DEPARTMENT OF HEALTH AND HUMAN SERVICES — CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 0W2W12

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: LTC0053

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **035099**
2.STATE VENDOR OR MEDICAID NO.
(L2) **835118**

3. NAME AND ADDRESS OF FACILITY
(L3) **SAPPHIRE OF TUCSON NURSING AND REHAB, LLC**
(L4) **2900 EAST MILBER STREET**
(L5) **TUCSON, AZ** (L6) **85714**

4. TYPE OF ACTION: **6** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **240** (L18)
13.Total Certified Beds **240** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	240			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): **YES** (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
Sapphire of Tucson Nursing and Rehab, L.L.C. abbreviated survey revisit was conducted on 10/24/19. Sapphire of Tucson Nursing and Rehab, L.L.C. is back in compliance with Federal regulations based on allegation of compliance and acceptable plan of correction with evidence of compliance.

17. SURVEYOR SIGNATURE
for Chris Benson, Surveyor DE sg
Date : 10/24/2019 (L19)

18. STATE SURVEY AGENCY APPROVAL
Andy Farmer DE
Date: 10/24/2019 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
00000 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

October 24, 2019

Receipt Of This Notice Is Presumed To Be 10/24/2019
Important Notice - Please Read Carefully

Brian Balliet, Administrator
Sapphire of Tucson Nursing and Rehab, L.L.C.
2900 East Milber Street
Tucson, AZ 85714

Dear Mr. Balliet:

On October 24, 2019, an offsite revisit was conducted for your facility by the Arizona Department of Public Health, Licensing, and Certification Bureau, to determine if your facility was in compliance with federal participation requirements at the time of the follow-up investigation to Complaint #0W2W12.

The enclosed Center for Medicare and Medicaid Services (CMS) form, entitled "Statement of Deficiencies and Plan of Correction" (CMS 2567), documents that no deficiencies of participation requirements were identified during this revisit. The plan of correction was accepted for the Federal citations.

Enclosed is the **Federal Post-Certification Revisit Report**, please retain a copy for your files. If we can be of further assistance, please contact the Bureau of Long Term Care at (602) 364-2690.

Sincerely,

Sandy Farmer
LTC Customer Service Representative IV

\sf

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035099	A. BUILDING _____ B. WING _____	R-C 10/24/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS The offsite follow up for the Federal complaint investigation was conducted on 10/24/19, no deficiencies were cited.	{F 000}		

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.

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
035099 Y1	A. Building B. Wing Y2	10/24/2019 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SAPPHIRE OF TUCSON NURSING AND REHAB, LLC	2900 EAST MILBER STREET TUCSON, AZ 85714

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0603 Reg. # 483.12(a)(1) LSC	Correction Completed 10/24/2019	ID Prefix F0842 Reg. # 483.20(f)(5), 483.70(i)(1)-(5) LSC	Correction Completed 10/24/2019	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☒	REVIEWED BY (INITIALS) DA	DATE 10/24/19	SIGNATURE OF SURVEYOR [signature]	DATE 10/24/19
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
9/13/2019	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

September 27, 2019

Receipt Of This Notice Is Presumed To Be -09/27/2019
Important Notice - Please Read Carefully

Brian Balliet, Administrator
Sapphire Of Tucson Nursing And Rehab, LLC
2900 East Milber Street
Tucson, AZ 85714

Dear Mr. Balliet:

On **September 13, 2019**, a Medicare abbreviated survey was conducted at your facility by the Department of Health Services, Bureau of Long Term Care to determine if your facility was in compliance with Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. During this survey, complaints investigations may have also been conducted.

[] This survey found the most serious deficiency(ies) in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy, as evidenced by the attached form 2567 whereby corrections are required (D).

[X] This survey found the most serious deficiency(ies) in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy, as evidenced by the attached form 2567 whereby corrections are required (E).

[] This survey found the most serious deficiency(ies) in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy, as evidenced by the attached form 2567 whereby corrections are required (F).

All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Plan of Correction

A Plan of Correction (PoC) for the deficiencies must be submitted by **October 7, 2019.** You must include all pages of the Statement of Deficiencies when submitting your PoC.
Failure to submit an acceptable PoC by **October 7, 2019** may result in the imposition of remedies. **Plans of correction sent by fax will not be accepted.**

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice, on both a temporary and permanent basis, including the date the correction will be accomplished;

- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;

- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and,

- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and the title, or position, of the person responsible for implementing/monitoring the corrective action.

- The signature and date you approve the Plan of Correction on the first page.

- Please provide all in-service records to include:

    - What was taught
    - When it was taught
    - Sign-in sheets of those who attended
    - Any copies of monitoring aduits being done up to your Allegation of Compliance date

Allegation of Compliance

Your properly signed Plan of Correction constitutes your credible allegation of compliance. We may accept the Plan of Correction and presume compliance until substantiated by a revisit or other means.

To ensure that this office has time to confirm compliance before mandatory remedies are imposed, the Bureau of Long Term Care recommends that an allegation of compliance date be within one week of October 28, 2019.

If, upon a subsequent revisit, your facility has not achieved substantial compliance, the Bureau of Long Term Care will recommend that remedies be imposed by the CMS Regional Office or the State Medicaid Agency and continue until substantial compliance is achieved.

Recommended Remedies

The remedies which will be recommended if substantial compliance is not achieved include the following:

Recommending to CMS Civil Money, effective September 13, 2019
Recommending to CMS Denial of Payment for New Admission

Mandatory Remedies

Your current period of noncompliance began on September 13, 2019. If you do not achieve substantial compliance within three months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions. The CMS Regional Office must terminate your provider agreement if substantial compliance has not been reached by **March 11, 2020.**

Informal dispute resolution for the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate). A change in the seriousness of the deficiencies may result in a change in the remedy selected. When this occurs, you will be advised of any change in remedy.

Notice for Statutory Denial of Payment for New Admissions (DPNA)

Based on deficiencies cited during this survey and as authorized by CMS San Francisco Regional Office, we are giving formal notice of imposition of statutory Denial of Payment for New Admissions effective **December 12, 2019.** This remedy will be effectuated on the stated date unless you demonstrate substantial compliance with an acceptable plan of correction and subsequent revisit.
This notice in no way limits the prerogative of CMS to impose discretionary DPNA at any appropriate time. CMS Regional Office will notify your intermediary and the Medicaid Agency. If effectuated, denial of payment will continue until your facility achieves substantial compliance or your provider agreement is terminated. [Facilities are prohibited from billing those Medicare/Medicaid residents or their responsible parties during the denial period for services normally billed to Medicare or Medicaid} The Medicare and Medicaid programs will make no payment for residents whose plans of care begin on or after the DPNA effective date.

FILING AN APPEAL

If you disagree with the determination of noncompliance (and/or substandard quality of care resulting in the loss of your Nurse Aide Training and Competency Evaluation Program (NATCEP), if applicable), you or your legal representative may request a hearing before an administrative law judge of the U.S. Department of Health and Human Services, Departmental Appeals Board. Procedures governing this process are set out in 42 CFR §498.40, et. seq. You may appeal the

finding of noncompliance that led to an enforcement action, but not the enforcement action or remedy itself. A request for a hearing should identify the specific issues, and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You may have counsel represent you at a hearing (at your own expense). Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted unless you do not have access to a computer or internet service. **You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at *https://dab.efile.hhs.gov* no later than 60 days from the date of receipt of this letter.**

When using DAB E-File for the first time, you will need to create an account by a) clicking Register on the DAB E-File home page; b) entering the requested information on the Register New Account form; and c) clicking Register Account at the bottom of the form. Each representative authorized to represent you must register separately to use the DAB E-File on your behalf.

The e-mail address and password given during registration must be entered on the login screen at: *https://dab.efile.hhs.gov/user_sessions/new* to access DAB E-File. A registered user's access to DAB E-File is restricted to the appeals for which he/she is a party or an authorized representative. You can file a new appeal by a) clicking the *File New Appeal* link on the Manage Existing Appeals screen; then b) clicking *Civil Remedies Division* on the File New Appeal screen; and c) entering and uploading the requested information and documents on the File New Appeal-Civil Remedies Division form.

The Civil Remedies Division (CRD) requires all hearing requests to be signed and accompanied by the notice letter from CMS that addresses the action taken and your appeal rights. All submitted documents must be in Portable Document Format (PDF). Documents uploaded to DAB E-File on any day on or before 11:59p.m. ET will be considered to have been received on that day. You will be expected to accept electronic service of any appeal-related documents filed by CMS or that the CRD issues on behalf of the Administrative Law Judge (ALJ) via DAB E-File. Further instructions are located at: *https://dab.efile.hhs.gov/appeals/to_crd_instructions*. Please contact the Civil Remedies Division at (202) 565-9462 if you have questions regarding the DAB E-Filing System. If you experience technical issues with the DAB E-Filing System, please contact E-File System Support at OSDABImmediateOffice@hhs.gov or call (202) 565-0146 before 4:00p.m. ET.

If you do not have access to a computer or internet service, you may call the Civil Remedies Division at (202) 565-9462 to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

In addition, please email a copy of your request to Western Division of Survey and Certification-San Francisco at ROSFEnforcements@cms.hhs.gov.

Informal Dispute Resolution

In accordance with §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, an explanation of why you are disputing those deficiencies along with supporting information that shows that the facility was in compliance at the time of the survey to Diane Eckles, Bureau Chief, Bureau of Long Term Care, 150 North 18th Avenue, Suite 440, Phoenix, Arizona 85007. This request must be sent during the same 10 days you have for submitting a PoC for the cited deficiencies.

An informal dispute resolution process will not delay the effective date of any enforcement action. **Please note: Facilities requesting an Informal Dispute Resolution must submit separate requests, one for State deficiencies cited and one for Federal deficiencies cited, if applicable.**
Retain a copy of the PoC for your files. If the PoC is not received by this Office by October 7, 2019, licensure and/or recertification may be denied. **Plans of correction sent by fax will not be accepted.** If you have any questions concerning the instructions contained in this letter, please contact the Bureau of Long Term Care at (602) 364-2690.

Sincerely,

Diane Eckles

Diane Eckles
Bureau Chief

DE:dc

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint (AZ15887 and AZ159001) investigation was conducted on September 12 and 13, 2019. The following deficiencies were cited.	F 000	"This Plan of Correction is submitted to meet requirements established by state law. This Plan of Correction constitutes this facility's demonstration of compliance for the deficiencies cited. Submission of this Plan of Correction is not an admission that a deficiency existed or that one was correctly cited."	
F 603 SS=E	Free from Involuntary Seclusion CFR(s): 483.12(a)(1) §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: 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 July 16, 2019 with diagnoses that included traumatic subdural hemorrhage without loss of consciousness, cognitive communication deficit, and hypertension.	F 603	<u>F603</u> **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice, on both a temporary and permanent basis, including the date the correction will be accomplished?** Resident #1 was relocated to a non-secured unit on the second floor on 09/24/2019. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** Nursing and Social Services is reviewing the charts of each resident of the secured units to identify residents who are appropriate to relocate to the non-secured units on the second floor. This will be completed by 10/24/2019. RECEIVED OCT - 3 2019 By	10/24/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tina Ballint	ADMINISTRATOR	10/1/2019

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.

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 603	Continued From page 1 A Baseline Careplan dated July 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 psychotropic medications. Review of an Evaluation Criteria for Behavioral Health Specialty Unit dated July 16, 2019 revealed the resident did not have a behavioral health related diagnosis and did not exhibit any behaviors which put himself at risk or required the close supervision of the unit. 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 July 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 July 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 July 23, 2019 revealed the resident's BIMS (Brief Interview for Mental Status) score was a 13 or intact cognition.	F 603	**What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** Administrator, Director of Nursing and Behavioral Health Operations Manager will review the admission criteria to ensure the criteria for the secured units is appropriate. This will be completed by 10/11/2019. A new secured unit resident acknowledgement form was developed, implemented and distributed to marketing and admissions staff, as well as facility nursing, social service and guest relations staff on 09/26/2019. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and the title, or position, of the person responsible for implementing/monitoring the corrective action?** Behavioral Health Operations Manager will audit admissions to the secured units to ensure appropriateness. The results of the audits will be reported to the QAPI Committee x 3 months. On-going monitoring for appropriateness of residents of the secured units will be conducted by the IDT and reported to the QAPI Committee by the Behavioral Health Operations Manager.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 603	Continued From page 2 Review of a Notification of Change dated July 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 July 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 July 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 July 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 July 31, 2019 revealed the resident did not have a history of escape or elopement, did not say that he	F 603		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 603	Continued From page 3 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 August 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 August 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 August 29, 2019 revealed that it was the physician's recommendation that the resident should live in a supervisory care facility. A Nursing Note dated August 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 September 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 September 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	F 603		

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 603	Continued From page 4	F 603		

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 September 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 September 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 September 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.

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F 603	Continued From page 5 An interview was conducted with a certified nursing assistant (CNA/staff #181) on September 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 September 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 September 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 #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 September 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 September 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	F 603		

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F 603	Continued From page 6 behavioral health operations manager (staff #1) on September 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 September 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 August 2018 documented "To establish uniform guidelines for personnel to follow when admitting consumers to the unit...Consumers admitted to the unit typically have a diagnosis of mental illness as defined in the DSM (Diagnostic and Statistical Manual of Mental Disorders): including schizophrenia, schizoaffective disorder, shared psychotic disorder, bipolar, depressive disorder, borderline personality disorder, post traumatic stress disorder, obsessive compulsive disorder, and dementia. Consumers admitted to the unit typically have a history of multiple inpatient psychiatric hospitalizations and not appropriate for the transitional living level of services..."	F 603		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)	F 842		

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F 842	Continued From page 7 §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.	F 842	F842 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice, on both a temporary and permanent basis, including the date the correction will be accomplished?** Resident #1 was relocated to a non-secured unit on the second floor on 09/24/2019. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** Administrator, Nursing Management and Social Services are reviewing the charts of each secured unit resident to ensure each has a secured unit acknowledgement form appropriately signed and dated. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** A thorough investigation was conducted into the allegation and the offending staff members were disciplined on 09/17/2019. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and the title, or position, of the person responsible**	09/24/19

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F 842	Continued From page 8 §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: 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 July 16, 2019 with diagnoses that included traumatic subdural hemorrhage without loss of	F 842	**for implementing/monitoring the corrective action?** The Administrator will review and audit the secured unit acknowledgement form for each new resident of the secured units. Audit findings will be reported to the QAPI Committee x 3 months.	

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F 842	Continued From page 9 consciousness, cognitive communication deficit, and hypertension. Review of the resident's admission MDS (Minimum Data Set) assessment dated July 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 July 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 September 12, 2019, copies of the resident's clinical record were requested by licensing surveyor. When the copies were provided an unrequested copy dated July 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 July 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 September 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 July 24, 2019. An interview was conducted with the medical records director (staff #15) on September 12, 2019 at 3:45 p.m. Staff #15 stated that the above form had not been scanned into the computer yet	F 842		

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F 842	Continued From page 10 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 September 13, 2019 at 8:30 a.m. Staff #2 stated the an LPN unit manager (staff #152) had the resident sign the form on September 12, 2019 consenting to reside in a a locked unit and that she dated it July 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..."	F 842		

SAPPHIRE
OF TUCSON
NURSING AND REHAB

October 1, 2019

Ms. Diane Eckles, Bureau Chief
Bureau of Long Term Care Licensing
Arizona Department of Health Services
150 North 18th Avenue, Suite 440
Phoenix, AZ 85007-3247

Dear Ms. Eckles:

Enclosed please find the Statements of Deficiencies with the corresponding Plans of Correction for each of the citations received in the September 13, 2019 Complaint Survey conducted at Sapphire of Tucson Nursing & Rehabilitation. Included are the Statements of Deficiencies and the Plans of Correction for the F-Tags and the Y-Tags cited in the Survey.

Please accept these Plans of Correction as the credible allegation of substantial compliance.

Please contact me with any questions.

Sincerely,

Brian Balliet, LNHA
Administrator

RECEIVED
OCT - 3 2019
By

2900 E Milber Street Tucson, Arizona 85714 **office** 520.294.0005 **fax** 520.807.2500
sapphireoftucson.com

ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

October 24, 2019

Important Notice - Please Read Carefully

Brian Balliet, Administrator
Sapphire of Tucson Nursing and Rehab, L.L.C.
2900 East Milber Street
Tucson, AZ 85714

Re: Complaint Intake #AZ00159001
Investigation # 0W2W11

Dear Mr. Balliet:

Surveyors of the Arizona Department of Health Services (Department) have thoroughly investigated the above referenced complaint. Prior to being investigated, this complaint was broken down into allegations that correspond to the Department's rules for the facility.

The overall finding of this investigation is that at least one of the allegations was found to be substantiated.

You are in receipt of a Statement of Deficiencies that reflect the finding of this survey.

If we may be of further assistance, please contact the Bureau of Long Term Care at (602) 364-2690.

Sincerely,

Sandy Farmer
LTC Customer Service Representative IV
Bureau of Long Term Care Licensing

ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

October 24, 2019

Important Notice - Please Read Carefully

Brian Balliet, Administrator
Sapphire Of Tucson Nursing And Rehab, Llc
2900 East Milber Street
Tucson, AZ 85714

Re: Complaint Intake #AZ00158887
Investigation # 0W2W11

Dear Mr. Balliet:

Surveyors of the Arizona Department of Health Services (Department) have thoroughly investigated the above referenced complaint. Prior to being investigated, this complaint was broken down into allegations that correspond to the Department's rules for the facility.

The overall finding of this investigation is that at least one of the allegations was found to be substantiated.

You are in receipt of a Statement of Deficiencies that reflect the finding of this survey.

If we may be of further assistance, please contact the Bureau of Long Term Care at (602) 364-2690.

Sincerely,

Sandy Farmer
LTC Customer Service Representative IV
Bureau of Long Term Care Licensing

Supplemental POC Documents

SAPPHIRE
OF TUCSON

Secure Unit Consent

Sapphire of Tucson Nursing and Rehabilitation Behavioral Health Program Plan

Visitation:
Visitation can be restricted and is reviewed on a case-by-case basis. Children under the age of 18 are not allowed on the unit without prior approval from management.

Belongings:
All belongings of the resident and visitors are subject to be searched before entering the unit including but not limited to food and drinks. Bags and backpacks of visitors are prohibited.

Smoking and Leave of Absence:
Residents are to abide by all policies and procedures, including but not limited to smoking and LOA policy.

Food and Beverages:
All food is to be stored appropriately.

Environment:
All residents are expected to be respectful to staff and peers and maintain a safe home-like environment.

I _____ (Printed Name) _____, *consent that I agree to be housed in a secure unit at Sapphire of Tucson Nursing and Rehabilitation Center for care including but not limited to medical and/or psychiatric care. I understand that violation of policies and procedures may result in consequences addressed on a case-by-case basis up to and including the individual being transferred to a more appropriate setting.*

Signature: _____ Date: _____

Facility Representative: _____ Date: _____