STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **035099**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **01/10/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SAPPHIRE OF TUCSON NURSING AND REHAB, LLC	**2900 EAST MILBER STREET TUCSON, AZ 85714**

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 0552 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that residents are fully informed and understand their health status, care and treatments.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed clinical record review, staff interviews and policies and procedures, the facility failed to ensure that one resident (#135) had been informed in advance of the risks and benefits of an antipsychotic medication. Findings include: Resident #135 was admitted on (MONTH) 7, (YEAR), with [DIAGNOSES REDACTED]. Review of the closed clinical record revealed a form titled Admission Record dated (MONTH) 7, (YEAR), which included the resident was self-responsible. A form titled, Consent to Admit and Treat dated (MONTH) 7, (YEAR) included a statement that the signer of the form was the responsible party for medical decision making. The form was signed by resident #135. A physician's orders [REDACTED]. A written care plan initiated on (MONTH) 10, (YEAR) for the use of [MEDICAL CONDITION] medications related to behavioral management included an intervention for staff to educate the resident/family/caregivers about the risks, benefits and side effects and toxic symptoms of the medication. Further review of the clinical record revealed no evidence that the resident was informed of the risks, benefits and side effects of Risperdone. An interview was conducted on (MONTH) 10, 2019 at 9:17 a.m., with the Director of Nursing (DON/staff #125). The DON stated that when an antipsychotic drug is prescribed, the use of the medication is explained to the resident, and they have a form which includes the risks and benefits of the medications. The DON stated that they are to obtain informed consent. The DON said that after the risks and benefits are explained, the resident signs the form. An interview was conducted on (MONTH) 10, 2019 at 9:35 a.m. with a RN (Registered Nurse/staff #165). During the interview, the nurse stated that there are consent forms for antipsychotic medications. Staff #165 said if the resident is unable to sign the consent form, consent is obtained from the resident's responsible party. Staff #165 stated they are required to obtain informed consent, prior to providing an antipsychotic medication to a resident. An interview was conducted on (MONTH) 10, 2019 at 10:04 a.m. with medical records staff (#183), who stated that there was no informed consent for the use of Risperdone for resident #135. A policy regarding resident rights included that Federal and State laws guarantee certain basic rights to all residents of the facility. These rights include the resident's right to choose a treatment and participate in decisions and care planning.
F 0578 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, staff interviews and policy review, the facility failed to ensure that two residents (#164 and #121) were afforded the right to formulate advance directives. Findings include: -Resident #164 was admitted to the facility on (MONTH) 18, (YEAR), with [DIAGNOSES REDACTED]. Review of an Admission Minimum Data Set (MDS) assessment dated [DATE], revealed the resident scored a 9 on the Brief Interview for Mental Status (BIMS), which indicated moderate cognitive impairment. Review of the resident's clinical record revealed no evidence of any advance directives for resident #164. There was also no documentation that the resident declined formulating advance directives. Further review of the clinical record revealed there was no code status listed on the resident's face sheet or in the available space specific for code status in the electronic record. According to the current physician's orders [REDACTED]. In an interview with a Licensed Practical Nurse (LPN/staff #153) on (MONTH) 10, 2019 at 9:30 a.m., she stated if she needed to find out a resident's code status, she would look in the electronic record, as there is a place where the code status is easily viewable. Further, she stated the resident's code status is listed on their report sheet. She stated the code status should be updated, as soon as the resident is admitted . An interview with medical record staff (staff #184) was conducted on (MONTH) 10, 2019 at 9:34 a.m. At this time, she reviewed resident #164's scanned documents and was unable to find any advance directives. She stated it could be in a stack of documents that are waiting to be scanned, however, no advanced directives were located. She also stated it could be in the physician's binder waiting to be signed by the physician, however, no advanced directives were found in the binder. In an interview with the Director of Nursing (DON/staff #125) on (MONTH) 10, 2019 at 1:31 p.m., she stated an audit had just been done in late December, ensuring that all residents had advanced directive forms filled out. -Resident #121 was admitted to the facility on (MONTH) 13, (YEAR), with [DIAGNOSES REDACTED]. Review of the admission MDS assessment dated (MONTH) 20, (YEAR), revealed the resident was cognitively intact. A physician's orders [REDACTED]. However, review of the clinical record revealed there were no advance directives which were signed by the resident. Also, the code status was not listed on the resident's face sheet or in the available space specific for code status in the resident's electronic record. An interview was conducted with a LPN (staff #150) on (MONTH) 8, 2019 at 1:25 PM. The LPN stated that upon admission all consent forms are signed including advance directives. She stated that a resident's code status could be found on the face sheet or in the document section of the electronic medical record. Staff #150 was unable to locate any advanced directives which were signed by the resident. An interview was conducted with Medical Records (staff #183) on (MONTH) 8, 2019 at 1:46 PM. She stated there was no record of advance directives on file for resident #121. She said the advance directives should be filled out upon admission or a few days later. An interview with the DON (staff #125) was conducted on (MONTH) 10, 2019 at 11:40 AM. She stated the floor nurse is

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 0578 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) responsible for obtaining signed consents, including advance directives when the resident is admitted to the facility. She said if there is a problem social services should be notified. The DON stated she could not answer for what happened in September, as she was not employed by the facility at that time. The facility policy for Interpretation and Implementation for Advance Directives indicated that upon admission, the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive, if he or she chooses to do so. The policy stated that the information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record. The Director of Nursing or designee will notify the attending physician of advance directives, so that appropriate orders can be documented in the resident's medical record and plan of care.
F 0584 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** Based on observations, and family, resident and staff interviews, the facility failed to maintain an environment that was free of odors. Findings include: During a family interview conducted on (MONTH) 7, 2019 at 11:07 a.m., the family member of a resident stated that the hallways on the second floor always smell like urine. An interview with a resident who resided on the second floor was conducted on (MONTH) 7, 2019 at 11:49 a.m. The resident stated that he keeps his door to the bathroom shut, because of the sewage odor. During an interview conducted on (MONTH) 7, 2019 at 1:28 p.m. with another resident who resided on the second floor, a strong pervasive urine odor was detected in this resident's room and in the bathroom. During the survey from (MONTH) 7 through 10, 2019, pervasive urine odors were frequently smelled in the hallways on the second floor. An environmental tour was conducted on (MONTH) 10, 2019 at 12:30 p.m., with the maintenance director (staff #180) and the administrator (as of (MONTH) 12/staff #222). At this time, there was still a slight sewage odor in the first resident's bathroom on the second floor. An interview was conducted with the maintenance director (staff #180) on (MONTH) 10, 2019 at 12:40 p.m. Staff #180 stated that he would call a plumber to address the odor in the bathroom. An interview was conducted with staff #222 on (MONTH) 10, 2019 at 12:45 p.m. Staff #222 stated that she thought she smelled urine yesterday, when the resident was being changed. The facility did not have policy regarding the prevention of odors throughout the facility.
F 0600 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**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 observation, clinical record reviews, staff and resident interviews, facility documents and policies and procedures, the facility failed to ensure that one resident (#225) with dementia and behaviors was free from neglect, failed to ensure that one resident (#61) was free from abuse by resident (#275), failed to ensure that one resident (#117) was free from abuse by resident (#61), and that one resident (#21) was free from abuse by resident (#62). Findings include: -Resident #225 was admitted on (MONTH) 22, (YEAR) and readmitted on (MONTH) 16, (YEAR), with [DIAGNOSES REDACTED]. Review of the clinical record revealed a written care plan initiated on (MONTH) 11, (YEAR), with a revision date of (MONTH) 16, (YEAR), which identified that the resident was an elopement risk/wanderer, related to escapist behavior and history of attempts to leave the facility unattended. A goal included the resident would not leave the facility unattended. Interventions included identifying a pattern of wandering and intervening as appropriate, monitoring the resident's location every 30 minutes and documenting wandering behavior. A quarterly MDS (Minimum Data Set) assessment dated (MONTH) 25, (YEAR) included a BIMS (Brief Interview for Mental Status) score of 9, which indicated the resident had moderate cognitive impairment. The MDS also included the resident was delusional, had physical and verbal behavioral symptoms directed at others, refused care, wandered daily and had dementia and [MEDICAL CONDITION]. A nurse practitioner assessment dated (MONTH) 2, (YEAR), revealed the resident had dementia, wandering, [MEDICAL CONDITION], anxiety, adjustment disorder and depression. The assessment included the resident was residing on the behavioral unit for safety and received psychiatric services. The assessment also included the resident desperately tries to escape if given the chance. She speaks Spanish mostly, but understands a lot of English. Under assessment and plan it included the following: wandering-provide a safe and nuturing environment. A nursing note dated (MONTH) 17, (YEAR) at 6:34 a.m. included the resident had been exit seeking from the unit through the main locked door to the unit and also by a (locked) back door to the unit. A nursing note dated (MONTH) 23, (YEAR) included the following: the resident had been exit seeking and had attempted to leave through the front door, and had struck a staff member when redirected back to the unit. A nursing note dated (MONTH) 5, (YEAR) at 10:05 a.m. revealed the resident was discovered missing at 8:15 a.m. The note included the resident was not discovered in her room and that a code yellow had been initiated. Continued review of the closed record for resident #225 revealed that the resident did not return to the facility after she eloped. Review of the facility's investigative report dated (MONTH) 5, (YEAR) revealed that on the morning of (MONTH) 5, (YEAR), the resident had not reported for breakfast and the missing person procedures were immediately implemented. The investigation included the resident was able to leave the facility, obtain transportation, cross the border into Mexico, and after entering Mexico obtained transportation to a family home in Mexico, arriving unharmed. The report also included that the resident had been residing on a behavioral health (secured) unit, and that exit seeking and wandering behaviors were being monitored. Continued review of the investigative report revealed a written staff statement obtained by a CNA (Certified Nursing Assistant/staff #222) dated (MONTH) 5, (YEAR) at 2:45 p.m. The statement included that the resident was last seen in the resident dining room on (MONTH) 4, (YEAR) between 8:30 p.m. and 9:00 p.m. The report further included that facility policies were not followed, as safety checks were missed. An interview was conducted with the Administrator (staff #20) on (MONTH) 7, 2019 at 10:15 a.m. The Administrator stated that it had been determined through the facility investigation that resident #225 had obtained an identification badge from a staff member (which the staff member thought had been misplaced) two weeks prior to her elopement from the facility, and had obtained money in small increments over time from her visitors, which enabled her to purchase bus fare. The Administrator also stated that the security camera footage, which had been examined during the investigation showed the resident had used a staff badge to open the exit door and then quickly exited the unit. An interview was conducted on (MONTH) 8, 2019 at 12:30 p.m. with a CNA (staff #97), who stated that she had been assigned to provide care to resident #225 on (MONTH) 5, (YEAR) on the night shift (11:00 p.m. until 7:00 a.m.). She stated that when she arrived at 11:00 p.m., the previous CNA reported to her that all of the residents in her section were in bed, including resident #225 and that she observed the door to the resident's room was closed. Staff #97 stated that there were other residents in her section who were very ill and she was unable to check on resident #225, because she was busy caring for the residents who were ill. Staff #97 said the facility protocol was to check the residents every 15-30 minutes but not less than hourly, and that she did not check the resident that night. She stated that she assumed her co-worker (CNA/staff #49) who was assigned to another section was checking on all of the residents and assumed that resident #225 was in her room, because the door to her room was closed. She stated that she never actually saw the resident on her shift. She

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F 0600 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2)

further stated that at approximately 2:00 a.m., she observed staff #49 enter the resident's room as he was passing water, and then exit the resident's room, and assumed that the resident was in her room. The CNA stated she was aware that the resident had a history of [REDACTED].#49 told her that although he entered the resident's room to pass ice water during the night shift, he did not see the resident in her room and did not know where she was.
During an interview conducted on (MONTH) 8, 2019 at 12:35 p.m. with a CNA (staff #49), the CNA stated that he did not remember resident #225 and did not remember anything about a resident eloping from the facility.
An interview was conducted on (MONTH) 8, 2019 at 1:15 p.m. with a LPN (Licensed Practical Nurse/staff #201). Staff #201 stated that she worked on the secured behavioral unit on the night shift on (MONTH) 5, (YEAR). Staff #210 said that she did not see the resident on her shift and the door to the resident's room was closed all night. The nurse stated that she was aware that the resident had made frequent statements that she was going to leave the facility and go to Mexico where she owned a home.
The facility was unable to provide a written policy regarding frequent resident safety checks on the behavioral unit.
A policy and procedure titled, Recognizing Signs and Symptoms of Abuse/Neglect included the definition of neglect, as the failure to provide goods and services as necessary to avoid physical harm, mental anguish, or mental illness. The policy also listed signs of actual physical neglect that included inadequate provision of care and leaving someone unattended who needs supervision.
Review of the Reporting Abuse policy revealed that all suspected violations or substantiated incidents of abuse/neglect will be immediately reported to the State licensing/certification agency.
-Resident #61 was admitted to the facility on (MONTH) 20, 2014, with [DIAGNOSES REDACTED].
Review of a Nursing Note dated (MONTH) 4, (YEAR) revealed .Resident has had a few outbursts when there is an excessive amount of noise. Resident had three episodes of yelling out (using profanity) and two episodes of attempting to go down to the room of the resident who was yelling out to shut him up. Staff was there to redirect resident immediately.
A Nursing Note dated (MONTH) 3, (YEAR) revealed Resident had several verbal outbursts during shift. Resident primarily has these outbursts when other residents are having an increase in behaviors by making loud noises and yelling .
A Nursing Note dated (MONTH) 21, (YEAR) revealed Resident has episodes of yelling out when he is startled with other loud noises like other residents yelling or doors slamming .
A quarterly MDS assessment dated (MONTH) 6, (YEAR), revealed the resident had short-term and long-term memory problems and was severely impaired with daily decision making. The MDS also included the resident required extensive assistance with one staff assistance with activities of daily living.
A Behavior care plan dated (MONTH) 20, (YEAR) revealed resident #61 has behavior problems (agitation, poor safety awareness, verbal aggression, repetitive statements, disruptive/intrusive, wandering, mood issues, pacing, exit seeking, refusal of care, disorganized thinking and physical aggression), related to [MEDICAL CONDITION], anxiety, mood disorder and status [REDACTED]. The goal included the resident will have fewer episodes of behaviors. Interventions were to administer medications as ordered; assist the resident to develop more appropriate methods of coping and interacting with other dementia residents; encourage the resident to express feelings appropriately and if reasonable, discuss the resident's behavior; explain/reinforce why behavior is inappropriate and/or unacceptable; intervene as necessary to protect the rights and safety of others; approach/speak in a calm manner; divert attention; remove from situation and take to alternate location as needed; monitor behavior episodes and attempt to determine underlying cause; and when resident is sitting next to other peers, ensure appropriate space to prevent physical aggression towards peers.
Review of a Nursing Note dated (MONTH) 30, (YEAR) revealed .Resident began having a verbal altercation with another resident and he went up to the other resident and struck her in the face on the right cheek. The other resident retaliated and struck this resident on both arms. Both residents were immediately separated. No visible injuries noted to this resident .
Review of the annual MDS assessment dated (MONTH) 1, (YEAR) revealed resident #61 had a BIMS (Brief Interview for Mental Status) score of 9, which indicated moderate impaired cognition.
A Nursing Note dated (MONTH) 16, (YEAR) revealed a CNA reported to this writer that resident #61 and resident #275 were swinging their arms with closed fists. Both residents were separated. Resident #61 stated that resident #275 hit him in the face. Reddened area noted to resident face.
-Resident #275 was admitted to the facility on (MONTH) 27, (YEAR), with [DIAGNOSES REDACTED].
Review of a Nursing Note dated (MONTH) 17, (YEAR) revealed called into room by staff at 5:55 p.m., observed resident #275 laying in bed, and another resident was sitting on floor mat with blood on his face. The other resident was unable to explain what happened due to cognitive deficit. Resident #275 stated the resident woke him up and was messing with his bed and he hit peer in the face .
A Nursing Note dated (MONTH) 11, (YEAR) revealed that resident #275 started hitting a resident from another room with a wire waste basket in the hallway. Resident #275 was upset that another resident was wearing his hoodie. Resident #275 has shown that he is very territorial and aggressive with male residents that might wander into his room, let's not forget that this is a unit where many of the residents suffer from dementia .
A Behavior care plan dated (MONTH) 20, (YEAR) revealed that resident #275 has a history of initiating physical aggression. The goal was resident will not initiate aggression towards other residents. Resident should have a quiet area to stay in after dinner. He is sensitive to noise and busyness. Interventions to prevent the behaviors were to anticipate and prevent new incidents of violence towards another resident; provide snack, provide activities that promote non-aggressive interactions with other residents like one to one social activity; and provide activity so resident is not focused on busyness after meal times, as it is becoming evident he is not able to tolerate noise.
Review of the quarterly MDS assessment dated (MONTH) 6, (YEAR), revealed a BIMS score of 1, which indicated the resident had severe cognitive impairment.
A Nursing Note dated (MONTH) 16, (YEAR) revealed this writer was notified by a CNA that resident #275 and resident #61 were swinging their arms with closed fists. Residents were quickly separated by CN[NAME] Reddened area noted on resident #61's face.
Further review of resident#275's clinical record revealed he had two more altercations with other residents on (MONTH) 14 and 19, (YEAR) in which he was the aggressor. Resident #275 was discharged from the facility on (MONTH) 19, (YEAR).
An interview was conducted with a CNA who stated that the facility usually staffed three CNA's on this unit for 20-24 high acuity behavioral residents. The CNA stated that one CNA is supposed to monitor the hallway at all times to ensure that resident to resident altercations do not occur, but that doesn't always happen when staff call in.
An interview was conducted with another CNA who stated that we are supposed to have someone monitor the hallway at all times, but that does not always happen. The CNA stated we do the best we can but if there is a call in we often do not have someone to monitor the hallway and that's when the residents get in to it. The CNA stated that resident #275 got into a lot of incidents with other residents and would laugh afterwards. The CNA stated that resident #61 does not like loud noises and doors slamming and that was usually when he got into altercations with other residents, because it upset him. The CNA stated that when resident #61 got upset he clapped his hands and said shhh and that irritated a lot of residents. The CNA further stated that a lot of the resident to resident altercations usually occurred when the facility did not have someone to monitor the hallway.
An interview was conducted with a LPN who stated that resident #61 runs up and down the hall and resident #275 is paranoid. The LPN stated that staffing was recently cut on this high acuity behavioral unit and that they do the best they can.
An interview was conducted with the administrator (staff #20) on (MONTH) 10, 2019 at 9:25 a.m. Staff #20 stated that there should be a monitor on the hallway at all times on that unit.
-Resident #117 was admitted to the facility on (MONTH) 27, (YEAR), with [DIAGNOSES REDACTED].
A care plan revised on (MONTH) 28, (YEAR), included the resident required a secured unit due to [DIAGNOSES REDACTED]. Interventions included redirecting the resident when having behaviors.
A quarterly MDS assessment dated (MONTH) 17, (YEAR) revealed the resident had short-term and long-term memory problems and was moderately impaired with daily decision making. The assessment also included the resident required supervision with set up help only for most activities of daily living and utilized a walker.
Review of the clinical record revealed multiple nursing notes for (MONTH) (YEAR) describing the resident as being verbally aggressive toward staff and laughing loudly at other residents.
A nursing note dated (MONTH) 30, (YEAR) revealed that at approximately 9:53 a.m., resident #117 began having a verbal

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They began yelling back and forth and before staff could intervene, resident #61 hit resident #117 and then resident #117 hit resident #61. The residents were separated and resident #117 was moved to another room. No injuries were noted. When resident #117 was asked about the incident, she stated He hit me! Per the report, a housekeeping staff (#135) witnessed the incident. She reported that resident #117 was cursing at her and resident #61 told resident #117 to be quiet. Resident #117 kept cursing, and then resident #61 got up, went to resident #117 and they both made contact with each other. A statement from a licensed practical nurse (LPN/staff #166) included that she did not witness the incident but was at the nurses' station and heard resident #117 yelling that resident #61 hit her. She immediately went to the hallway and found resident #61 standing in front of resident #117 with his fists up. The residents were separated immediately. In an interview with staff #135 on (MONTH) 9, 2019 at 9:32 a.m., she stated she had worked at the facility for over three years and is usually on the secured behavioral unit. She said that resident #117 is constantly being verbally aggressive and intimidates a lot of people. In an interview with a LPN (staff #148) on (MONTH) 9, 2019 at 9:41 a.m., she stated that resident #61 usually hangs out in the hallway and is not one to instigate things. Staff #148 said he has a behavior of yelling out, which sometimes sets other residents off inadvertently, and he is easily triggered by noises. She stated when resident #117 used to be on her hall, her loud laughing and yelling would irritate resident #61. She stated staff tried to redirect resident #117 by asking her to stop or taking her to an activity or to a different area. In an interview with a LPN (staff #156) on (MONTH) 9, 2019 at 9:49 a.m., he stated resident #117's behaviors include laughing out loud at random and yelling at others. He stated the other residents sometimes get agitated and they think resident #117 may be doing it on purpose. He stated sometimes she yells racial slurs and the other residents tell her to shut up. Additionally, he stated resident #117 is easily redirectable, but that does not work all the time. The LPN stated she is followed by the behavioral health team but for the most part, her behavior does not change. An observation was conducted on (MONTH) 9, (YEAR) at 10:35 a.m., during a resident smoke break. Resident #117 was observed to be laughing loudly and sticking her tongue out, which appeared to be directed at no one in particular. The staff present redirected the resident who then sat back down and continued to smoke her cigarette without further incident. In an interview with the administrator (staff #20) on (MONTH) 10, 2019 at 1:17 p.m., he stated when he receives an allegation of a resident to resident altercation, he will get more information about what happened, report to appropriate parties and begin an investigation. -Resident #21 was admitted to the facility on (MONTH) 18, (YEAR), with [DIAGNOSES REDACTED]. A quarterly Minimum Data Set (MDS) assessment dated [DATE] included the resident had a BIMS score of 15, indicating no cognitive impairment. The MDS assessment also included the resident had verbal behavioral symptoms directed toward others. Review of the care plan regarding antipsychotic medication related to [MEDICAL CONDITION] included the following interventions: when the resident becomes agitated intervene before agitation escalates; guide the resident away from the source of distress; engage calmly in conversation; and if the response is aggressive remove other residents from the area and approach later. A nursing note dated 11/29/2018 revealed that at approximately 10:50 a.m., resident #21 was witnessed sitting towards the end of the hall in front of another resident's (#62) room. Resident #21 began to yell and curse in Spanish. Resident #62 approached the doorway and told resident #21 to move. Both residents were yelling and swinging their arms at each other. The residents were immediately separated and redirected into opposite directions. No injuries noted at this time. -Resident #62 was admitted on (MONTH) 06, (YEAR), with [DIAGNOSES REDACTED]. A quarterly MDS assessment dated [DATE] included a BIMS score of 15, which indicated the resident had no cognitive impairment. The MDS assessment also included the resident had verbal behavioral symptoms directed toward others. Review of the current behavior care plan revealed the resident had the potential to be physically aggressive and threatening toward other residents and staff. Interventions included for staff to escort the resident from room to destination and from destination to room, and keep him a safe distance from other residents. A nurse's note dated 11/29/2018 included that at approximately 10:50 a.m., resident #62 was witnessed standing in front of resident #21. Resident #21 was sitting in front of his doorway in a wheelchair and resident #62 told him to move. Resident #21 started to yell and curse at him in Spanish. Resident #62 then raised his left hand and with a closed fist, hit resident #21. Both residents were swinging their arms at each other. They were immediately separated and redirected into opposite directions. No injuries were noted. Review of the facility's investigative report revealed that on (MONTH) 29, (YEAR) at 10:50 a.m., resident #21 was sitting in his wheelchair in front of the door to resident #62's room. Resident #62 asked resident #21 to move, and angry words were exchanged. The residents struck out at each other and no injuries were noted. The report also included a witness statement from the housekeeper (staff #135) that she heard the residents arguing in front of resident #62's door who was telling resident #21 to move. The statement included that resident #21 hit resident #62 in the face and that both residents were hitting each other. The report revealed that resident #21 was unable to recall the incident and resident #62 reported that He kept cussing at me and I told him to stop. I told him if he didn't stop I would hit him, and he didn't stop, so I hit him. During an interview conducted with resident #62 on 1/8/19 at 2:29 p.m., the resident stated that resident #21 was sitting in front of his door and that he asked him to leave. Resident #62 stated that the resident called his mother names in Spanish and that he hit him. During an interview conducted with resident #21 on 1/8/2019 at 2:43 p.m., the resident stated that resident #62 yelled at him and he yelled back. Resident #21 stated that resident #62 hit him and that he hit him back and that they punched each other until they were separated. An interview was conducted with a LPN (staff #148) on 1/09/19 at 10:01 a.m. The LPN stated that she heard yelling and saw the housekeeper separating resident #21 and resident #62. She stated that she helped separate the residents and then assessed them for injuries. The LPN stated that both residents do occasionally yell and blow off steam, but that resident #62 is often more verbal and physically threatening. Review of the facility's policy regarding Abuse Prevention Program revealed Our residents have the right to be free from abuse, neglect . Our facility is committed to protecting our residents from abuse by anyone including, but not necessarily limited to staff and other residents . The facility's policy regarding Unmanageable Residents revealed that each resident will be provided with a safe place of residence. The policy included that should a resident's behavior become abusive in any way that would jeopardize his or her safety or the safety of others, the Nurse Supervisor/Charge Nurse must immediately provide for the safety of all concerned. The policy also included unmanageable residents may not be retained by the facility. Review of a facility policy titled, Resident-to-Resident Altercations included that staff will monitor residents for aggressive/inappropriate behavior towards other residents. The policy included that all altercations, including those that may represent resident-to-resident abuse, shall be investigated and reported to the Administrator/Director of Nursing.
F 0607 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**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, facility documents and policy review, the facility failed to include in their Abuse policy that all alleged violations of abuse and neglect, must be reported to the State Survey Agency within two hours after the allegation is made, as manifested by an allegation of neglect for one resident (#225). Findings include: Resident #225 was admitted on (MONTH) 22, (YEAR), with [DIAGNOSES REDACTED]. A nursing note dated (MONTH) 5, (YEAR) at 10:05 a.m. revealed the resident was discovered missing at 8:15 a.m. The note

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NAME OF PROVIDER OF SUPPLIER **SAPPHIRE OF TUCSON NURSING AND REHAB, LLC**		STREET ADDRESS, CITY, STATE, ZIP **2900 EAST MILBER STREET TUCSON, AZ 85714**	

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F 0607 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 4) included the resident was not discovered in her room and that a code yellow had been initiated. Review of the facility's investigative report dated (MONTH) 5, (YEAR) revealed that on the morning of (MONTH) 5, (YEAR), it was determined that the resident had not reported for breakfast, so missing person procedures were immediately implemented. The report included the resident was able to leave the facility obtain transportation, cross the border into Mexico, and after entering Mexico obtained transportation to a family home, arriving unharmed. Continued review of the investigative report revealed that although the resident was discovered missing on (MONTH) 5, (YEAR) at 8:30 a.m., the facility did not notify the State Survey Agency until 3:30 p.m. on (MONTH) 5. An interview was conducted with the Administrator (staff #20) on (MONTH) 8, 2019 at 2:46 p.m. The Administrator stated that the facility had two hours to report all allegations of abuse, including neglect to the State Agency. The Administrator also stated that he was unable to explain why the elopement of resident #225 was reported late to the State Agency. Review of the facility's policy and procedure titled, Reporting Abuse to State Agencies and other Entities/Individuals revealed that all suspected violations and all substantiated incidents of abuse will be immediately reported to appropriate state agencies and other entities as may be required by law. The policy included that should a suspected violation or substantiated incident of mistreatment, neglect or abuse be reported, the facility Administrator or his/her designee, will promptly notify the State licensing/certification agency. The verbal/written notice to agencies will be made within twenty-four hours of the occurrence (not two hours as required).
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 documents and policies and procedures, the facility failed to ensure that an allegation of neglect for one resident (#225) was reported to the State Survey Agency within two hours after the allegation. Findings include: Resident #225 was admitted on (MONTH) 22, (YEAR), with [DIAGNOSES REDACTED]. A nursing note dated (MONTH) 5, (YEAR) at 10:05 a.m. revealed the resident was discovered missing at 8:15 a.m. The note included the resident was not discovered in her room and that a code yellow had been initiated. Review of the facility's investigative report dated (MONTH) 5, (YEAR) revealed that on the morning of (MONTH) 5, (YEAR), it was determined that the resident had not reported for breakfast, so missing person procedures were immediately implemented. The report included the resident was able to leave the facility obtain transportation, cross the border into Mexico, and after entering Mexico obtained transportation to a family home, arriving unharmed. The report also included that the resident had been residing on a behavioral health (secured) unit, and that exit seeking and wandering behaviors were being monitored. Continued review of the facility investigative report revealed that although the resident was discovered missing on (MONTH) 5, (YEAR) at 8:30 a.m., the facility did not notify the State Survey Agency until 3:30 p.m. on (MONTH) 5. An interview was conducted with the Administrator (staff #20) on (MONTH) 8, 2019 at 2:46 p.m. The Administrator stated that the facility had two hours to report all allegations of abuse, including neglect to the State Agency. The Administrator also stated that he was unable to explain why the elopement of resident #225 was reported late to the State Agency. A facility's policy and procedure titled Recognizing Signs and Symptoms of Abuse/Neglect included a definition of neglect as the failure to provide goods and services as necessary to avoid physical harm, mental anguish, or mental illness. The policy also listed signs of actual physical neglect that included inadequate provision of care and leaving someone unattended who needs supervision. Review of the facility's policy and procedure titled, Reporting Abuse to State Agencies and other Entities/Individuals revealed that all suspected violations and all substantiated incidents of abuse will be immediately reported to appropriate state agencies and other entities as may be required by law. The policy included that should a suspected violation or substantiated incident of mistreatment, neglect or abuse be reported, the facility Administrator or his/her designee, will promptly notify the State licensing/certification agency. The verbal/written notice to agencies will be made within twenty-four hours of the occurrence (not two hours as required).
F 0623 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, staff interviews and review of policies and procedures, the facility failed to notify the State Long Term Care Ombudsman when one resident (#50) was transferred/discharged to the hospital on two separate occasions, and when one resident (#175) was discharged to home. Findings include: -Resident #50 was readmitted to the facility on (MONTH) 26, (YEAR), with [DIAGNOSES REDACTED]. A progress note dated (MONTH) 26, (YEAR) revealed the resident was sent to the emergency room , due to difficulty breathing. A progress note dated (MONTH) 29, (YEAR) revealed the resident was readmitted to the facility. Review of a quarterly MDS (Minimum Data Set) assessment dated (MONTH) 31, (YEAR), revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. A progress note dated (MONTH) 23, (YEAR) revealed that the resident was admitted to Banner South Hospital Intensive Care Unit. Another progress note dated (MONTH) 26, (YEAR) revealed that the resident was readmitted to the facility. However, there was no documentation that the State Long Term Care Ombudsman was sent a copy of the notice of discharges for each hospitalization . An interview was conducted with a licensed practical nurse (LPN/staff #150) on (MONTH) 8, 2019 at 1:08 p.m., who stated that when she gets a patient ready to be transferred, she does not notify the Ombudsman and said the case manager (#190) completes the paperwork when a patient is being discharged . An interview was conducted on (MONTH) 8, 2019 at 1:19 p.m. with case manager (staff #190), who stated that she completes the paperwork when a resident is being discharged and staff #193 notifies the Ombudsman about the discharge. Staff #193 was interviewed on (MONTH) 8, 2019 at 2:42 p.m. He stated that the facility had a meeting last fall to talk about a better way to make sure the Ombudsman is notified. He said that he called the Ombudsman and asked if he could notify her by email, when a resident is discharged . He said that she told him that she doesn't want to be notified, because they don't need the information and they are being inundated with notifications. He said that Social Services was handling the notifications at that time. An interview was conducted on (MONTH) 8, 2019 at 3:06 p.m. with the Director of Social Services (staff #204), who stated that there was a meeting with the Ombudsman on (MONTH) 6, (YEAR), because she wanted to verify the process for notifying the Ombudsman when a resident is discharged . She said the Ombudsman didn't want to be notified when a resident is discharged . She acknowledged that the facility has not been notifying the Ombudsman when a resident is discharged and stated that she will be notifying the Ombudsman in writing on a monthly basis from this point forward. -Resident #175 was admitted to the facility on (MONTH) 1, (YEAR), with a [DIAGNOSES REDACTED]. Review of the discharge care plan initiated on (MONTH) 4, (YEAR) revealed resident #175 was to discharge to her previous residence an assisted living facility, after skilled nursing services were completed. A physician's orders [REDACTED]. A review of the Minimum Data Set (MDS) assessment discharge/return not anticipated dated (MONTH) 13, (YEAR), revealed the resident was discharged to the community. Review of the clinical record revealed there was no documentation that the State long term care ombudsman had been sent a copy of the notice of discharge. An interview was conducted with the Director of Social Services (staff #204) on (MONTH) 9, 2019 at 9:21 AM. She stated the

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F 0623 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 5) facility has not been notifying the ombudsman when a resident is discharged . She stated that she is aware that the facility is responsible for notifications, but the ombudsman did not want to be notified of discharges. An interview with the Director of Nursing (DON/staff #125) was conducted on (MONTH) 10, 2019 at 11:04 AM. The DON stated that she had been told the ombudsman did not want to be notified of discharges, but that the facility must notify her anyway. She stated the facility will be sending a list of discharges to the ombudsman at the end of every month. Review of a facility policy regarding Transfer or Discharge Notice revealed the resident an/or representative will be notified of an impending transfer or discharge from the facility as soon as it is practicable but before the transfer or discharge, when the transfer is necessary for the resident's welfare and the resident's needs cannot be met in the facility or when an immediate transfer or discharge is required by the resident's urgent medical needs. The policy also stated that a copy of the discharge notice will be sent to the Office of the State Long-Term Care Ombudsman.
F 0641 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and the Resident Assessment Instrument (RAI) manual, the facility failed to ensure a Minimum Data Set (MDS) assessment was accurate regarding antibiotic use and refusal of care for one resident (#62). Findings include: Resident #62 was admitted on (MONTH) 06, (YEAR), with [DIAGNOSES REDACTED]. Review of the physician's orders [REDACTED]. -Bactrim 400-80 milligrams (mg) by mouth once a day by mouth for [MEDICATION NAME] for chronic UTI dated (MONTH) 16, (YEAR) -[MEDICATION NAME] HFA aerosol solution 17 micrograms (mcg) one puff orally every 6 hours for [MEDICAL CONDITIONS] dated (MONTH) 24, (YEAR) -[MEDICATION NAME] 25 mg by mouth once a day for hypertension dated (MONTH) 25, (YEAR) -[MEDICATION NAME] 75 mcg by mouth once a day for [MEDICAL CONDITION] dated (MONTH) 25, (YEAR). A review of the MAR for (MONTH) (YEAR) revealed that the resident was administered Bactrim from (MONTH) 16-31. The MAR indicated [REDACTED]. However, review of the quarterly MDS assessment dated (MONTH) 1, (YEAR), revealed the resident did not receive an antibiotic and displayed no refusal of care during the 7 day look-back period. The MDS assessment also included a Brief Interview for Mental Status score of 15 which indicated the resident had no cognitive impairment and that the resident displayed verbal behaviors directed towards others. An interview was conducted with a MDS Coordinator (staff #182) on 01/09/19 at 11:31 AM. Staff #182 stated that information obtained from the nurses' notes and the medication records are used to code a MDS assessment. She also stated that information is obtained from speaking with the residents and the staff. She acknowledged that the quarterly MDS assessment dated (MONTH) 1, (YEAR) was an error in documentation regarding refusal of care. During an interview conducted with the Director of Nursing (DON/staff #125) on 01/09/19 at 11:44 AM., the DON stated that her expectation is that the MDS assessments are accurate, and that incorrect information on the MDS assessment is not acceptable. An interview was conducted with a MDS Coordinator (staff #181) on 01/10/19 at 01:18 PM. She stated that her hand written notes for (MONTH) included the resident was on antibiotics through the end of (MONTH) (YEAR). She agreed that the MDS assessment was marked incorrectly and stated that it was an oversight. The RAI manual for the MDS assessment states that the importance of accurately completing and submitting the MDS assessment cannot be over emphasized. The manual also included that the MDS assessment is the basis for the development of an individualized care plan. The RAI manual instructs to review the clinical record for documentation regarding any antibiotics that were received by the resident during the 7 day look-back period and record the number of days it was received. The RAI manual also instructs to review the clinical record and interview staff for any refusal of care (e.g. taking medications) during the 7 day look-back period and code the behavior if it occurred.
F 0645 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**PASARR screening for Mental disorders or Intellectual Disabilities** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and review of facility policies and procedures, the facility failed to ensure one resident (#61) was referred to the appropriate state-designated authority for Level II PASARR (pre-admission screening and resident review) evaluation and determination. Findings include: Resident #61 was admitted to the facility on (MONTH) 20, 2014 with [DIAGNOSES REDACTED]. Review of the resident's clinical record revealed a Level I PASARR dated (MONTH) 4, (YEAR) which revealed the resident had a primary [DIAGNOSES REDACTED]. Further review of the clinical record revealed no evidence that the facility referred the resident to the appropriate state-designated authority for a Level II PASARR. An interview was conducted with a social worker (staff #203) on (MONTH) 9, 2019 at 9:00 a.m. Staff #203 stated that if a resident had a primary [DIAGNOSES REDACTED]. Staff #203 stated that she was unsure if a referral for a Level II PASARR was completed for this resident. An interview was conducted with another social worker (staff #204) on (MONTH) 9, 2019 at 10:26 a.m. Staff #204 stated that the facility did an audit about a month ago and the resident qualified for a referral for a Level II PASARR. Staff #204 stated that the referral was not completed yet. Review of the facility's policy Admission Criteria revealed .Nursing and medical needs of individuals with mental disorders or intellectual disabilities will be determined by coordination with the Medicaid Pre-Admission Screening and Resident Review program (PASARR) to the extent possible .
F 0657 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview, and policy and procedure, the facility failed to ensure a care plan was revised for one resident (#74). Findings include: Resident #74 was admitted to the facility on (MONTH) 7, (YEAR) with [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. The quarterly Minimum Data Set (MDS) assessment dated (MONTH) 8, (YEAR) revealed the resident was cognitively intact and required extensive/total assist with activities of daily living (ADLS). Review of the care plan for mobility dated (MONTH) 24, (YEAR) revealed the resident had limited physical mobility related to current co-morbidities including [MEDICAL CONDITION] (MS). Interventions included applying splints to both arms at night and removing in the morning. Further review of the care plan revealed it was not revised to reflect the splints had been discontinued. An interview was conducted with the Assistant Director of Nursing (ADON/staff #21) on (MONTH) 9, 2019 at 3:46 PM. Staff #21 stated the resident's splints had been discontinued. She stated that she did not know why the care plan had not been updated. The ADON stated all departments are responsible for updating the care plan, including nursing. She said the nursing management meets every morning to discuss residents' care plans, change of condition, etc. An interview was conducted with the Director of Nursing (DON/staff #125) on (MONTH) 10, 2019 at 9:29 AM. The DON stated anything in the care plan related to nursing is updated daily. She said they have an interdisciplinary team (IDT) meeting every morning. She stated they are good at adding to the care plan but need to get better at discontinuing things. The DON said the splints should have been resolved in the care plan. Review of the facility's policy titled Care Plans - Comprehensive revealed assessments of residents are ongoing and care

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F 0657 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 6) plans are revised as information about the resident and the resident's condition change.
F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**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 observations, staff interviews, and review of policies and procedures, the facility failed to ensure that a public restroom accessible to residents was free from accident hazards. Findings include: During an observation conducted on (MONTH) 7, 2019 at 10:30 a.m., two unlocked restrooms were observed near the front entrance of the facility. When the door to restroom [ROOM NUMBER] was opened and released, the door rapidly slammed shut causing a potential accident hazard to residents who may use the restroom. Multiple residents passed by this area to go to the front lobby and to go outside of the facility. An interview was conducted with a receptionist (staff #191) on (MONTH) 8, 2019 at 9:25 a.m. Staff #191 stated that they asked the residents not to use the public restrooms but that some of them go in there anyway. Staff #191 stated that the residents probably use the public restrooms at night when no one is at the receptionist desk. Staff #191 further stated the public bathroom doors used to be locked. Additional observations conducted on (MONTH) 8, 9, and 10, 2019 revealed the area near the public restrooms and front lobby continued to be a high traffic area with residents going to the front lobby or out of the facility. An interview was conducted with another receptionist (staff #194) on (MONTH) 10, 2019 at 11:00 a.m. Staff #194 stated that the residents were asked to not use the public restrooms. Staff #194 further stated the doors used to be locked. An interview was conducted with the managing partner of the facility (staff #220) on (MONTH) 10, 2019 at 12:35 p.m. Staff #220 stated that the facility will be repairing the door today so that it does not slam shut. Review of the facility's policy Safety and Supervision of Residents revealed Our facility strives to make the environment as free from accident hazards as possible. The policy included resident safety and supervision and assistance to prevent accidents are facility-wide priorities.
F 0695 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews and policy and procedures, the facility failed to ensure one resident (#50) was provided respiratory care consistent with the physician's order. Findings include: Resident #50 was readmitted to the facility on (MONTH) 26, (YEAR), with [DIAGNOSES REDACTED]. Review of the current summary of physician's orders revealed an order for [REDACTED]. Review of the quarterly MDS (Minimum Data Set) assessment dated (MONTH) 31, (YEAR) revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. The assessment also included the resident was receiving oxygen therapy. The current care plan revealed the resident had altered respiratory status related to [MEDICAL CONDITION] with [MEDICAL CONDITION]. The interventions included administering medication/puffers as ordered and monitoring for effectiveness and side effects and monitoring/documenting/reporting abnormal breathing patterns to the physician. During an interview conducted with the resident on (MONTH) 7, 2019 at 3:23 p.m., the oxygen concentrator was observed to be set at 2.5 liters, however, the resident did not have on the nasal cannula, as it was lying on the resident's tray. Observation of the tubing revealed no date when the tubing had been changed. On (MONTH) 9, 2019 at 12:28 p.m., the resident was observed sleeping in his wheelchair with the oxygen tubing on and the concentrator was set at 2.5 liters. The tubing was not observed to have a date to reflect when the tubing had been last changed. An interview was conducted with a certified nursing assistant (CNA/staff #58) on (MONTH) 10, 2019 at 9:14 a.m., who stated that the CNA's on the overnight shift change the tubing on the oxygen concentrators every Sunday, and tape the date on the tubing to show when the tubing was changed. She stated that if there is no date on the tubing or if the date indicates that it is overdue, she changes the tubing. After observing the oxygen tubing, she confirmed that there was no date on the resident's tubing or anywhere on the oxygen machine. She also confirmed that the level of oxygen was set at 2.5 liters per minute. An interview was conducted on (MONTH) 10, 2019 at 9:22 a.m. with a licensed practical nurse (LPN/staff #159), who stated that the CNA's on the night shift change and date the oxygen tubing every Sunday and document the tubing was changed in the computer in the task section. She stated that if she did not see a date on the tubing, she would change the tubing. She also stated that it is the nurse's responsibility to monitor the amount of oxygen received per a minute. After reviewing the orders, she stated the order is for oxygen at 2 liters. Review of the resident's electronic record including in the task section, revealed there was no documentation that the tubing was changed in (MONTH) and (MONTH) (YEAR). During an interview conducted with the Director of Nursing (DON/staff #125) on (MONTH) 10, 2019 at 11:05 a.m., she stated the expectation is that the oxygen tubing is to be changed by the CNA's on the night shift every Sunday. The facility's policy regarding Oxygen Administration included the following: -The purpose of this procedure is to provide guidelines for safe oxygen administration. -Verify that there is a physician's order for this procedure. -Review the physician's order or facility protocol for oxygen administration. The policy did not address a process for monitoring when oxygen equipment is to be changed.
F 0698 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Past noncompliance - remedy proposed** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policy review, the facility failed to ensure physician orders [REDACTED].#151) regarding [MEDICAL TREATMENT]. Findings include: Resident #151 was admitted to the facility on (MONTH) 16, (YEAR) with [DIAGNOSES REDACTED]. An admission Minimum Data Set (MDS) assessment dated (MONTH) 23, (YEAR) included the resident had short-term and long-term memory problems and had severe impairment with daily decision making. The MDS assessment also included the resident was receiving [MEDICAL TREATMENT]. A nursing note dated (MONTH) 23, (YEAR) revealed the resident had a right sided vascular catheter. Review of the clinical record revealed the resident went out to [MEDICAL TREATMENT] appointments on several occasions in (MONTH) and (MONTH) (YEAR) and (MONTH) 2019. A care plan dated (MONTH) 21, (YEAR) included the resident needs [MEDICAL TREATMENT] related to end stage [MEDICAL CONDITION]. Interventions included checking and changing the dressing daily at access site and document. However, review of the clinical record revealed no evidence that there was a physician's orders [REDACTED]. In an interview with a licensed practical nurse (LPN/staff #165) on (MONTH) 10, 2019 at 10:31 a.m., he stated that for a resident receiving [MEDICAL TREATMENT], there should be an order for [REDACTED]. The nurse reviewed resident #151's electronic record and was unable to locate an order for [REDACTED].>During an interview conducted with the LPN (staff #153) caring for this resident on (MONTH) 10, 2019 at 10:38 a.m., she stated the resident was currently at the [MEDICAL TREATMENT] center. She stated she knows when the resident is scheduled for [MEDICAL TREATMENT] based on an appointment log that is reviewed every day and her report sheet that has the [MEDICAL TREATMENT] days and time. The LPN also stated that when the resident returns from [MEDICAL TREATMENT] an assessment is done which includes checking the site. She stated the site should be assessed and documented every shift, and that there should be an order to monitor the site. In an interview with the Director of Nursing (DON/staff #125) on (MONTH) 10, 2019 at 10:43 a.m., she stated there should be a physician's orders [REDACTED]. She also stated there should be an order to monitor the resident's [MEDICAL TREATMENT]

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F 0698 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 7) site, whether it is a fistula or a port. Review of the facility's policy titled [MEDICAL TREATMENT] Access Care did not include physician's orders [REDACTED]. Per the DON, there was no other policy specific to [MEDICAL TREATMENT].
F 0725 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** Based on resident and staff interviews, facility documentation and policies and procedures, the facility failed to have sufficient nursing staff to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. Findings include: Multiple resident interviews were conducted on (MONTH) 7, (YEAR) regarding facility staffing. Ten random residents stated that there was not enough staff and that they have to wait too long for staff assistance and for their call lights to be answered. An interview was conducted with a CNA (certified nursing assistant). The CNA stated that the A-1 unit for high acuity behavioral residents was usually staffed with 3 CNA's to care for 20-24 residents. The CNA stated that one CNA is supposed to be in the hall at all times to monitor to prevent resident to resident altercations, but that does not always happen because of call ins. An interview was conducted with another CNA, who stated that someone is always supposed to be monitoring the hallway on the A-1 unit, but that does not always happen and it's kind of irritating. The CNA stated we do the best we can, but if there is a call in there is no one to monitor the hallway and the residents get in to altercations. An interview was conducted with another CNA who stated that it is challenging to care for the residents when there are call ins. An interview was conducted with a fourth CNA, who stated that sometimes it is hard to care for the residents when there are call ins. An interview was conducted with another CNA, who stated that care and showers do not get done when there is not enough staff. The CNA further explained that care gets done but not like it should and showers get missed. An interview was conducted with another CNA, who stated that the facility attempts to staff adequately, but some days they are short. An interview was conducted with a seventh CNA, who stated that they used to have four CNA's for this hallway and now they have three. The CNA stated that it was hard to monitor the hallway, because most of the residents on this hallway require two staff to provide care. An interview was conducted with another CNA, who stated that she thought the afternoon shift could use more staff especially on the weekends. The CNA stated that they used to have a hall monitor, but do not anymore. An interview was conducted with a CNA, who stated that sometimes they only have two CNA's on 2nd shift for this hallway and it's hard because most of the residents on this hallway require two staff to provide care. The CNA stated that the facility is trying to staff adequately because they are now using agency staff. An interview was conducted with a LPN (licensed practical nurse). The LPN stated they could use more staff. The LPN stated that when they are short, I do not focus on my medications or paperwork and help the CNAs. An interview was conducted with another LPN, who stated that they used to have enough staff, but when the new management company took over they cut staff. The LPN stated we do the best we can. The LPN further stated that there are more CNAs scheduled today, because the surveyors are here for the annual survey. Review of the Resident Council Minutes from (MONTH) (YEAR) through (MONTH) (YEAR) revealed the following concerns from residents: -February 26: Not enough staff all shifts. -May 8: The residents are concerned with ratio of staff and residents. The lights are not being answered promptly. -July 9: Many say there's not enough staff (pending concern already). -August 30: Residents are concerned with lights not being answered promptly. Concerns with 7:00 a.m. - 3:00 p.m. B2 (long term care unit). -September 13: Residents feel like they lack staff. -October 12: Call lights are not answered quick and residents and family are waiting more than 15 minutes on B2. -November 8: Overworked and understaffed was stated by one resident. B2 (all shifts). CNA's do a very good job but most are exhausted. -December 6: B2 resident stated there have been 2 CNA's to 30 patients and needs are not being met. Residents stated staffing issues for the dining room have happened three times this week. Residents need help with feeding and passing food.According to the resident council meeting documentation, a meeting was held on (MONTH) 9, 2019 at 2:10 p.m., with six residents. Per the documentation, four of the six residents stated that there was not enough staff and that they had to wait extended periods of time for staff assistance. On the last page of the Resident Council Minutes for the above months was a section titled, Interventions to be implemented however, each month this section was blank. An interview was conducted with the activity director (staff #2) on (MONTH) 9, 2019 at 2:45 p.m. Staff #2 stated that she has been the activity director since (MONTH) (YEAR), and that she took the minutes for the resident council meeting. Staff #2 stated that she gave the staffing concerns to nursing and they are supposed to respond to the residents' concerns so that we could let the resident council know. Staff #2 stated that she had not received responses from nursing yet regarding staffing. An interview was conducted with the administrator (staff #20) on (MONTH) 10, 2019 at 9:25 a.m. Staff #20 stated that there should be a monitor in the hallways of the A1 and B1 units. Staff #20 stated that the facility is aware of the residents concerns regarding staffing. An interview was conducted with the managing partner of the facility (staff #220) on (MONTH) 10, (YEAR) at 10:40 a.m. Staff #220 stated that different units have different staffing needs. Staff #220 stated the facility has never had a resident to resident altercation that resulted in a serious injury, because of staffing. Staff #220 stated that ratio wise, there was enough staff and the concern could be the accountability of the staff. Staff #220 stated that he was not aware of the residents and staff concerns regarding staffing. Review of the facility's policy regarding Staffing revealed, Our facility provides sufficient numbers of staff with the skill and competency necessary to provide care and services for all residents in accordance with resident care plans and the facility assessment .Inquiries or concerns relative to our facility's staffing should be directed to the Administrator or his/her designee.
F 0758 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed clinical record review, staff interviews, and policies and procedures, the facility failed to ensure that one resident (#135) who was prescribed an antipsychotic medication upon admission, had indications for its use. Findings include: Resident #135 was admitted on (MONTH) 7, (YEAR) with [DIAGNOSES REDACTED]. The resident was discharged (MONTH) 26, (YEAR).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **035099**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **01/10/2019**

NAME OF PROVIDER OF SUPPLIER **SAPPHIRE OF TUCSON NURSING AND REHAB, LLC**	STREET ADDRESS, CITY, STATE, ZIP **2900 EAST MILBER STREET TUCSON, AZ 85714**

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 0758 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 8) Review of hospital records prior to the resident's admission, revealed a H&P (History and Physical) report dated (MONTH) 5, (YEAR) that the resident had a significant history of Alzheimer's dementia and [MEDICAL CONDITION] and was cooperative with normal mood and cognition. The hospital H&P included a list of medications that the resident was receiving in the hospital. The list did not include the [MEDICATION NAME] (antipsychotic) or any other antipsychotic medication. Continued review of the hospital records revealed a discharge summary dated (MONTH) 7, (YEAR) that included an order for [REDACTED]. Review of the closed clinical record revealed a physician's orders [REDACTED]. The Medication Administration Record [REDACTED]. A discharge MDS (Minimum Data Set) assessment dated (MONTH) 26, (YEAR) included a BIMS (Brief Interview for Mental Status) score of 11 which indicated the resident had moderately impaired cognition. The assessment included the resident felt tired, depressed, had difficulty sleeping, and verbal behaviors directed at others. The assessment also included the resident received antipsychotic medications. However, the assessment did not include the resident had a psychiatric mood disorder. Further review of the closed record did not reveal any additional documented evidence that the [DIAGNOSES REDACTED]. An interview was conducted on (MONTH) 10, 2019 at 9:17 a.m. with the Director of Nursing (DON/staff #125). The Director stated that a [DIAGNOSES REDACTED]. The DON stated that when a resident is admitted from the hospital, the medications that are prescribed must verify with the physician by the nurse. The DON stated that an antipsychotic drug cannot be prescribed for dementia unless there is a [DIAGNOSES REDACTED]. The DON further stated that the use of the antipsychotic drug for resident #135 should have been clarified with the physician. During an interview conducted on (MONTH) 10, 2019 at 9:35 a.m. with a RN (Registered Nurse/staff #165), the nurse stated that if a [DIAGNOSES REDACTED]. The facility's policy and procedure titled Antipsychotic Medication Use included a policy statement that antipsychotic medications may be considered for residents with dementia but only after medical, physical, functional, psychological, emotional psychiatric, social and environmental causes of behavioral symptoms have been identified and addressed. The policy included residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective.
F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews and policies and procedures, the facility failed to ensure that electronic and paper health records for one resident (#225) were readily accessible to the State Survey Team. Findings include: Resident #225 was admitted on (MONTH) 22, (YEAR) with [DIAGNOSES REDACTED]. Resident #225 was discharged on (MONTH) 5, (YEAR). During random reviews of the facility electronic records conducted on (MONTH) 7, 2019 it was revealed the electronic health records for resident #225 were not accessible in the data base provided by the facility. An interview was conducted with the administrator (staff #20) on (MONTH) 7, 2019 at 10:15 a.m. The administrator stated that the facility did not have access to electronic records for resident #225, and that access to those records had been removed by the previous owner of the facility when the facility was purchased by the current owner in (MONTH) (YEAR). The Administrator stated that he would notify the previous owner that access to the records was needed, and that the facility staff were aware that they were supposed to have access to all electronic health records for resident #225. An interview was conducted with a corporate staff member (staff #220) on (MONTH) 7, 2019 at 1:45 p.m. Staff #220 stated that he was aware of the requirement that access to medical records was to be maintained for 7 years. Staff #220 also stated that staff were in communication with the previous owners of the facility to obtain access to the health records for resident #225. An interview was conducted on (MONTH) 8, 2019 at 8:30 a.m. with medical records (staff #184). Staff #184 stated that the paper records and electronic health records for resident #225 were not accessible, because the records had been removed by the previous owner of the facility. Staff #184 stated that the previous owner was scanning records to the facility. She stated that the process of uploading the documents would take hours and that the documents would be printed after the upload. Staff #184 stated that she did not know whether or not the records for resident #225 were being pre-screened by the previous owner prior to being uploaded. During an interview conducted with the administrator on (MONTH) 8, 2019 at 9:24 a.m., the administrator stated that they were unable to obtain access to electronic health records from the previous owner of the facility. In a follow-up interview with staff #184 conducted on (MONTH) 8, 2019 at 2:08 p.m., the staff #184 provided a stack of printed paper records for resident #225 and stated that there would be no access to electronic health records for resident #225. Review of the facility's policy and procedure titled Electronic Medical Records included a statement that authorized Federal and State survey agents as outlined in current regulations may be granted access to electronic medical records.
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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on concerns identified during the survey, staff interview and policy review, the quality assessment and assurance (QAA) committee failed to identify quality concerns and implement appropriate plans of action to correct the quality deficiencies. Findings include: During the facility's annual recertification survey, multiple concerns were identified in the following areas: -Pervasive odors throughout the facility. -Resident to resident abuse involving 5 residents. -One resident eloped from the facility. -Implement facility policy regarding reporting an allegation of neglect. -Report an allegation of neglect within two hours. -A physician's orders [REDACTED]. -Failed to maintain adequate staffing. -Failed to provide access to electronic records timely. An interview was conducted with the administrator (staff #20) on (MONTH) 10, 2019 at 2:26 p.m. Staff #20 stated that when staff identify a quality concern they bring their concerns to the QAA committee. Staff #20 stated that if a performance improvement plan is developed the QAA committee monitors the progress. The administrator further acknowledged there were no action plans regarding the quality concerns identified during the survey and that the QAA process had not identified the above issues. Review of the facility's policy regarding Quality Assurance and Performance Improvement (QAPI) Committee revealed .The primary goals of the QAPI Committee are to .Help identify actual and potential negative outcomes relative to resident care and resolve them appropriately .
F 0919 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Make sure that a working call system is available in each resident's bathroom and bathing area.** **Make sure that a working call system is available in each resident's bathroom and bathing area.**

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SAPPHIRE OF TUCSON NURSING AND REHAB, LLC	**2900 EAST MILBER STREET TUCSON, AZ 85714**

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F 0919 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 9) Based on observations and staff interviews, the facility failed to ensure that two public restrooms, which were unlocked, were equipped to allow residents to call for staff assistance. Findings include: During an observation conducted on (MONTH) 7, 2019 at 10:30 a.m., two unlocked restrooms were observed near the front entrance of the facility. Neither restroom was equipped with a communication system to alert staff should a resident require assistance while in the restroom. Once inside of each restroom a deadbolt lock was observed on the doors. The deadbolt lock was unable to be unlocked from the outside of the door in the event of an emergency. Signs were posted on both of the restroom doors which stated Lobby restrooms are for visitors and staff only. Residents, please utilize resident restrooms. Thank you for your cooperation. Kind regards, Sapphire Management. Multiple residents passed by this area to go to the front lobby or to go outside of the facility. An interview was conducted with a receptionist (staff #191) on (MONTH) 8, 2019 at 9:25 a.m. Staff #191 stated that they ask the residents not to use the public restrooms but that some of the residents go in there anyway. Staff #191 stated that the residents probably use the public restrooms at night when no one is at the receptionist desk. Staff #191 further stated that the public bathroom doors used to be locked. Observations conducted on (MONTH) 8, 9, and 10, 2019 revealed the area near the public restrooms and front lobby continued to be a high traffic area with residents going to the front lobby or out of the facility. An interview was conducted with another receptionist (staff #194) on (MONTH) 10, 2019 at 11:00 a.m. Staff #194 stated that the residents were asked to not use the public restrooms. Staff #194 stated that the facility put the signs on the doors of the public restrooms due to the fact that residents could go in there and fall and they would not know that they were in there because there is no call light. Staff #194 further stated the doors used to be locked. An interview was conducted with the managing partner of the facility (staff #220) on (MONTH) 10, 2019 at 12:35 p.m. Staff #220 stated that the unlocked bathroom doors were his fault. Staff #220 stated that when he first came to the facility he thought it was a dignity issue to be in the restroom and have people knocking on the door when you were in there. Staff #220 stated that he felt installing the occupied/unoccupied deadbolts on the door would resolve the dignity issue. The facility did not have a policy regarding resident call systems.