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 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews and policy and procedure, the facility failed to ensure that one of twelve sampled residents (#3) was treated with respect and dignity. The deficient practice could result in residents experiencing a negative psychosocial outcome and decrease in quality of life. Findings include: Resident #3 was admitted to the facility on (MONTH) 17, (YEAR), with [DIAGNOSES REDACTED]. Review of a care plan revised on (MONTH) 7, 2019, revealed the resident had self care deficits with activities of daily living (ADL). A goal was that the resident would not experience complications related to decreased function. An intervention was to provide one to one assistance with eating. Review of the annual Minimum Data Set (MDS) assessment dated (MONTH) 22, 2019, revealed a Brief Interview for Mental Status (BIMS) score of 0, which indicated the resident was severely cognitively impaired. The MDS also included that the resident required extensive assistance with eating. An interview was conducted with a Certified Nursing Assistant (CNA/staff #84) during a dining observation on (MONTH) 21, 2020 at 12:06 p.m. During the interview, staff #84 stated that resident #3 was a feeder (which referred to what type of eating assistance the resident required). Staff #84 was speaking in the presence of resident #3 and another resident. An interview was conducted with a CNA (staff #3) on (MONTH) 22, 2020 at 12:27 p.m. He said staff were expected to treat residents with respect. He said he tried to treat residents the same way he would treat family. He said he has never heard a staff member call a resident a feeder. During a random observation conducted on (MONTH) 22, 2020 at 1:46 p.m., three staff members were observed engaged in conversation in between the unit hallway and the doorway leading to the kitchen preparation area. One staff member was overheard making a reference to an unidentified resident by saying, he's a feeder. An interview was conducted with the Director of Nursing (DON/staff #10) on (MONTH) 23, 2020 at 10:12 a.m. She stated her expectation was that staff would not label residents by their [DIAGNOSES REDACTED]. She said she expected staff to knock on the resident's door, introduce themselves, explain procedures, allow resident participation and thank them for their time. She said staff should address residents by name, and nicknames should only be used with permission of the resident. Review of the facility's policy regarding Resident Rights revealed the resident has a right to a dignified existence. The policy included the facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance of his or her quality of life. Per the policy, the facility must protect and promote the rights of residents.
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.

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

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F 0607 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) 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. 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. 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 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 facility's policy regarding Abuse, Neglect, Injuries of Unknown Source and Misappropriation of Property dated (MONTH) 25, (YEAR) revealed to .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 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

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F 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) 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 .
F 0757 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **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 that one (#7) out of five sampled residents received laboratory monitoring related to the use of an anticoagulant medication. The deficient practice could result in residents receiving anticoagulant medications outside of the therapeutic ranges. Findings include: Resident #7 was admitted to the facility on (MONTH) 14, 2019 and readmitted on (MONTH) 13, 2020, with [DIAGNOSES REDACTED]. Review of the quarterly Minimum Data Set (MDS) assessment dated (MONTH) 30, 2019, revealed a Brief Interview for Mental Status (BIMS) score of 10, which indicated the resident had moderate cognitive impairment. The MDS assessment also included the resident had received an anticoagulant for the seven days of the look back period. Review of the clinical record revealed the resident was discharged from the facility on (MONTH) 1, 2020 and was readmitted on (MONTH) 13, 2020. Review of the admission physician's orders [REDACTED]. Further review of the admission physician's orders [REDACTED]. A care plan initiated (MONTH) 14, 2019 revealed the resident was at risk for bleeding related to anticoagulant use. The goal was that the resident would be free from adverse reactions. Interventions included administering anticoagulant medications as ordered, monitoring for side effects and effectiveness, and daily skin inspections and reporting abnormalities to the nurse. Review of the Medication Administration Record [REDACTED]. However, review of the clinical record revealed no evidence of any PT/INR levels which were done, in order to ensure therapeutic levels. An interview was conducted with a Licensed Practical Nurse (LPN/staff #11) on (MONTH) 23, 2020 at 1:43 p.m. He said for residents receiving [MEDICATION NAME] daily, the frequency of lab monitoring would be based on the physician's orders [REDACTED]. He said this resident recently returned from the hospital with a new order for [MEDICATION NAME]. He said he did not know the resident's current PT/INR values. He said he believed the resident received PT/INR monitoring for [MEDICATION NAME] twice a week when he went to [MEDICAL TREATMENT], but he did not have any [MEDICAL TREATMENT] communication forms or lab results from [MEDICAL TREATMENT]. He said the last time the resident had lab blood draws in the facility was (MONTH) 16, 2019, but these results did not include the PT/INR levels. An interview was conducted with the Director of Nursing (DON/staff #10) on (MONTH) 23, 2020. She stated her expectation is that residents receiving [MEDICATION NAME] would have orders for lab monitoring, consistent lab draws, current lab results and monitoring for side effects and adverse effects. She also stated her expectation was that nurses would have an understanding of the therapeutic range for [MEDICATION NAME] and provide education to the resident and resident's family. In a follow up interview the same day, staff #10 stated the facility did not have any PT/INR results for this resident. Review of the facility's policy for Anticoagulant Management revealed that the nurse on duty at the time of the resident's readmission is to confirm with the attending physician if the current order for anticoagulation medication is to be continued and the schedule for the next PT/INR lab test. The nurse on duty at the time that the PT/INR results are ready is to file the results in the resident's medical record or route the results for physician review before filing in the medical record, as applicable. The DON or on-call designee is to review the scheduled labs from the previous day to ensure that all labs had been drawn as ordered and that results had been communicated to the resident's physician. The DON or on-call designee would contact the resident's physician for any labs that had been missed for additional orders. A master tracking of all lab testing will be maintained and monitored by the DON or program director.
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 clinical record review, staff interviews and policy review, the facility failed to ensure that a gradual dose reduction was attempted or that there was documentation by the provider of the clinical rationale as to why a dose reduction was contraindicated for one of five residents (#8) receiving [MEDICAL CONDITION] medications. The deficient practice could result in residents being administered unnecessary [MEDICAL CONDITION] medications. Findings include: Resident #8 was admitted to the facility on (MONTH) 18, 2019, with [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. A care plan dated (MONTH) 18, 2019 included the resident was at risk for adverse reactions due to [MEDICAL CONDITION] medications. An intervention was to administer [MEDICAL CONDITION] medications as ordered by the physician and to monitor for side effects and effectiveness every shift. Review of a History and Physical dated (MONTH) 19, 2019 revealed the resident had advanced dementia with hallucinations and [MEDICATION NAME] for agitation/aggressive behavior. Review of the Medication Administration Record [REDACTED]. Further review of the (MONTH) 2019 MAR indicated [REDACTED]. The documentation from (MONTH) 18 through 30 showed that the resident only exhibited behaviors on (MONTH) 25, 29 and 30. Review of the (MONTH) 2019 MAR indicated [REDACTED]. Per the MAR, the resident only exhibited the behavior on (MONTH) 2. Review of a pharmacy recommendation dated (MONTH) 6, 2019 revealed that the resident has advanced dementia. The recommendation included the following: Upon admission he was prescribed [MEDICATION NAME] 0.5 milligrams by mouth twice daily. The administration of antipsychotics in elderly residents with dementia may be at an increased risk of mortality and morbidity. (FDA Black Box warning). Upon review of available hospital documentation, he was not receiving [MEDICATION NAME] while at home. Therefore, please consider a taper of [MEDICATION NAME] to discontinuation. Please consider decreasing [MEDICATION NAME] to 0.5 milligrams by mouth once daily at bedtime times 7 nights, then discontinue. Further review revealed that the resident's provider agreed to the pharmacy recommendation but not until (MONTH) 1, 2020. Further review of the resident's clinical record revealed no evidence that the [MEDICATION NAME] dose was decreased or that there was documentation by the provider as to why a gradual dose reduction was contraindicated from (MONTH) 6 through 18, 2019. A physician's orders [REDACTED]. as evidenced by yelling out and [MEDICATION NAME] 1 mg, give 1 tablet by mouth in the evening (5:00 p.m.) for agitation as evidenced by hitting/yelling. Review of the MAR for (MONTH) 2019 revealed that [MEDICATION NAME] was administered from (MONTH) 20-31. The MAR indicated [REDACTED]. Further review of the pharmacy recommendation from (MONTH) 6, 2019 revealed that the resident's provider agreed to the pharmacy recommendation on (MONTH) 1, 2020. A physician progress notes [REDACTED]. Review of a Gradual Dose Reduction note dated (MONTH) 8, 2020 revealed that the gradual dose reduction dose was reviewed. However, there was no further documentation that a gradual dose reduction was attempted related to [MEDICATION NAME] or the clinical rationale by the provider as to why it was contraindicated.

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F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) A physician progress notes [REDACTED].per caregiver at bedside he was very agitated overnight. Confused last night. Decreased appetite .Alzheimer's dementia with agitation .hospice consult pending .Agitation controlled with some episodes of agitation overnight. continue [MEDICATION NAME] 2 milligrams every night and 1 milligram every morning. 1 additional dose [MEDICATION NAME] 1 milligram overnight as needed for agitation . According to the (MONTH) 2020 MAR, the resident was being monitored on all shifts for a target behavior of yelling out related to Alzheimer's dementia and no behaviors were exhibited from (MONTH) 1-21. An interview was conducted with a LPN (licensed practical nurse/staff #12) on (MONTH) 22, 2020 at 1:32 p.m. Staff #12 stated that the resident didn't exhibit many behaviors during the daytime as the day staff are familiar with the resident and his personal caregiver was very good about redirecting his behaviors as she was very familiar with him. Staff #12 stated that he had never witnessed the resident exhibit any behaviors but heard that they escalate in the evening. Staff #12 stated that he would call the resident's physician regarding the pharmacy recommendation for the dose reduction which was done on (MONTH) 6, 2019 and approved by the resident's physician on (MONTH) 1, 2020. An interview was conducted with the resident's personal caregiver on (MONTH) 23, 2020 at 9:03 a.m. The personal caregiver stated that the resident was sleepy this morning and that was normal because he was on medication. Another interview was conducted with staff #12 on (MONTH) 23, 2020 at 9:16 a.m. Staff #12 stated that he called the resident's physician and the resident's [MEDICATION NAME] order was decreased to 0.5 milligrams at bedtime only. An interview was conducted with the DON (Director of Nursing/staff #10) on (MONTH) 23, 2020 at 10:02 a.m. Staff #10 stated that every week the facility met with the pharmacist and reviewed every resident who was administered [MEDICAL CONDITION] medication. Staff #10 stated that when the physician agreed to the pharmacist's recommendation for a dose reduction, the nurse should have also signed the recommendation and changed the physician's orders [REDACTED]. Review of the facility's policy titled, Unnecessary Medications-[MEDICAL CONDITION]/Mood Altering dated (MONTH) 22, 2019 revealed .Anti-psychotic medications specifically will be kept at a minimum within the community .Residents admitted with a prior use of [MEDICAL CONDITION] and/or mood altering medication are to be evaluated at the time of the resident's initial comprehensive assessment to determine if the medication is providing a therapeutic effect and whether the resident is a candidate to attempt a gradual dosage reduction .Gradual dose reductions for [MEDICAL CONDITION] medications will be encouraged for residents within the first year of admission including those with a [DIAGNOSES REDACTED].
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 policy review, the facility failed to ensure 1 of 32 sampled resident's (#7) clinical record was accurate and complete. The deficient practice could result in residents' clinical records not being accurate and complete. Findings include: Resident #7 was admitted to the facility on (MONTH) 14, 2019, with [DIAGNOSES REDACTED]. Review of the (MONTH) 2019 physician orders [REDACTED]. The care plan initiated (MONTH) 24, 2019 revealed the resident had a risk for adverse reactions related to [MEDICAL CONDITION] medication use. The goal was that the resident would be free from [MEDICAL CONDITION] drug related complications. Interventions included administering medications as ordered and monitoring for side effects and effectiveness each shift. Review of the quarterly Minimum Data Set (MDS) assessment dated (MONTH) 30, 2019, revealed a Brief Interview for Mental Status (BIMS) score of 10, which indicated the resident had moderately impaired cognition. The assessment also included that the resident had received an antidepressant medication for the seven days of the look back period. Continued review of the clinical record revealed two documents titled Informed Consent for Antipsychotic and Mood Altering Medication for [MEDICATION NAME]. Both documents listed the medication and the reason for its use. One document was signed by the resident's representative. The other document stated, Refused to sign on the signature line. Neither document included a date. An interview was conducted with a Licensed Practical Nurse (LPN/staff #11) on (MONTH) 23, 2020 at 1:43 p.m. He said normally when a resident is admitted to the facility, the admitting nurse would obtain informed consent from the resident for [MEDICAL CONDITION] medication administration. He said the resident's representative would be approached if the resident was not sufficiently alert or oriented to sign medication consents. He stated that if a resident or representative refused to sign medication consents, education would be provided regarding the potential side effects of not continuing the medication. He also stated that if the resident or the representative still refused to sign the consent, the provider would be contacted with a request that the medication order be discontinued. The LPN stated that in this resident's situation, it was possible that the resident initially refused to sign the medication consent because his representative was not present and he preferred to have his representative involved in all of his medical decisions. The LPN also stated that he would have expected the nurse to follow up when the resident's representative was present to obtain medication consent. An interview was conducted with the Director of Nursing (DON/staff #10) on (MONTH) 23, 2020 at 2:05 p.m. She stated her expectation is that consent for [MEDICAL CONDITION] medication be obtained along with consent for treatment. She also stated that the medication should be discussed with the family if the resident is unable to give consent. In a follow-up interview the same day, the DON stated that she did not know the date the consent for [MEDICATION NAME] was obtained. Review of the facility's medication administration policy revealed that residents had the right to know which medications they were taking and the right to refuse medication. Review of the facility's policy for resident rights revealed the resident had the right to be informed of and participate in his or her treatment, including the right to be informed in advance of the risks and benefits of proposed care, of treatment alternatives and options, and to choose the alternative or option he or she prefers.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, personnel record reviews, staff interviews, and policy review, the facility failed to implement infection control procedures for the handling of a urine sample and failed to ensure two staff members (#17 and #46) had current evidence of freedom from [MEDICAL CONDITION]. The deficient practice could result in the spread of infection and residents having an increased risk of being exposed to infectious [MEDICAL CONDITION]. Findings include: -During an observation of medication administration conducted with a Licensed Practical Nurse (staff #11) on 1/22/20 at 8:56 AM, a urine sample was observed sitting on the top of the medication cart. Staff #11 stated the urine sample should not be on top of the medication cart. Staff #11 stated the top of the medication cart was contaminated due to the urine sample being on top of the cart. Staff #11 then removed the urine sample. During an interview conducted with the Director of Nursing (staff #10) on 1/22/20 at 2:15 PM, she stated the urine specimen should not have been placed on the medication cart. Review of the facility's policy titled, Urine Specimen Collection revealed non-sterile gloves shall be worn when handling the specimen container and to transport the specimen immediately to the laboratory. -Staff #17, a registered nurse, was hired at the facility on (MONTH) 8, 2019. A review of staff #17's personnel file on (MONTH) 22, 2020 revealed no documented evidence that staff #17 was free from infectious [MEDICAL CONDITION]. -Staff #46 a licensed practical nurse, was hired at the facility on (MONTH) 6, 2019. A review of staff #46's personnel file on (MONTH) 22, 2020 revealed no documented evidence that staff #46 was free from infectious [MEDICAL CONDITION]. An interview was conducted with the administrator (staff #49) on (MONTH) 22, 2020 at 2:10 p.m. Staff #49 stated that staff #17 was not tested for [MEDICAL CONDITION] on hire and received the test today. Staff #49 stated that the employee should have been tested for [MEDICAL CONDITION] upon hire. Another interview was conducted with the administrator (staff #49) on (MONTH) 23, 2020 at 8:15 a.m. Staff #49 stated that

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 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 4) staff #46 was not tested for [MEDICAL CONDITION] upon hire. Review of the facility's policy TB Testing for Associates, dated (MONTH) 4, 2019, documented .Based on CDC (Centers for Disease Control) guidelines communities will perform or have performed a Two-Step (TST ([MEDICATION NAME] skin test) at the time of hire. The nurse will administrate the initial TST before the associate performs any direct resident care duties .