally aggressive behavior and physically aggressive behavior. The policy further included that if an allegation of abuse is reported, discovered or suspected, the facility will protect all residents from physical and psychosocial harm during and after the investigation; including increase supervision of the alleged victim and residents. If the allegation of abuse involved another resident, the facility will separate the residents so that they do not interact with each other until circumstances of the reported incident can be determined and the facility would continue to assess, monitor and intervene as necessary to maximize resident health and safety.
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 reviews, staff interviews, facility documentation and policies and procedures, the facility failed to implement their Abuse and Neglect policy for three residents (#'s 4, 31 and 32). Findings include: -Resident #4 was readmitted to the facility on (MONTH) 7, (YEAR), with [DIAGNOSES REDACTED]. A Nursing Note dated (MONTH) 10, (YEAR) at 11:38 a.m. included that the Nurse practitioner was in to see patient related to being found outside. Orders given to start IV (intravenous) fluids and [MEDICATION NAME] was administered for pain. Will continue to monitor. A Nursing Note dated (MONTH) 10, (YEAR) at 2:35 p.m. revealed Checked on patient related to being found outside this morning. Thighs were noted to be red and starting to get blisters. Nurse practitioner .called and orders were given to apply Aloe [NAME] Gel to thighs every shift and as needed and to finish the liter of fluids .Denies pain at this time but states that his legs hurt if you touch them . Another Nursing Note dated (MONTH) 10, (YEAR) at 3:00 p.m. revealed Resident was found outside the patio by CNA (certified nursing assistant), warm to touch, observed with altered cognition. Offered fluids as tolerated, cool compress applied. Nurse practitioner present, evaluated resident. Assisted to bed, kept comfortable and continue offering fluids, and cool compress. Observed slight redness lower abdomen and reddened area on both front of thighs and feet .Resident alert, oriented and able to verbalize needs at this time, but unaware of him being outside . Review of a physician progress notes [REDACTED].Earlier this month the patient went outside, quite atypically for him and sat in the sunshine during the day. He was later found, and with the polyester pants that he had on collecting the sunlight, he sustained sunburns from his knees to his hips on the dorsum of his thighs that are almost coalescent in places. While originally just [DIAGNOSES REDACTED] and blisters, as they have evolved some of these are undoubtedly full-thickness and covered with eschar. These are currently left uncovered and cleaned daily. He also has a one centimeter area on his medial aspect of his left great toe that occurred on the same day .I requested today that they be updated, having been asked to see the 'sunburn' for the first time today. Some of these wounds on this particular patient will take the better part of 6 months to heal .He unfortunately sustained significant solar injury to his thighs that will take time to heal . Review of the facility's investigative report revealed that on (MONTH) 10, (YEAR) at approximately 10:05 a.m., resident #4 was in his room. At approximately 10:45 a.m., a CNA checked the resident in the courtyard Thus, it is believed that (name of resident) was outside for approximately 30 to 40 minutes .Review of the weather temperatures on Monday (MONTH) 10, (YEAR) identify that at 6:00 a.m. the temperature was 90 degrees and at 12:00 p.m. temperatures were recorded at 99 degrees.Further review of the facility's investigative report revealed that the incident occurred on (MONTH) 10, (YEAR), however, it was not reported to the State Survey Agency until (MONTH) 25, (YEAR). An interview was conducted with the Administrator (staff #121) on (MONTH) 15, (YEAR) at 8:05 a.m. Staff #121 stated that it is the policy of the facility to report allegations of neglect and abuse, within the required time frames. Staff #121 stated that the incident which occurred on (MONTH) 10, (YEAR), was not reported to the State Agency until (MONTH) 25, (YEAR), due to differing opinions as to whether the incident was reportable, because initially the resident had a mild sunburn but then the wounds worsened. Review of the facility's Abuse policy revealed that all allegations of abuse and neglect will be reported to the appropriate State or Federal agencies in the applicable timeframes, as per this policy and applicable regulations . -Resident #31 was admitted to the facility on (MONTH) 14, (YEAR), with [DIAGNOSES REDACTED]. -Resident #32 was admitted to the facility on (MONTH) 14, (YEAR), with [DIAGNOSES REDACTED]. Review of the facility's investigative documentation revealed that on (MONTH) 25, (YEAR), resident #31 and resident #32 were witnessed yelling at each other. The report included that resident #32 had resident #31 by the arm near his left elbow and pinched him, and then resident #31 hit resident #32 on the bottom with a cane. Resident #31 sustained a skin tear to the left arm. Further review of the facility's investigative report revealed there were no interviews with resident #31 or resident #32 as to what occurred, nor were there interviews with other residents who may have been in the area at the time of the incident. The report also did not include a statement from a second witness or from any other staff members. An interview was conducted with the Administrator (staff #121) on (MONTH) 15, (YEAR) at 10:44 a.m. He stated that during an investigation they interview any witnesses and obtain their statements, they obtain statements from the residents involved if able, and talk with other residents and staff. Staff #121 said that the investigation was completed by the previous DON and was not a complete investigation. He stated that they did not follow their policy and procedures, as the investigation did not include a statement from a CNA who witnessed the incident, nor any interviews with staff or other residents who may have been in the area. Review of the Abuse policy revealed that the investigation should include interviews with the residents involved, other residents, staff (on all shifts) and any witnesses to the incident, who may have information regarding the alleged incident.
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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview, facility documentation and policies and procedures, the facility failed to report an incident of neglect to the State Agency within two hours as required for one resident (#4). Findings include: Resident #4 was readmitted to the facility on (MONTH) 7, (YEAR), with [DIAGNOSES REDACTED]. A Nursing Note dated (MONTH) 10, (YEAR) at 11:38 a.m. included that the Nurse practitioner was in to see the resident related to being found outside. Orders given to start IV (intravenous) fluids and [MEDICATION NAME] was administered for pain. Will continue to monitor. A Nursing Note dated (MONTH) 10, (YEAR) at 2:35 p.m. revealed Checked on patient related to being found outside this morning. Thighs were noted to be red and starting to get blisters. Nurse practitioner .called and orders were given to apply Aloe [NAME] Gel to thighs every shift and as needed and to finish the liter of fluids .Denies pain at this time but

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035232	A. BUILDING _____ B. WING _____	**11/15/2018**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MOUNTAIN VIEW CARE CENTER	**1313 WEST MAGEE ROAD TUCSON, AZ 85704**

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 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) states that his legs hurt if you touch them . Another Nursing Note dated (MONTH) 10, (YEAR) at 3:00 p.m. revealed Resident was found outside the patio by CNA (certified nursing assistant), warm to touch, observed with altered cognition. Offered fluids as tolerated, cool compress applied. Nurse practitioner present, evaluated resident. Assisted to bed, kept comfortable and continue offering fluids, and cool compress. Observed slight redness lower abdomen and reddened area on both front of thighs and feet .Resident alert, oriented and able to verbalize needs at this time, but unaware of him being outside . Review of a physician progress notes [REDACTED].Earlier this month the patient went outside, quite atypically for him and sat in the sunshine during the day. He was later found, and with the polyester pants that he had on collecting the sunlight, he sustained sunburns from his knees to his hips on the dorsum of his thighs that are almost coalescent in places. While originally just [DIAGNOSES REDACTED] and blisters, as they have evolved some of these are undoubtedly full-thickness and covered with eschar. These are currently left uncovered and cleaned daily. He also has a one centimeter area on his medial aspect of his left great toe that occurred on the same day .I requested today that they be updated, having been asked to see the 'sunburn' for the first time today. Some of these wounds on this particular patient will take the better part of 6 months to heal .He unfortunately sustained significant solar injury to his thighs that will take time to heal . Review of the facility's investigative report revealed that on (MONTH) 10, (YEAR) at approximately 10:05 a.m., resident #4 was in his room. At approximately 10:45 a.m., a CNA checked the resident in the courtyard Thus, it is believed that (name of resident) was outside for approximately 30 to 40 minutes .Review of the weather temperatures on Monday (MONTH) 10, (YEAR) identify that at 6:00 a.m. the temperature was 90 degrees and at 12:00 p.m. temperatures were recorded at 99 degrees.Further review of the facility's investigative report revealed that the incident occurred on (MONTH) 10, (YEAR), however, it was not reported to the State Survey Agency until (MONTH) 25, (YEAR). An interview was conducted with the Administrator (staff #121) on (MONTH) 15, (YEAR) at 8:05 a.m. Staff #121 stated that it is the policy of the facility to report allegations of neglect and abuse, within the required time frames. Staff #121 stated that the incident which occurred on (MONTH) 10, (YEAR), was not reported to the State Agency until (MONTH) 25, (YEAR), due to differing opinions as to whether the incident was reportable, because initially the resident had a mild sunburn but then the wounds worsened. Review of the facility's Abuse policy revealed all allegations of abuse and neglect will be reported to the appropriate State or Federal agencies in the applicable timeframes, as per this policy and applicable regulations .
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 interview, facility documentation and policy and procedures, the facility failed to ensure that an allegation of resident to resident abuse involving two residents (#31 and #32) was thoroughly investigated. Findings include: -Resident #31 was admitted to the facility on (MONTH) 14, (YEAR), with [DIAGNOSES REDACTED]. -Resident #32 was admitted to the facility on (MONTH) 14, (YEAR), with [DIAGNOSES REDACTED]. Review of the facility's investigative report revealed that on (MONTH) 25, (YEAR), resident #31 and resident #32 were witnessed yelling at each other. The report included that resident #32 had resident #31 by the arm near his left elbow and pinched him, and then resident #31 hit resident #32 on the bottom with a cane. Resident #31 sustained a skin tear to the left arm. Further review of the facility's investigative report revealed there were no interviews with resident #31 or resident #32 as to what occurred, nor were there interviews with other residents who may have been in the area at the time of the incident. The report also did not include a statement from a second witness (a CNA) or from any other staff members. An interview was conducted with the Administrator (staff #121) on (MONTH) 15, (YEAR) at 10:44 a.m. He stated that during an investigation they interview any witnesses and obtain their statements, they obtain statements from the residents involved if able, and talk with other residents and staff. Staff #121 said that the investigation was completed by the previous DON and was not complete. He said they did not follow their policy and procedure, as the investigation did not include a statement from one of the witnesses (CNA), nor any interviews with staff or other residents in the area. Review of the Abuse policy revealed that the investigation should include interviews with the residents involved, other residents, staff (on all shifts) and any witnesses to the incident, who may have information regarding the alleged incident.