STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035099	A. BUILDING _____ B. WING _____	**09/13/2019**

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 0603 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Protect each resident from separation (from other residents, his/her room, or confinement to his/her room).** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on observations, clinical record review, resident interview, staff interviews, and review of facility policies and procedures, the facility failed to ensure that one of three sampled residents (#1) was not involuntarily secluded in a secured high acuity behavioral unit. Findings include: Resident #1 was admitted to the facility on (MONTH) 16, 2019 with [DIAGNOSES REDACTED]. A Baseline Careplan dated (MONTH) 16, 2019 revealed the resident planned on being discharged to his own home after the completion of occupational and physical therapy. Further review of the Baseline Careplan revealed the resident was not being administered any [MEDICAL CONDITION] medications. Review of an Evaluation Criteria for Behavioral Health Specialty Unit dated (MONTH) 16, 2019 revealed the resident did not have a behavioral health related [DIAGNOSES REDACTED]. Further review of the Evaluation Criteria for Behavioral Health Specialty Unit documented Resident is NOT a good candidate for residence in the Behavioral Health Program. Patient alert and oriented x 3. Pleasant . A Psychological-Social Evaluation dated (MONTH) 16, 2019 documented .(Resident's name) was able to communicate clearly and showed an alert and oriented x 4 .plans on going back home once he is discharged . A Medication Review Report dated (MONTH) 16, 2019 documented .Resident is capable of participating in own plan of care. Resident is capable of understanding and exercising rights, does have dementia, is redirectable . Review of the resident's admission MDS (Minimum Data Set) assessment dated (MONTH) 23, 2019 revealed the resident's BIMS (Brief Interview for Mental Status) score was a 13 or intact cognition. Review of a Notification of Change dated (MONTH) 24, 2019 revealed the resident was transferred to the facility's secure high acuity behavioral unit. The Reason for Move was Patient is moved to lock down unit. Review of the clinical record revealed no documentation in the nursing notes as to why the resident was moved to the facility's secured high acuity behavioral unit. A review of a Physician Extender Note dated (MONTH) 24, 2019 documented Awake and anxious, he is moving to another room. Per nursing he has been wandering and confused, walking into other rooms. Review of a careplan dated (MONTH) 30, 2019 documented The plan for the resident is to complete skilled nursing services and evaluate/plan for a safe discharge if appropriate .Secure unit indicated related to poor safety awareness, wandering, aggression, memory impairments. An intervention documented was Staff to assist and coordinate with the resident as needed for a safe discharge. Another care plan dated (MONTH) 30, 2019 documented (Resident's name) has a behavior problem including but not limited to wandering, pacing, following staff, needing frequent reassurance related to dementia. An intervention documented was Staff to discuss risks and benefits of negative behaviors and natural consequence as needed. An Elopement Risk assessment dated (MONTH) 31, 2019 revealed the resident did not have a history of escape or elopement, did not say that he wanted to leave or go home, and did not wander aimlessly. Further review of the Elopement Risk Assessment revealed the resident's elopement risk score was a 2 or low risk for elopement. A review of a Psychiatry Note dated (MONTH) 20, 2019 documented .During today's visit, patient appears to be mentally stable and capable of making his own decisions . Review of a Social Service Note dated (MONTH) 28, 2019 documented .The resident stated that he did not want to be at Sapphire .The resident stated that he wanted to continue to explore alternate options with the idea of going home still being his end goal . A review of a Health Professional's Report dated (MONTH) 29, 2019 revealed that it was the physician's recommendation that the resident should live in a supervisory care facility. A Nursing Note dated (MONTH) 30, 2019 documented .Later asked to use the phone again and apparently called 911 stating was being held against his will . Review of a Nursing Note dated (MONTH) 1, 2019 documented .Requested room change as 'I cannot stand my roommate. He's in and out 10 times a day. I cannot sleep.' Stated 'I'm leaving tomorrow anyway' when explained that there were no rooms to change . A Social Service Note dated (MONTH) 4, 2019 documented .Doctor .was given documents by daughter to complete to evaluate his cognitive function. Doctor .stated he would be back in the facility on 9/5/19 with completed documentation and stated that patient was 'just on the border' of cognitive decline, but that very clearly he was able to express in detail his wishes .This writer reported that since admission the resident has had improved cognitive ability to which Doctor .reported that it was 'probably due to not drinking.' The patient will continue to be monitored and assisted with safe discharge plan. An interview was conducted with the administrator (staff #2) on (MONTH) 12, 2019 at 8:15 a.m. Staff #2 stated that when the resident was admitted to the facility he was very confused but that he was now more alert. Staff #2 stated that the resident was residing in the facility's secured high acuity behavioral unit. An interview was conducted with the behavioral health operations manager (staff #1) on (MONTH) 12, 2019 at 9:30 a.m. Staff #2 stated that the resident's daughter wanted doctors to deem the resident incompetent but he is not. Staff #2 stated that the resident was transferred to the secured high acuity behavioral unit because he was screaming, yelling, and trying to kick his roommate's family out of the facility. Staff #2 further stated there were no rooms available in the facility's secured dementia unit. An interview was conducted with the resident on (MONTH) 12, 2019 at 10:00 a.m. The resident stated that he used to be in a room on the facility's second floor. The resident stated that he did not know why he was moved downstairs to the secured high acuity behavioral unit. The resident stated that his physical and occupational therapy had been discontinued and he just wanted to go back to his own home. An interview was conducted with a certified nursing assistant (CNA/staff #181) on (MONTH) 12, 2019 at 1:10 p.m. Staff #181 stated that the only behaviors the resident had was that he liked to hoard food in his room. Staff #181 further stated that the resident didn't have the behaviors like some of the other residents had on the secured high acuity behavioral unit. An interview was conducted with a CNA (staff #269) on (MONTH) 12, 2019 at 1:20 p.m. Staff #269 stated that she had not seen the resident exhibit any behaviors. An interview was conducted with another CNA (staff #88) on (MONTH) 12, 2019 at 1:25 p.m. Staff #88 stated this unit is a high acuity behavioral unit for residents who exhibit physical and verbal behaviors toward staff and other residents. Staff

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 0603 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) #88 stated that the resident didn't exhibit any behaviors other than he liked to hoard food, An interview was conducted with a registered nurse (RN/staff #270) on (MONTH) 12, 2019 at 1:32 p.m. Staff #270 stated that the resident's behaviors are not as acute as some of the other residents on the unit. Staff #270 stated that the resident had more dementia type behaviors. An interview was conducted with a licensed practical nurse (LPN/staff #92) on (MONTH) 12, 2019 at 2:00 p.m. Staff #92 stated that the resident should have probably been moved to the facility's dementia unit rather than the secured high acuity behavioral unit, if the only behavior he had was wandering into other resident's rooms. Another interview was conducted with the behavioral health operations manager (staff #1) on (MONTH) 12, 2019 at 2:45 p.m. Staff #1 stated that the resident was moved to the facility's secured high acuity behavioral unit because there was not a bed available in the dementia unit. Staff #1 stated that the criteria for the secured high acuity behavioral unit was all related to safety as a secured unit is a restraint and has to be evaluated on a case by case basis and risk for elopement. Another interview was conducted with the resident on (MONTH) 12, 2019 at 3:30 p.m. The resident stated that when he moved from upstairs to the secured high acuity behavioral unit he was not told that the unit was locked. The resident further stated I don't need to be here, I'm not getting therapy any more. Review of the facility's policy Admission Criteria for Behavioral Health Secure Unit dated (MONTH) (YEAR) documented To establish uniform guidelines for personnel to follow when admitting consumers to the unit .Consumers admitted to the unit typically have a [DIAGNOSES REDACTED]. Consumers admitted to the unit typically have a history of multiple inpatient psychiatric hospitalization s and not appropriate for the transitional living level of services .
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 clinical record review, staff interviews, and review of facility policies and procedures, the facility failed to ensure that one resident's (#1) clinical record was accurately documented in accordance with accepted professional standards of practices. Findings include: Resident #1 was admitted to the facility on (MONTH) 16, 2019 with [DIAGNOSES REDACTED]. Review of the resident's admission MDS (Minimum Data Set) assessment dated (MONTH) 23, 2019 revealed the resident's BIMS (Brief Interview for Mental Status) score was a 13 or intact cognition. Review of a Notification of Change dated (MONTH) 24, 2019 revealed the resident was transferred to the facility's secure high acuity behavioral unit. The Reason for Move was Patient is moved to lock down unit. On (MONTH) 12, 2019, copies of the resident's clinical record were requested by licensing surveyor. When the copies were provided an unrequested copy dated (MONTH) 24, 2019 was provided to licensing surveyor. The form documented I (resident's name) consent that I agree to be housed in a locked unit at Sapphire of Tucson where no unauthorized visitors are allowed. The form was signed by the resident and dated (MONTH) 24, 2019. This form was not observed in the clinical record when copies of the clinical record were requested. An interview was conducted with the resident on (MONTH) 12, 2019 at 3:30 p.m. The resident stated that he was asked to sign the above form today and did not remember signing such a form when he transferred to the secured high acuity behavioral unit on (MONTH) 24, 2019. An interview was conducted with the medical records director (staff #15) on (MONTH) 12, 2019 at 3:45 p.m. Staff #15 stated that the above form had not been scanned into the computer yet and was on top of her file cabinet in a stack of papers to be scanned. An interview was conducted with the administrator (staff #2) on (MONTH) 13, 2019 at 8:30 a.m. Staff #2 stated the an LPN unit manager (staff #152) had the resident sign the form on (MONTH) 12, 2019 consenting to reside in a a locked unit and that she dated it (MONTH) 24, 2019. Staff #2 further stated that staff #152 did not have an answer as to why she did that but that she falsified a resident's clinical record by doing that. Staff #152 was unable to be interviewed. A review if the facility's policy Welcome to New Hire Orientation, undated, documented .Conduct which interferes with the safe operation of the facility, brings discredit to the facility, its residents or staff, and any act that is offensive to a resident, family member, visitor, or employee is unacceptable .falsifying or making a willful misstatement of facts on a resident's record .