STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035294	A. BUILDING _____ B. WING _____	01/23/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE SPRINGS AT THE HACIENDA BLDG 6	2720 EAST RIVER ROAD TUCSON, AZ 85718

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0607 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on clinical record review, staff interviews, review of facility documentation, and policies and procedures, the facility failed to implement their abuse policy, by failing to ensure that an allegation of abuse for one (#8) of four sampled residents was immediately reported to the administrator and the State Survey Agency, and by failing to prevent the potential for further abuse after the allegation was made. The deficient practice could result in further allegations of resident abuse not being reported and corrective action implemented. Findings include: Resident #8 was admitted to the facility on (MONTH) 18, 2019, with [DIAGNOSES REDACTED]. A review of the admission MDS (Minimum Data Set) assessment dated (MONTH) 24, 2019 revealed the resident had severe impairment with cognitive skills for daily decision making. The MDS also included the resident required extensive assistance with activities of daily living. Review of an Incident Note dated (MONTH) 20, 2020 at 6:29 p.m. revealed that at 6:10 p.m., writer was called into the resident's room and was told by the personal caregiver (staff #86) that the resident threw his glass of tea and his top right hand hit the tray, which caused a very small skin tear, which was treated. No other concerns were noted. A second Incident Note dated (MONTH) 20, 2020 revealed this writer investigated further and it was determined that the resident grabbed the caregivers (staff #86) wrist and hand aggressively (leaving a pronounced finger and a thumb mark on her wrist and hand). At 6:45 p.m. when checking on the resident, the resident said that the caregiver was attracted to me and is touching me as if he was distressed. Writer noted no actions of this sort towards the resident by the caregiver. The caregiver was notably hurt and misty eyed by the resident's unfound accusations. MD and Power of Attorney were made aware. According to the facility's investigative report revealed that on (MONTH) 20, 2020 at 6:10 p.m., the resident alleged that his caregiver touched him inappropriately on his stomach and back and that it made him feel uncomfortable. The report included that the resident was yelling rape and that the resident was upset because the caregiver wouldn't pick something off of the floor that wasn't there and because she wasn't feeding the dogs that were under his bed. The report also included that the resident told a social worker that the caregiver cut his scab with a knife. The caregiver denied the allegations. Per the report, the administrator was not notified of the allegations of abuse until (MONTH) 21, 2020. Further review of the investigative documentation revealed that the allegation of abuse was not reported to the State Survey Agency until (MONTH) 21, 2020 at 6:15 pm. In addition, there was no evidence that the residents were protected from the potential for further abuse, after the allegation was made, as the caregiver was not removed from providing direct care at the time that the allegation was made. An interview was conducted with the administrator (staff #49) on (MONTH) 21, 2020 at 3:56 p.m. Staff #49 stated that the resident alleged that his personal caregiver touched him inappropriately on (MONTH) 20, 2020. Staff #49 stated that she had just became aware of the allegation and had planned on following the facility's abuse policy. Another interview was conducted with the administrator (staff #49) on (MONTH) 23, 2020 at 8:30 a.m. Staff #49 stated that the resident's personal caregiver (staff #86) reported to the LPN (licensed practical nurse/staff #47) that the resident threw his tea across his room and grabbed her hand, leaving a mark. Staff #49 stated that when staff #47 went in to the resident's room, the resident stated that staff #86 was attracted to him and inappropriately touched him. Staff #49 stated that she spoke with the resident's caseworker and staff #86 was removed from the resident's care on (MONTH) 21, 2020. Staff #49 stated that staff #47 completed an incident report and gave it to the DON (Director of Nursing (staff #10), but it was not reviewed until the following day on (MONTH) 21, 2020. Staff #49 stated that the allegation should have been reported to her immediately. An interview was conducted with the DON (staff #10) on (MONTH) 23, 2020 at 10:00 a.m. Staff #10 stated that she received a text message from staff #47 on (MONTH) 20, 2020 at 8:12 p.m. Staff #10 stated that she misunderstood the text message and did not interpret it to be an allegation of abuse. Staff #10 stated that when she reviewed the incident report on (MONTH) 21, 2020, the resident alleged that he was touched inappropriately. Staff #10 further stated that she should have immediately initiated the facility's abuse policy on (MONTH) 20, 2020, when she received the text message from staff #47. Review of the text message sent from staff #47 to staff #10 on (MONTH) 20, 2020 at 8:12 p.m. revealed the following: (resident's room number) got a small skin tear to his right upper hand after grabbing and leaving hand marks on the personal caregiver's hand. He then reported that she was attracted to him and touching him. A incident report was made on paper and in a note. Doctor is aware and the power of attorney is aware . Another interview was conducted with the administrator (staff #49) on (MONTH) 23, 2020 at 10:10 a.m. Staff #49 stated that the caregiver was not removed from the facility after the allegation was made and continued to work the remainder of her shift, with the resident who made the allegation against her. Staff #49 stated that it was facility policy that if there was an allegation of abuse that the alleged perpetrator should be immediately suspended pending the facility's investigation. Review of the facility's policy regarding Abuse, Neglect, Injuries of Unknown Source and Misappropriation of Property dated (MONTH) 25, (YEAR) revealed .Upon receiving an allegation of abuse, the facility shall immediately implement measures to prevent further potential abuse while the matter is being investigated. If allegation involves an employee or employee(s), the facility will separate the employee from all residents .Ensure that all alleged violations involving abuse .are reported immediately but no later than 2 hours after the allegation is made within the skilled nursing facility to the administrator of the facility and to other officials (including the State Survey Agency) .
F 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on clinical record review, staff interviews, facility documentation and policy review, the facility failed to immediately report an allegation of abuse for one (#8) of four sampled residents to the administrator and the State Survey Agency. The deficient practice could result in further allegations of resident abuse not being reported. Findings include: Resident #8 was admitted to the facility on (MONTH) 18, 2019 with [DIAGNOSES REDACTED]. Review of an Incident Note dated (MONTH) 20, 2020 at 6:29 p.m. revealed that at 6:10 p.m., writer was called into the resident's room and was told by the personal caregiver (staff #86) that the resident threw his glass of tea and his top right hand hit the tray, which caused a very small skin tear, which was treated. No other concerns were noted.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on clinical record review, staff interviews, facility documentation and policy review, the facility failed to prevent the potential for further abuse after an allegation of abuse was made for one (#8) of four sampled residents. The deficient practice could result in the potential for further abuse to occur. Findings include: Resident #8 was admitted to the facility on (MONTH) 18, 2019 with [DIAGNOSES REDACTED]. Review of an Incident Note dated (MONTH) 20, 2020 at 6:29 p.m. revealed that at 6:10 p.m., writer was called into the resident's room and was told by the personal caregiver (staff #86) that the resident threw his glass of tea and his top right hand hit the tray, which caused a very small skin tear, which was treated. No other concerns were noted. A second Incident Note dated (MONTH) 20, 2020 revealed this writer investigated further and it was determined that the resident grabbed the caregivers (staff #86) wrist and hand aggressively (leaving a pronounced finger and a thumb mark on her wrist and hand). At 6:45 p.m. when checking on the resident, the resident said that the caregiver was attracted to me and is touching me as if he was distressed. Writer noted no actions of this sort towards the resident by the caregiver. The caregiver was notably hurt and misty eyed by the resident's unfound accusations. MD and Power of Attorney were made aware. According to the facility's investigative report revealed that on (MONTH) 20, 2020 at 6:10 p.m., the resident alleged that his caregiver touched him inappropriately on his stomach and back and that it made him feel uncomfortable. The report included that the resident was yelling rape and that the resident was upset because the caregiver wouldn't pick something off of the floor that wasn't there, and because she wasn't feeding the dogs that were under his bed. The report also included that the resident told a social worker that the caregiver cut his scab with a knife. The caregiver denied the allegations. Further review of the investigative documentation revealed that the caregiver continued to work her shift on (MONTH) 20, 2020 and was not removed from providing direct care until the following day, on (MONTH) 21. An interview was conducted with the administrator (staff #49) on (MONTH) 23, 2020 at 10:10 a.m. Staff #49 stated that the caregiver was not removed from the facility after the allegation was made and continued to work the remainder of her shift, with the resident who made the allegation against her. Staff #49 stated that it was facility policy that if there was an allegation of abuse, the alleged perpetrator would be immediately suspended pending the investigation. Review of the policy regarding Abuse, Neglect, Injuries of Unknown Source and Misappropriation of Property dated (MONTH) 25, (YEAR) revealed .Upon receiving an allegation of abuse, the facility shall immediately implement measures to prevent further potential abuse while the matter is being investigated. If allegation involves an employee or employee(s), the facility will separate the employee from all residents .