STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035152	A. BUILDING _____ B. WING _____	**10/10/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
YUMA NURSING CENTER	**1850 WEST 25TH STREET YUMA, AZ 85364**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**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 and policies and procedures, the facility failed to report an injury of an unknown source involving one resident (#73) to the State Survey Agency, within 2 hours as required. The deficient practice could result in additional incidents regarding injuries of an unknown source not being reported to the State Agency; resulting in the State Agency not being informed of possible abuse situations. Findings include: Resident #73 was admitted to the facility on (MONTH) 12, (YEAR) and readmitted on (MONTH) 21, 2019, with [DIAGNOSES REDACTED]. Review of the Significant Change Minimum Data Set (MDS) assessment dated (MONTH) 19, 2019, revealed a Brief Interview for Mental Status (BIMS) score of 3, indicating the resident had a severe cognitive impairment. The MDS also revealed the resident was totally dependent on staff assistance when moving from one place to another on the unit. Review of a progress note dated (MONTH) 4, 2019 revealed the resident was observed lying on her left side on the floor by her wheelchair. The resident had left hip and groin pain and the left leg was shorter than the right leg when extended. Per the note, the resident was transferred to the hospital and was admitted due to a femoral neck fracture. The facility was unable to provide any evidence that the incident regarding an injury of an unknown source was reported to the State Agency. On (MONTH) 9, 2019 at 10:13 a.m., an interview was conducted with a LPN (staff #10), who stated that a male activities volunteer found the resident on the floor next to her wheelchair in the 300 hall by the (RNA) room. She said that she was at the nurse's station when staff called her. She said that when she arrived, she found the resident lying on the floor by her wheelchair which was by the RNA door on the 300 unit. She said that she does not know how the resident got there, as the resident is not able to self-propel herself. She said if a CNA assists the resident with leaving her room, the CNA usually takes the resident to the area where the TV is located. On (MONTH) 9, 2019 at 10:30 a.m., an interview was conducted with an activities volunteer (staff #139), who stated that he remembered that he was taking a resident from the dining hall back to the room, when he saw a woman lying on the floor by the RNA door on the Unit 300. He said that her wheelchair was next to her. He said he could hear her moaning and asked her what happened, but she kept saying Please help me. He said that he did not witness the incident and did not know what had happened to her. An interview was conducted on (MONTH) 9, 2019 at 11:27 a.m. with the Director of Nursing (DON/staff #65), who stated that when there is an injury of unknown origin, the nurse is to report the incident to DON as soon as possible. She said it is her responsibility to notify the State agency, within 2 hours. She said that she was notified about the resident being found lying on the floor and that no one was around when it occurred, but it was thought that the resident fell . At this time, the facility's Abuse policy was reviewed and staff #65 stated that the incident should have been reported to the State Agency. Review of the facility's Abuse policies revealed that allegations of abuse, neglect, mistreatment, exploitation, including injuries of unknown source, are to be immediately reported to a supervisor/charge nurse, who will report the incident to the Administrator/designee. All alleged violations of abuse, neglect, exploitation, mistreatment, including injuries of unknown source will be reported immediately to the State Survey agency, but no later than 2 hours if involves abuse or has resulted in serious bodily injury.
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 and policies and procedures, the facility failed to ensure that an injury of an unknown source was thoroughly investigated for one resident (#73) and failed to report the results of the investigation to the State Agency, within 5 working days of the incident as required. The deficient practice could result in causative factors related to injuries of an unknown source not being identified, including possible abuse and not implementing corrective action to prevent further occurrences. Findings include: Resident #73 was admitted to the facility on (MONTH) 12, (YEAR) and readmitted on (MONTH) 21, 2019, with [DIAGNOSES REDACTED]. Review of the Significant Change Minimum Data Set (MDS) assessment dated (MONTH) 19, 2019, revealed a Brief Interview for Mental Status (BIMS) score of 3, indicating the resident had a severe cognitive impairment. The MDS also revealed the resident was totally dependent on staff assistance when moving from one place to another on the unit. Review of a progress note dated (MONTH) 4, 2019 revealed the resident was observed lying on her left side on the floor by her wheelchair. The resident had left hip and groin pain and the left leg was shorter than the right leg when extended. Per the note, the resident was transferred to the hospital and was admitted due to a femoral neck fracture. The facility was unable to provide any evidence that a thorough investigation was completed for this incident regarding an injury of unknown source. On (MONTH) 9, 2019 at 10:13 a.m., an interview was conducted with a LPN (staff #10), who stated that a male activities volunteer found the resident on the floor next to her wheelchair in the 300 hall by the (RNA) room. She said that she was at the nurse's station when staff called her. She said that when she arrived, she found the resident lying on the floor by her wheelchair which was by the RNA door on the 300 unit. She said that she does not know how the resident got there, as the resident is not able to self-propel herself. She said if a CNA assists the resident with leaving her room, the CNA usually takes the resident to the area where the TV is located. On (MONTH) 9, 2019 at 10:30 a.m., an interview was conducted with an activities volunteer (staff #139), who stated that he remembered that he was taking a resident from the dining hall back to the room, when he saw a woman lying on the floor by the RNA door on the Unit 300. He said that her wheelchair was next to her. He said he could hear her moaning and asked her what happened, but she kept saying Please help me. He said that he did not witness the incident and did not know what had happened to her. An interview was conducted on (MONTH) 9, 2019 at 11:27 a.m. with the Director of Nursing (DON/staff #65), who stated that when there is an injury of unknown origin, the nurse is to report the incident to DON as soon as possible. She said it is her responsibility to notify the State Agency, within 2 hours. She said that she was notified about the resident being

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	(continued... from page 1) found lying on the floor and that no one was around when it occurred, but it was thought that the resident fell . At this time, the facility's Abuse policy was reviewed and staff #65 stated that the incident should have been investigated by the facility. Review of a policy regarding Accidents and Incidents revealed that all accidents or incidents involving residents occurring on their premises must be investigated and reported to the Administrator. Regardless of how minor an accident or incident may be, including injuries of an unknown source, it must be reported to the department supervisor as soon as discovered or when the information is learned. Review of the facility's Abuse policies revealed that allegations of abuse, neglect, mistreatment, exploitation, including injuries of unknown source, are to be immediately reported to a supervisor/charge nurse, who will report the incident to the Administrator/designee. All alleged violations of abuse, neglect, exploitation, mistreatment, including injuries of unknown source will be reported immediately to the State Survey agency, but no later than 2 hours if involves abuse or has resulted in serious bodily injury. If an incident or suspected incident of abuse, neglect, exploitation, mistreatment, including injuries of unknown source is reported, the Administer will assign the investigation to an appropriate individual. The incident shall be thoroughly investigated and include reviewing all events leading up to the incident, clinical record review, interviews with the resident and the roommate, any witnesses and staff on all shifts who had contact with the resident. The policy also included a written report of the investigation will be sent to the State Agency.