STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035068	A. BUILDING ______ B. WING _____	**06/13/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PUEBLO SPRINGS REHABILITATION CENTER	**5545 EAST LEE STREET TUCSON, AZ 85712**

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 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, staff interview, review of facility documentation, and review of facility policies and procedures, the facility failed to implement their abuse policy regarding reporting and investigating an allegation of physical abuse for one resident (#3). The deficient practice could result in the potential for abuse to be ongoing, unreported and uninvestigated.
Findings include:
Resident #3 was readmitted to the facility on (MONTH) 10, 2019 with [DIAGNOSES REDACTED].
Review of the annual Minimum Data Set (MDS) assessment dated (MONTH) 17, 2019 revealed the resident's BIMS (Brief Interview for Mental Status) score was a 12 (moderately impaired cognition).
Review of a Social Services Note dated (MONTH) 7, 2019 at 4:01 p.m. documented This morning writer was in hallway by patient's room when she started to yell repetitive 'she hit me with her hand' when LNA (licensed nursing assistant) and LPN (licensed practical nurse) walked out of the room after finishing her care. Writer asked what happened? Patient stated 'aide hit me with her hand.' A few minutes later therapists arrived to get her up. Patient then stated 'the nurse hit me with a clip board.' Patient is a two person care given past allegations. It was noted staff did not have a clip board when in the room. Executive director, director of nursing, and assistant director of nursing notified of the above.
Review of facility documentation revealed no evidence that the allegation of abuse was reported to the State Survey Agency and adult protective services. Further review of facility documentation revealed no evidence that the facility conducted a thorough investigation regarding the allegation of abuse.
An interview was conducted with the administrator (staff #18) on (MONTH) 12, 2019 at 12:40 p.m. Staff #18 stated that it was facility policy to report all allegations of abuse to the State Survey Agency and adult protective services. Staff #18 stated that it was also facility policy to thoroughly investigate all allegations of abuse. Staff #18 further stated that the reason why he did not report and investigate the allegation of abuse was because two staff were in the resident's room at the time the allegation was made.
Review of the facility's policy Abuse: Prevention of and Prohibition Against dated (MONTH) 28, (YEAR) documented .All allegations of abuse .will be promptly and thoroughly investigated by the Administrator or his/her designee .Allegations of abuse .will be reported outside the Facility and to the appropriate State or Federal agencies in the applicable timeframes, as per this policy and applicable regulations .

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 interviews, review of facility documentation, and review of facility policies and procedures, the facility failed to ensure that an allegation of physical abuse for one resident (#3) was reported to the State Survey Agency and adult protective services. The deficient practice could result in the potential for abuse to be ongoing, unreported and uninvestigated.
Findings include:
Resident #3 was readmitted to the facility on (MONTH) 10, 2019 with [DIAGNOSES REDACTED].
Review of the annual Minimum Data Set (MDS) assessment dated (MONTH) 17, 2019 revealed the resident's BIMS (Brief Interview for Mental Status) score was a 12 (moderately impaired cognition).
A care plan dated (MONTH) 21, 2019 revealed the resident had an anxiety disorder. An intervention documented was Monitor/record occurrence of for target behavior symptoms pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others .
Review of a Social Services Note dated (MONTH) 7, 2019 at 4:01 p.m. documented This morning writer was in hallway by patient's room when she started to yell repetitive 'she hit me with her hand' when LNA (licensed nursing assistant) and LPN (licensed practical nurse) walked out of the room after finishing her care. Writer asked what happened? Patient stated 'aide hit me with her hand.' A few minutes later therapists arrived to get her up. Patient then stated 'the nurse hit me with a clip board.' Patient is a two person care given past allegations. It was noted staff did not have a clip board when in the room. Executive director, director of nursing, and assistant director of nursing notified of the above.
A Nursing Note dated (MONTH) 7, 2019 at 4:15 p.m. documented Approximately 11:00 a.m. this writer heard loud yelling from room. This writer knocked and entered room, noted patient lying on bed turned on left side, as CNA (certified nursing assistant) doing peri-care. Patient yelling out at CNA while doing peri-care. This nurse assisted with task. CNA explained to patient to keep right hand off buttock, due to patient scratching buttock. CNA explained she cleaned patient's hand due to BM (bowel movement) on hand and under fingernails. Patient at that time stated CNA hit her hand. Hand checked and no bruise and no swelling/bump noted. CNA explained to patient that she had to clean her hand and at that time, swung at CNA with right hand. Patient yelled at CNA swearing that she is a 'b----' and 'lies.' Stated 'I want to file a report.' Social services, director of nursing made aware. Patient continued to yell out loudly from room, reassured patient. Patient stated that CNA hit her with a 'clipboard.' This nurse explained to patient that CNA did not have a clipboard during pericare and stated 'you are taking her side.' Reassured patient that nurse supervisor is aware. Transferred out to [MEDICAL TREATMENT] as scheduled.
Another Nursing Note dated (MONTH) 7, 2019 at 4:44 p.m. documented Received call from [MEDICAL TREATMENT] staff and reported that patient stated she wants to file a complaint on '(staff #103) for hitting her hand with a clipboard.' [MEDICAL TREATMENT] given information that assistant director of nursing and social services are aware of report. Will follow up with patient's concern. Social services aware.
Review of a Nursing Note dated (MONTH) 7, 2019 at 9:15 p.m. documented Received a call earlier from [MEDICAL TREATMENT]
waiting to be picked up. Called assistant director of nursing for transport arrangements. 9:45 p.m. received a call from (name of hospital) case manager. Patient is in emergency room with same allegation as earlier. Placed a call to administrator and assistant director of nursing for updates.
Further review of the clinical record revealed no evidence that the allegation of physical abuse was reported to the State Survey Agency and adult protective services.
A written statement by the administrator (staff #18) dated (MONTH) 7, 2019 documented This writer spoke with CNA (staff #103) and LPN (staff #37) on (MONTH) 7, 2019 at approximately 10:00 a.m. This writer was across the hall when hearing patient screaming for help, and witnessed (staff #103) exiting the room to get assistance from (staff #37). (Staff #103)

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 **035068**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **06/13/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PUEBLO SPRINGS REHABILITATION CENTER	**5545 EAST LEE STREET TUCSON, AZ 85712**

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 1)
had indicated she was trying to assist in cleaning (resident #3), but kept putting her hand near her butt to scratch at wound, and feces would continue to be on her hand. She was throwing her arms everywhere.[NAME]needed assistance to help redirect (resident #3) and went and got (staff #37). Once (staff #37) entered the room they both assisted her in getting changed. (Resident #3) then stated 'you just hit me with a clipboard', when neither employee had a clipboard in the room. After speaking with (staff #37), (staff #37) indicated the same. She entered the room to help calm down and re-direct (resident #3). During that time in the room is when she stated one of them hit her with a clipboard. This writer then spoke to (resident #3) around 10:45 a.m. to further look into her complaint of someone hitting her with a clipboard. (Resident #3) was hard to follow in conversation. I asked her if she knew who hit her with the clipboard, and she couldn't name an employee. I asked when it occurred, and she stated it occurred when 'those two women were trying to clean me in my room.' I followed up and said 'so while the nurse and the CNA were in the room together is when one of them hit you with a clipboard, and she said yes'.
Review of a written statement by a CNA (staff #103) dated (MONTH) 10, 2019 documented I (staff #103) walk in to the room. (Resident #3) was yelling loud I need to be changed. She said I will help in a little bit. Got my stuff ready to change her but still yelling at me. Put her head (of the bed) down to start changing her so I took her brief off. She was full of BM .was very dirty with BM. So she puts her right hand to scratch herself. Ask her not put her hands in because of the BM but she didn't care. Trying to clean her and starts swinging at me. Trying to hit me with her hand all full of BM. I moved and she kept swinging at me. Open the door and call my charge nurse to come help me finish changing her and all this time she was still yelling and saying stop hitting me and told charge nurse that I was hitting her .
Review of a written statement by a occupational therapist (staff #34) dated (MONTH) 10, 2019 documented I entered (resident #3's) room for occupational therapy session. Upon entering patient screaming 'It hurts!' 'She hit me and my hand hurts.' I did not witness patient being hit, just heard her repeatedly yell about it and the pain she was in. Patient repeatedly stated it was the nurse who hit her because she was angry at patient for not being able to get out of bed. I attempted to look at patient's hand and noticed redness over knuckles. Patient insisted she would file a report. I informed patient I would notify nurse on duty. All of this time the director of social services was in the room, trying to calm down resident.A written statement by a therapy aide (staff #24) dated (MONTH) 10, 2019 documented On (MONTH) 7, 2019 I the rehabilitation technician for therapy walked in (resident #3's) room because she was screaming it hurts. I then asked her what was hurting. She said her hand, don't recall which one. (Resident #3) said the nurse hit her with a clipboard. I asked her which nurse, then she said she hit me which was the therapists. It was was clear that (resident #3) didn't know who hit her as she kept saying different people hit her .(Resident #3) also said CNA (staff #103) hit her.
An interview was conducted with an LPN (staff #8) on (MONTH) 12, 2019 at 12:00 p.m. Staff #8 stated that if she received an allegation of abuse no matter if she thought it was credible or not it was her responsibility to report the allegation to the State Survey Agency. Staff #8 stated that she would also report the allegation to the administrator immediately.
An interview was conducted with another LPN (staff #63) on (MONTH) 12, 2019 at 12 :12 p.m. Staff #63 stated that if she received an allegation of abuse she would immediately notify the administrator and director of nursing because they have two hours to report the allegation to the State Survey Agency.
An interview was conducted with the social worker (staff #47) on (MONTH) 12, 2019 at 12:16 p.m. Staff #47 stated that if the DON and the administrator were not available that she would report an allegation of abuse to the State Survey Agency. Staff #47 stated that she was outside the resident's room when the allegation was made but the door to the resident's room was closed because care was being provided. Staff #47 stated that she reported the allegation to the administrator immediately.An interview was conducted with the administrator (staff #18) on (MONTH) 12, 2019 at 12:40 p.m. Staff #18 stated that the reason why he did not report the allegation of abuse is because two staff were with the resident at the time the allegation was made. Staff #18 also stated that there was not a clipboard in the resident's room. Staff #18 further stated that he felt the allegation was unsubstantiated because of two staff being with the resident at the time the allegation was made.
A review of the facility's policy Abuse: Prevention of and Prohibition Against dated (MONTH) 28, (YEAR) documented .Allegations of abuse .will be reported outside the facility and to the appropriate State or Federal agencies in the applicable timeframes .

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 review, staff interview, review of facility documentation, and review of facility policies and procedures, the facility failed to ensure that an allegation of physical abuse for one resident (#3) was thoroughly investigated. The deficient practice could result in the potential for abuse to be ongoing and uninvestigated.
Findings include:
Resident #3 was readmitted to the facility on (MONTH) 10, 2019 with [DIAGNOSES REDACTED].
Review of the annual Minimum Data Set (MDS) assessment dated (MONTH) 17, 2019 revealed the resident's BIMS (Brief Interview for Mental Status) score was a 12 (moderately impaired cognition).
Review of a Social Services Note dated (MONTH) 7, 2019 at 4:01 p.m. documented This morning writer was in hallway by patient's room when she started to yell repetitive 'she hit me with her hand' when LNA (licensed nursing assistant) and LPN (licensed practical nurse) walked out of the room after finishing her care. Writer asked what happened? Patient stated 'aide hit me with her hand.' A few minutes later therapists arrived to get her up. Patient then stated 'the nurse hit me with a clip board.' Patient is a two person care given past allegations. It was noted staff did not have a clip board when in the room. Executive director, director of nursing, and assistant director of nursing notified of the above.
A written statement by the administrator (staff #18) dated (MONTH) 7, 2019 documented This writer spoke with CNA (staff #103) and LPN (staff #37) on (MONTH) 7, 2019 at approximately 10:00 a.m. This writer was across the hall when hearing patient screaming for help, and witnessed (staff #103) exiting the room to get assistance from (staff #37). (Staff #103) had indicated she was trying to assist in cleaning (resident #3), but kept putting her hand near her butt to scratch at wound, and feces would continue to be on her hand. She was throwing her arms everywhere.[NAME]needed assistance to help redirect (resident #3) and went and got (staff #37). Once (staff #37) entered the room they both assisted her in getting changed. (Resident #3) then stated 'you just hit me with a clipboard', when neither employee had a clipboard in the room. After speaking with (staff #37), (staff #37) indicated the same. She entered the room to help calm down and re-direct (resident #3). During that time in the room is when she stated one of them hit her with a clipboard. This writer then spoke to (resident #3) around 10:45 a.m. to further look into her complaint of someone hitting her with a clipboard. (Resident #3) was hard to follow in conversation. I asked her if she knew who hit her with the clipboard, and she couldn't name an employee. I asked when it occurred, and she stated it occurred when 'those two women were trying to clean me in my room.' I followed up and said 'so while the nurse and the CNA were in the room together is when one of them hit you with a clipboard, and she said yes'.
Review of facility documentation revealed that the facility obtained written statements from a CNA, an occupational therapist, and a therapy aide. Further review of facility documentation revealed no evidence that the facility initiated an investigation regarding the allegation of abuse.
An interview was conducted with the administrator (staff #18) on (MONTH) 12, 2019 at 12:40 p.m. Staff #18 stated that an investigation was not conducted because two staff were with the resident at the time the allegation was made. Staff #18 further stated that he felt the allegation was unsubstantiated because two staff were with the resident.
A review of the facility's policy Abuse: Prevention of and Prohibition Against dated (MONTH) 28, (YEAR) documented .Investigation .The investigation will include the following: .Interviews with other residents to whom the accused employee provides care or services or who may have information regarding the alleged incident. An interview with staff members having contact with the accused employee. A review of all circumstances surrounding the incident .The investigation, and the results of the investigation, will be documented .

F 0684

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide appropriate treatment and care according to orders, resident's preferences and goals.
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY >

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **035068**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **06/13/2019**
NAME OF PROVIDER OF SUPPLIER **PUEBLO SPRINGS REHABILITATION CENTER**		STREET ADDRESS, CITY, STATE, ZIP **5545 EAST LEE STREET TUCSON, AZ 85712**	

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 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) Based on clinical record review, staff interviews, and review of facility policies and procedures, the facility failed to contact hospice staff when one resident (#2) sustained a fall with injury resulting in a transfer to the hospital for evaluation. The deficient practice could result in other resident's hospice care not being coordinated with the facility. Findings include: Resident #2 was admitted to the facility on (MONTH) 17, (YEAR) with [DIAGNOSES REDACTED]. A physician order [REDACTED].hospice for a [DIAGNOSES REDACTED]. Review of a hospice care plan dated (MONTH) 23, (YEAR) revealed the following intervention: Work cooperatively with hospice team to ensure the resident's spiritual, emotional, intellectual, physical, and social needs are met. A Change of Condition Note dated (MONTH) 30, 2019 documented Staff responding to loud noise heard from room .Patient noted standing in front of sink/mirror in bathroom with blood on his face. Patient stated 'I fell and hit my head on the toilet.' Face cleaned. Patient has a gash 2 centimeters long, depth unknown, sutures needed. Bleeding stopped and pressure dressing applied. Ice also applied. Patient also has a .5 centimeter long abrasion to right cheek bone. Patient transported to (name of hospital) emergency room for evaluation. Review of the clinical record revealed no evidence that the facility had notified the resident's hospice agency of his fall or transfer to the hospital. An interview was conducted with a licensed practical nurse (LPN/staff #8) on (MONTH) 12, 2019 at 10:00 a.m. Staff #8 stated that if a resident fell and sustained an injury that she would notify the resident's physician and family. Staff #8 also stated that hospice and everyone involved with the resident's care needed to be notified. Staff #8 further stated that she would document who was notified in the nursing progress notes. An interview was conducted with another LPN (staff #63) on (MONTH) 12, 2019 at 10:15 a.m. Staff #63 stated that if she had to transfer a resident to the hospital she would notify the physician, the director of nursing and the resident's family. Staff #63 stated that she would also contact hospice because they would need to know where the resident was. Staff #63 further stated that she would document in the clinical record who was contacted. An interview was conducted with the assistant director of nursing (ADON/staff #94 on (MONTH) 12, 2019 at 10:45 a.m. Staff #94 stated that staff should document on the hospital transfer form or progress note who was notified of the resident's transfer to the hospital. An interview was conducted with an administrator of the facility's sister facility (staff #113) on (MONTH) 12, 2019 at 11:45 a.m. Staff #113 stated that the facility did not notify hospice when the resident was transferred to the hospital. Staff #113 further stated that the hospice agency stated that they were notified by the resident's family member the following day that the resident was transferred to the hospital. Review of the facility's policy Change of Condition Reporting dated (MONTH) 2019 did not reveal that hospice should be notified if the resident had a change in condition.