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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: V3CM
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: 2 (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) 08/17/2018

6. DATE OF SURVEY 01/10/2019 (L34)

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

10. THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
X 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: A1* (L12)

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

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): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
Sapphire of Tucson Nursing and Rehabilitation found to be out of compliance with federal regulations based on annual survey conducted on 1/10/19. This facility is back in compliance with federal regulations based on allegation of compliance and acceptable plan of correction with evidence of compliance, revisit survey completed on 4/5/19, State Agency recommended recertification.

17. SURVEYOR SIGNATURE: for Chris Benson, Surveyor
Date: 04/08/2019 (L19)

18. STATE SURVEY AGENCY APPROVAL: Sandy Farmer
Date: 04/08/2019 (L20)

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

19. DETERMINATION OF ELIGIBILITY
X 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
02/05/1985
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

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

25. LTC EXTENSION DATE:
(L27)

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

28. TERMINATION DATE:
(L28)

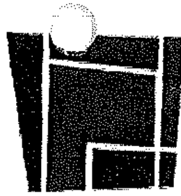
29. INTERMEDIARY/CARRIER NO.
01101
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL



ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

April 8, 2019

Important Notice - Please Read Carefully

Sheila Wiggins
Sapphire Of Tucson Nursing And Rehab, Llc
2900 East Milber Street
Tucson, AZ 85714

Re: Provider Number 035099

Dear Ms. Wiggins:

Your facility has just undergone its Federal/State recertification survey, as required by the Federal Title XVIII (Medicare) program and Federal Title XIX (Medicaid/AHCCCS) program. As the result of this survey, the facility's Medicare Provider Agreement will be continuous, unless you are contacted by our Bureau or the Centers for Medicare/Medicaid Services to the contrary.

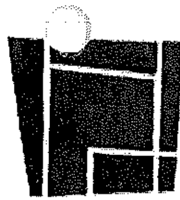
Please retain a copy of this notice with your signed provider agreement.

Sincerely,

Diane Eckles
Bureau Chief

DE/sf

Douglas A. Ducey | Governor Cara M. Christ MD, MS | Director
150 North 18th Avenue, Suite 440, Phoenix, AZ 85007-3247 P | 602-364-2690 F | 602-324-0993
W | azhealth.gov
Health and Wellness for all Arizonans



ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

April 8, 2019

IMPORTANT NOTICE- PLEASE READ CAREFULLY

Sheila Wiggins, Administrator
Sapphire Of Tucson Nursing And Rehab, Llc
2900 East Milber Street
Tucson, AZ 85714

Dear Ms. Wiggins:

On April 5, 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 for nursing homes participating in the Medicare and/or Medicaid programs. 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 based on an allegation of compliance and acceptable plan of correction.

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
Customer Service Representative IV

\sf

Enclosure

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

PRINTED: 04/08/2019
FORM APPROVED
OMB NO. 0938-0391

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 **04/05/2019**

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 follow up Federal Recertification and complaint investigation survey was conducted on 4/5/19, there were no deficiencies 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.

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
035099 Y1	A. Building B. Wing Y2	4/5/2019 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 F0552 Reg. # 483.10(c)(1)(4)(5) LSC	Correction Completed 04/05/2019	ID Prefix F0578 Reg. # 483.10(c)(6)(8)(g)(12)(i)-(v) LSC	Correction Completed 04/05/2019	ID Prefix F0584 Reg. # 483.10(i)(1)-(7) LSC	Correction Completed 04/05/2019
ID Prefix F0600 Reg. # 483.12(a)(1) LSC	Correction Completed 04/05/2019	ID Prefix F0607 Reg. # 483.12(b)(1)-(3) LSC	Correction Completed 04/05/2019	ID Prefix F0609 Reg. # 483.12(c)(1)(4) LSC	Correction Completed 04/05/2019
ID Prefix F0623 Reg. # 483.15(c)(3)-(6)(8) LSC	Correction Completed 04/05/2019	ID Prefix F0641 Reg. # 483.20(g) LSC	Correction Completed 04/05/2019	ID Prefix F0645 Reg. # 483.20(k)(1)-(3) LSC	Correction Completed 04/05/2019
ID Prefix F0657 Reg. # 483.21(b)(2)(i)-(iii) LSC	Correction Completed 04/05/2019	ID Prefix F0689 Reg. # 483.25(d)(1)(2) LSC	Correction Completed 04/05/2019	ID Prefix F0695 Reg. # 483.25(i) LSC	Correction Completed 04/05/2019
ID Prefix F0698 Reg. # 483.25(l) LSC	Correction Completed 04/05/2019	ID Prefix F0725 Reg. # 483.35(a)(1)(2) LSC	Correction Completed 04/05/2019	ID Prefix F0758 Reg. # 483.45(c)(3)(e)(1)-(5) LSC	Correction Completed 04/05/2019

REVIEWED BY STATE AGENCY ☒	REVIEWED BY (INITIALS) DA	DATE 4/5/19	SIGNATURE OF SURVEYOR [signature]	DATE 4/5/19
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
035099 Y1	A. Building B. Wing Y2	4/5/2019 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 F0842 Reg. # 483.20(f)(5), 483.70(i)(1)-(5) LSC	Correction Completed 04/05/2019	ID Prefix F0867 Reg. # 483.75(g)(2)(ii) LSC	Correction Completed 04/05/2019	ID Prefix F0919 Reg. # 483.90(g)(2) LSC	Correction Completed 04/05/2019

REVIEWED BY STATE AGENCY ☑	REVIEWED BY (INITIALS) DA	DATE 4/5/19	SIGNATURE OF SURVEYOR [signature]	DATE 4/5/19
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
1/10/2019	☐ 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

April 8, 2019

IMPORTANT NOTICE- PLEASE READ CAREFULLY

Sheila Wiggins, Administrator
Sapphire Of Tucson Nursing And Rehab, Llc
2900 East Milber Street
Tucson, AZ 85714

Dear Ms. Wiggins:

On March 8, 2019, an offsite **Life Safety Code/Emergency Preparedness,** revisit was conducted at 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 for nursing homes participating in the Medicare and/or Medicaid programs.

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 based on an allegation of compliance and acceptable plan of correction.

Enclosed is the **Life Safety Code/Emergency Preparedness 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
Customer Service Representative IV

\sf

Enclosure

Douglas A. Ducey | Governor   Cara M. Christ MD, MS | Director
150 North 18th Avenue, Suite 440, Phoenix, AZ 85007-3247   P | 602-364-2690   F | 602-324-0993
W | azhealth.gov
Health and Wellness for all Arizonans

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035099	A. BUILDING 01 - MAIN BUILDING 01 B. WING	R 03/08/2019

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
{K 000}	INITIAL COMMENTS All noted deficiencies on the survey dated March 05, 2019, have been corrected.This is a NO ON SITE follow-up based on an approved plan of correction with allegations of correction and supporting documentation.	{K 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.

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
035099 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	3/8/2019 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 Reg. # NFPA 101 LSC K0291	Correction Completed 03/05/2019	ID Prefix Reg. # NFPA 101 LSC K0325	Correction Completed 03/05/2019	ID Prefix Reg. # NFPA 101 LSC K0353	Correction Completed 03/05/2019
ID Prefix Reg. # NFPA 101 LSC K0511	Correction Completed 03/05/2019	ID Prefix Reg. # NFPA 101 LSC K0761	Correction Completed 03/05/2019	ID Prefix Reg. # NFPA 101 LSC K0914	Correction Completed 03/05/2019
ID Prefix Reg. # NFPA 101 LSC K0918	Correction Completed 03/05/2019	ID Prefix Reg. # NFPA 101 LSC K0920	Correction Completed 03/05/2019	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

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE 3/8/19
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 1/15/2019	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

PRINTED: 04/08/2019
FORM APPROVED
OMB NO. 0938-0391

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 03/08/2019

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
{E 000}	Initial Comments All noted deficiencies on the survey dated March 05, 2019, have been corrected.This is a NO ON SITE follow-up based on an approved plan of correction with allegations of correction and supporting documentation.	{E 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.

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
035099 Y1	A. Building B. Wing Y2	3/8/2019 Y3

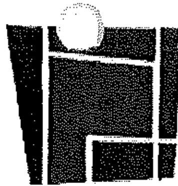
NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SAPPHIRE OF TUCSON NURSING AND REHAB, LLC	2900 EAST MILBER STREET TUCSON, AZ 85714

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 E0009 Reg. # 483.73(a)(4) LSC	Correction Completed 03/05/2019	ID Prefix E0015 Reg. # 483.73(b)(1) LSC	Correction Completed 03/05/2019	ID Prefix E0023 Reg. # 483.73(b)(5) LSC	Correction Completed 03/05/2019
ID Prefix E0024 Reg. # 483.73(b)(6) LSC	Correction Completed 03/05/2019	ID Prefix E0025 Reg. # 483.73(b)(7) LSC	Correction Completed 03/05/2019	ID Prefix E0026 Reg. # 483.73(b)(8) LSC	Correction Completed 03/05/2019
ID Prefix E0036 Reg. # 483.73(d) LSC	Correction Completed 03/05/2019	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

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR [signature]	DATE 3/8/19
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
1/15/2019	☐ 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

March 19, 2019

Receipt Of This Notice Is Presumed To Be 03/19/2019
Important Notice - Please Read Carefully

Sheila Wiggins, Administrator
Sapphire Of Tucson Nursing And Rehab, Llc
2900 East Milber Street
Tucson, AZ 85714

Dear . Wiggins:

The State Agency has received, the Statement of Deficiencies and Plan of Correction for the annual survey investigation conducted on January 10, 2019 which was submitted to the Bureau of Long Term Care on March 5, 2019.

The Plan of Correction is unacceptable for the following reasons:

F000: Initial comments: Need to delete in the last sentence the words ..."required by the provisions of the Federal and State law." Replace with wording that the facility is demonstrating compliance for the deficiencies cited.

F552: Send the policy and procedure for the nurse designee to obtain all psychotropic consents and what happens when that nurse is unavailable.

F578: Send copies of newly signed consents for residents# 121 & 164.
Send copies of material that was taught for the in-service on obtaining consents along with sign-in sheets for all those that attended

F584: Send copy of policy and procedure for Quality of Life-Homelike Environment.
Send copy of in-service material taught to staff along with the sign-in sheets for those staff members that attended.

F600: Send copy of in-service material taught for de-escalation techniques training to staff along with the sign-in sheets for those staff members that attended.
How are you reducing the resident to resident abuse allegations necessary to be put back in compliance?
Send copies of staffing needs for each unit.
Send copies of tracking log of behaviors to date.
Send your policy on monitoring cameras in the facility.
Send policy for observing residents during a CNAs shift; is it every 15, 30 minutes or 1 Hour?
You did not address monitoring every 15 minutes for residents that are elopement risks. How are you auditing this monitoring by staff?

F607: Send copy of newly revised abuse policy and procedure.
When will staff be updated on new abuse policy and procedure in an In-service?

F609: Send copy of updated Policy done on 3/4/2019.

F623: Send updated copy of discharges for December 2018.
Send copy of the monthly discharge notifications to the Ombudsman for January, February 2019.

F645: Send copy of PASARR Level 2 screening for resident #61.
Send copy of tracking log for Level 2 screenings needed and done.

F657: Send copy of updated care plan for resident #74.

F695: Send a copy of the updated oxygen administration policy.
Send copy of audit oxygen tubing change to date.

F698: Send copy of physician order for dialysis for resident #151.
Send copy of dialysis audits for accurate physician orders to date.

F725: Send a copy of the updated call-in policy. F758: Send copy of all audits conducted to date.

Y000: Initial comments: Please delete your initial comments and if you choose you may use the State AG's office of the approved initial comments or leave blank, "This Plan of Correction is submitted to meet the requirements established by State law. This Plan of Correction constitutes the 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."

The requested documents are required to be returned to this office no later than **March 26, 2019**, please retaining a copy for your files. If the requested documents for the Plan of Correction are not received by this office on or before **March 26, 2019** licensure action and/or civil penalties may be assessed.

Thank you for your cooperation. If you have any questions, please call the Bureau of Long Term Care at (602) 364-2690.

Sincerely,

Diane Eckles
Bureau Chief
DE\sg
Attachments

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 ______	01/10/2019

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 annual recertification survey was conducted from January 7 through January 10, 2019, in conjunction with the following Complaint investigations: AZ00147662, AZ00152817, AZ00151707, AZ00153440 and AZ00152668. The following deficiencies were cited.	F 000	Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the Provider of the truth of the facts alleged of the convictions set forth in the statement of deficiencies. We have implemented the Plan of Correction as stated below and the facility is demonstrating compliance for the deficiencies cited.	
F 552 SS=D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is not met as evidenced by: Based on closed clinical record review, staff interviews and policies and procedures, the facility failed to ensure that one resident (#135) had been informed in advance of the risks and benefits of an antipsychotic medication. Findings include:	F 552		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 3/29/19

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 552	Continued From page 1 Resident #135 was admitted on November 7, 2018, with diagnoses that included Alzheimer's disease, toxic encephalopathy and major depressive disorder. Review of the closed clinical record revealed a form titled Admission Record dated November 7, 2018, which included the resident was self-responsible. A form titled, Consent to Admit and Treat dated November 7, 2018 included a statement that the signer of the form was the responsible party for medical decision making. The form was signed by resident #135. A physician's order dated November 7, 2018 included for the resident to receive Risperdone 0.5 mg (antipsychotic medication) two times daily for dementia. A written care plan initiated on November 10, 2018 for the use of psychotropic medications related to behavioral management included an intervention for staff to educate the resident/family/caregivers about the risks, benefits and side effects and toxic symptoms of the medication. Further review of the clinical record revealed no evidence that the resident was informed of the risks, benefits and side effects of Risperdone. An interview was conducted on January 10, 2019 at 9:17 a.m., with the Director of Nursing (DON/staff #125). The DON stated that when an antipsychotic drug is prescribed, the use of the medication is explained to the resident, and they	F 552	1. Resident had been discharged from the facility on 12/26/18. Going forward a nurse was delegated to be the point person to obtain all the psychotropic consents for all residents. 2. All residents who have orders for anti-psychotropic medications have the potential to be affected by this deficient practice. 3. A complete audit was done to identify if there were any missing consents on 2/27/19. One person will be responsible to obtain all consents. This nurse will review the new orders daily to determine if new orders require consents. * see attached policy for the nurse designee to obtain the consents and the staff delegated to perform this task in her absence. 4. The DON/Designee will review weekly to ensure all consents have been obtained and present to QAPI for 3 months.	3/3/19

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F 552	Continued From page 2 have a form which includes the risks and benefits of the medications. The DON stated that they are to obtain informed consent. The DON said that after the risks and benefits are explained, the resident signs the form. An interview was conducted on January 10, 2019 at 9:35 a.m. with a RN (Registered Nurse/staff #165). During the interview, the nurse stated that there are consent forms for antipsychotic medications. Staff #165 said if the resident is unable to sign the consent form, consent is obtained from the resident's responsible party. Staff #165 stated they are required to obtain informed consent, prior to providing an antipsychotic medication to a resident. An interview was conducted on January 10, 2019 at 10:04 a.m. with medical records staff (#183), who stated that there was no informed consent for the use of Risperdone for resident #135. A policy regarding resident rights included that Federal and State laws guarantee certain basic rights to all residents of the facility. These rights include the resident's right to choose a treatment and participate in decisions and care planning.	F 552		
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical	F 578		

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F 578	Continued From page 3 services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on clinical record reviews, staff interviews and policy review, the facility failed to ensure that two residents (#164 and #121) were afforded the right to formulate advance directives. Findings include:	F 578		

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F 578	Continued From page 4	F 578		

-Resident #164 was admitted to the facility on December 18, 2018, with diagnoses that included sepsis, end stage renal disease and type 2 diabetes mellitus.

Review of an Admission Minimum Data Set (MDS) assessment dated 12/25/18, revealed the resident scored a 9 on the Brief Interview for Mental Status (BIMS), which indicated moderate cognitive impairment.

Review of the resident's clinical record revealed no evidence of any advance directives for resident #164. There was also no documentation that the resident declined formulating advance directives.

Further review of the clinical record revealed there was no code status listed on the resident's face sheet or in the available space specific for code status in the electronic record.

According to the current physician's orders, there was no order for a code status for this resident.

In an interview with a Licensed Practical Nurse (LPN/staff #153) on January 10, 2019 at 9:30 a.m., she stated if she needed to find out a resident's code status, she would look in the electronic record, as there is a place where the code status is easily viewable. Further, she stated the resident's code status is listed on their report sheet. She stated the code status should be updated, as soon as the resident is admitted.

An interview with medical record staff (staff #184) was conducted on January 10, 2019 at 9:34 a.m. At this time, she reviewed resident #164's

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F 578	Continued From page 5 scanned documents and was unable to find any advance directives. She stated it could be in a stack of documents that are waiting to be scanned, however, no advanced directives were located. She also stated it could be in the physician's binder waiting to be signed by the physician, however, no advanced directives were found in the binder. In an interview with the Director of Nursing (DON/staff #125) on January 10, 2019 at 1:31 p.m., she stated an audit had just been done in late December, ensuring that all residents had advanced directive forms filled out. -Resident #121 was admitted to the facility on September 13, 2018, with diagnoses that included chronic osteomyelitis and quadriplegia. Review of the admission MDS assessment dated September 20, 2018, revealed the resident was cognitively intact. A physician's order dated November 20, 2018 indicated the resident was a full code. However, review of the clinical record revealed there were no advance directives which were signed by the resident. Also, the code status was not listed on the resident's face sheet or in the available space specific for code status in the resident's electronic record. An interview was conducted with a LPN (staff #150) on January 8, 2019 at 1:25 PM. The LPN stated that upon admission all consent forms are signed including advance directives. She stated that a resident's code status could be found on the face sheet or in the document section of the	F 578	The following actions have been taken for those residents noted to be affected by this alleged deficient practice: 1. The facility obtained a consent for code status for resident #164 on 1/10/2019. *see attached document. For resident #121 the facility located the signed consent for code status (dated and signed by the resident on 11/20/2018). *see attached document The consents are located in PCC (electronic medical record) under the documents section and the face sheet shows current code status. 2. All residents have the potential to be affected this alleged deficiency. 3. An in-service for nurses was conducted on 2/22/19 that included the instructions on obtaining mandatory consents upon admission including signed code status consents.* see attached in-service sign in sheet with 14 nurses in attendance. The in-service material is attached. The DON has instituted a system whereby all nurse managers will be assigned to review new admissions to determine that there is a signed consent for code status. This will be completed within 24 hours of admission. 4. The DON/Designee will monitor for compliance and be reviewed at monthly QAPI for 3 months	3/3/19

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F 578	Continued From page 6 electronic medical record. Staff #150 was unable to locate any advanced directives which were signed by the resident. An interview was conducted with Medical Records (staff #183) on January 8, 2019 at 1:46 PM. She stated there was no record of advance directives on file for resident #121. She said the advance directives should be filled out upon admission or a few days later. An interview with the DON (staff #125) was conducted on January 10, 2019 at 11:40 AM. She stated the floor nurse is responsible for obtaining signed consents, including advance directives when the resident is admitted to the facility. She said if there is a problem social services should be notified. The DON stated she could not answer for what happened in September, as she was not employed by the facility at that time. The facility policy for Interpretation and Implementation for Advance Directives indicated that upon admission, the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive, if he or she chooses to do so. The policy stated that the information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record. The Director of Nursing or designee will notify the attending physician of advance directives, so that appropriate orders can be documented in the resident's medical record and plan of care.	F 578		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)	F 584		

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F 584	Continued From page 7 §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable	F 584	1. The facility does have a policy for Quality of Life - Homelike Environment that addresses cleanliness and institutional odors. (see attached). The Housekeeping department will begin using a urine odor neutralizer when cleaning all mattresses. The shower drain on the second floor that had an odor is not regularly used. It was determined that because of that, the housekeeping department will flush the drain periodically to prevent odors. It was not a urine odor. 2. All residents could be affected by this alleged deficiency. 3. Staff was in-serviced on 2/8/19 regarding answering call bells, preventing unnecessary odors, patient care rounds to ensure residents are clean and dry. *see attached sign in sheet with 53 staff in attendance. The Housekeeping Supervisor will conduct environmental rounds and report any unusual occurrences of pervasive odors and report to the unit managers and address any housekeeping concerns. 4. The Housekeeping/Laundry Director will report to the management team on a daily basis if there are problems detected from the environmental rounds. The housekeeping weekend supervisor will conduct rounds and address with the supervisor concerns noted from the weekend and report to the Director. The DON/Designee and the Administrator will for compliance and report findings the QA Committee for 3 months.	3/3/19

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F 584	Continued From page 8 sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, and family, resident and staff interviews, the facility failed to maintain an environment that was free of odors. Findings include: During a family interview conducted on January 7, 2019 at 11:07 a.m., the family member of a resident stated that the hallways on the second floor always smell like urine. An interview with a resident who resided on the second floor was conducted on January 7, 2019 at 11:49 a.m. The resident stated that he keeps his door to the bathroom shut, because of the sewage odor. During an interview conducted on January 7, 2019 at 1:28 p.m. with another resident who resided on the second floor, a strong pervasive urine odor was detected in this resident's room and in the bathroom. During the survey from January 7 through 10, 2019, pervasive urine odors were frequently smelled in the hallways on the second floor. An environmental tour was conducted on January 10, 2019 at 12:30 p.m., with the maintenance director (staff #180) and the administrator (as of January 12/staff #222). At this time, there was still a slight sewage odor in the first resident's bathroom on the second floor. An interview was conducted with the maintenance director (staff #180) on January 10, 2019 at 12:40	F 584		

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F 584	Continued From page 9 p.m. Staff #180 stated that he would call a plumber to address the odor in the bathroom. An interview was conducted with staff #222 on January 10, 2019 at 12:45 p.m. Staff #222 stated that she thought she smelled urine yesterday, when the resident was being changed. The facility did not have policy regarding the prevention of odors throughout the facility.	F 584		
F 600 SS=E	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation 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 observation, clinical record reviews, staff and resident interviews, facility documents and policies and procedures, the facility failed to ensure that one resident (#225) with dementia and behaviors was free from neglect, failed to ensure that one resident (#61) was free from abuse by resident (#275), failed to ensure that one resident (#117) was free from abuse by	F 600		

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F 600	Continued From page 10 resident (#61), and that one resident (#21) was free from abuse by resident (#62). Findings include: -Resident #225 was admitted on July 22, 2015 and readmitted on April 16, 2018, with diagnoses that included dementia with behavioral disturbance, mental disorder due to known physiological condition, delusional disorder and altered mental status. Review of the clinical record revealed a written care plan initiated on July 11, 2016, with a revision date of April 16, 2018, which identified that the resident was an elopement risk/wanderer, related to escapist behavior and history of attempts to leave the facility unattended. A goal included the resident would not leave the facility unattended. Interventions included identifying a pattern of wandering and intervening as appropriate, monitoring the resident's location every 30 minutes and documenting wandering behavior. A quarterly MDS (Minimum Data Set) assessment dated January 25, 2018 included a BIMS (Brief Interview for Mental Status) score of 9, which indicated the resident had moderate cognitive impairment. The MDS also included the resident was delusional, had physical and verbal behavioral symptoms directed at others, refused care, wandered daily and had dementia and psychotic disorder. A nurse practitioner assessment dated February 2, 2018, revealed the resident had dementia, wandering, delirium, anxiety, adjustment disorder and depression. The assessment included the	F 600	1. The following actions have been taken for those noted to be affected by this alleged deficient practice: Resident # 225 discharged on 4/5/18 Resident # 275 discharged on 12/19/18 Resident #62 discharged on 2/7/19 The above residents did not return to the facility. Resident #117 was moved to another room on 9/30/18 to be further away from Resident #61. Residents were assigned different dining locations. Resident #117 was moved off the secured unit on 11/29/18 to unit C1, a separate behavioral unit. 2. All residents have the potential to be affected by this alleged deficiency. The Behavioral Health Nursing Director identified other residents to be affected through behavioral tracking. An audit was conducted for the Elopement Risk assessment to determine if there were other residents at risk for elopement and care plans update accordingly. 3. The facility conducted de-escalating techniques training to recognize the first signs of possible altercations on 4/10/18. The in services were repeated on 12/21/18, 3/15/19 and 3/22/19. *see attached in-service sheets. Activities have been increased on the units. *see attached staffing pattern for Activities. The facility hired a LCSW for Behavioral training and to address residents psychological needs. Reviewed staffing patterns to determine the needs of the unit. *see attached staffing	3/3/19

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F 600	Continued From page 11 resident was residing on the behavioral unit "for safety" and received psychiatric services. The assessment also included the resident "desperately tries to escape if given the chance." She speaks Spanish mostly, but understands a lot of English. Under assessment and plan it included the following: wandering-provide a safe and nuturing environment. A nursing note dated March 17, 2018 at 6:34 a.m. included the resident had been exit seeking from the unit through the main locked door to the unit and also by a (locked) back door to the unit. A nursing note dated March 23, 2018 included the following: the resident had been exit seeking and had attempted to leave through the front door, and had struck a staff member when redirected back to the unit. A nursing note dated April 5, 2018 at 10:05 a.m. revealed the resident was discovered missing at 8:15 a.m. The note included the resident was not discovered in her room and that a "code yellow" had been initiated. Continued review of the closed record for resident #225 revealed that the resident did not return to the facility after she eloped. Review of the facility's investigative report dated April 5, 2018 revealed that on the morning of April 5, 2018, the resident had not reported for breakfast and the missing person procedures were immediately implemented. The investigation included the resident was able to leave the facility, obtain transportation, cross the border into Mexico, and after entering Mexico obtained transportation to a family home in Mexico, arriving	F 600	patterns that shows the desired staffing per unit. The facility initiated a Behavioral Health Tracking log to analyze patterns of behaviors. that will enable the facility to identify residents at high risk for behaviors. *see attached copies of a sample of these logs. This will be reviewed weekly with the Behavioral Health Team. The facility QAPI team discussed ways to reduce resident to resident abuse allegations that includes: a. Facility hired an experienced Behavioral Health Program Manager who is a LMSW. This position will oversee and coordinate services for the residents on the Behavioral Unit. She also reviews and makes recommendations for any incidents or behaviors for other residents not residing on the secured unit. b. The facility obtained a contract with a new psychiatric provider group. Their presence on the unit is more frequent and they are available to do increased on-site evaluations with medication recommendations. c. Hall monitors were hired for the A1 secured unit for 16 hours per day. d. Activities were increased to 10 hours per day. e. The facility will continue ongoing staff education regarding de-escalating behaviors, and other potential issues that could result in a resident to resident altercation. f. The IDT is focused on more specific ways to keep residents less agitated. g. The LMSW does counseling and listening sessions h. Behavioral Nurse Manager and LMSW has an office on the unit making them accessible.	

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F 600	Continued From page 12 unharmed. The report also included that the resident had been residing on a behavioral health (secured) unit, and that exit seeking and wandering behaviors were being monitored. Continued review of the investigative report revealed a written staff statement obtained by a CNA (Certified Nursing Assistant/staff #222) dated April 5, 2018 at 2:45 p.m. The statement included that the resident was last seen in the resident dining room on April 4, 2018 between 8:30 p.m. and 9:00 p.m. The report further included that facility policies were not followed, as safety checks were missed. An interview was conducted with the Administrator (staff #20) on January 7, 2019 at 10:15 a.m. The Administrator stated that it had been determined through the facility investigation that resident #225 had obtained an identification badge from a staff member (which the staff member thought had been misplaced) two weeks prior to her elopement from the facility, and had obtained money in small increments over time from her visitors, which enabled her to purchase bus fare. The Administrator also stated that the security camera footage, which had been examined during the investigation showed the resident had used a staff badge to open the exit door and then quickly exited the unit. An interview was conducted on January 8, 2019 at 12:30 p.m. with a CNA (staff #97), who stated that she had been assigned to provide care to resident #225 on April 5, 2018 on the night shift (11:00 p.m. until 7:00 a.m.). She stated that when she arrived at 11:00 p.m., the previous CNA reported to her that all of the residents in her section were in bed, including resident #225 and	F 600	The facility policy for monitoring of cameras in the facility is attached. The facility's policy for observing residents during a C.N.A. shift and residents at risk for elopement is attached. 4. The resident to resident altercations and other behavioral issues will be presented to QAPI for 3 months.	

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that she observed the door to the resident's room was closed. Staff #97 stated that there were other residents in her section who were very ill and she was unable to check on resident #225, because she was busy caring for the residents who were ill. Staff #97 said the facility protocol was to check the residents every 15-30 minutes but not less than hourly, and that she did not check the resident that night. She stated that she assumed her co-worker (CNA/staff #49) who was assigned to another section was checking on all of the residents and assumed that resident #225 was in her room, because the door to her room was closed. She stated that she never actually saw the resident on her shift. She further stated that at approximately 2:00 a.m., she observed staff #49 enter the resident's room as he was passing water, and then exit the resident's room, and assumed that the resident was in her room. The CNA stated she was aware that the resident had a history of elopement attempts. The CNA also stated later that morning after it was discovered the resident was missing, staff #49 told her that although he entered the resident's room to pass ice water during the night shift, he did not see the resident in her room and did not know where she was.

During an interview conducted on January 8, 2019 at 12:35 p.m. with a CNA (staff #49), the CNA stated that he did not remember resident #225 and did not remember anything about a resident eloping from the facility.

An interview was conducted on January 8, 2019 at 1:15 p.m. with a LPN (Licensed Practical Nurse/staff #201). Staff #201 stated that she worked on the secured behavioral unit on the night shift on April 5, 2018. Staff #210 said that

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she did not see the resident on her shift and the door to the resident's room was closed all night. The nurse stated that she was aware that the resident had made frequent statements that she was going to leave the facility and go to Mexico where she owned a home.

The facility was unable to provide a written policy regarding frequent resident safety checks on the behavioral unit.

A policy and procedure titled, Recognizing Signs and Symptoms of Abuse/Neglect included the definition of neglect, as the failure to provide goods and services as necessary to avoid physical harm, mental anguish, or mental illness. The policy also listed signs of actual physical neglect that included inadequate provision of care and leaving someone unattended who needs supervision.

Review of the Reporting Abuse policy revealed that all suspected violations or substantiated incidents of abuse/neglect will be immediately reported to the State licensing/certification agency.

-Resident #61 was admitted to the facility on February 20, 2014, with diagnoses that included unspecified psychosis not due to a substance or known physiological condition, Parkinson's disease, and schizoaffective disorder.

Review of a Nursing Note dated February 4, 2018 revealed "...Resident has had a few outbursts when there is an excessive amount of noise. Resident had three episodes of yelling out (using profanity) and two episodes of attempting to go down to the room of the resident who was yelling

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F 600	Continued From page 15 out to shut him up. Staff was there to redirect resident immediately. A Nursing Note dated May 3, 2018 revealed "Resident had several verbal outbursts during shift. Resident primarily has these outbursts when other residents are having an increase in behaviors by making loud noises and yelling..." A Nursing Note dated May 21, 2018 revealed "Resident has episodes of yelling out when he is startled with other loud noises like other residents yelling or doors slamming..." A quarterly MDS assessment dated August 6, 2018, revealed the resident had short-term and long-term memory problems and was severely impaired with daily decision making. The MDS also included the resident required extensive assistance with one staff assistance with activities of daily living. A Behavior care plan dated August 20, 2018 revealed resident #61 has behavior problems (agitation, poor safety awareness, verbal aggression, repetitive statements, disruptive/intrusive, wandering, mood issues, pacing, exit seeking, refusal of care, disorganized thinking and physical aggression), related to psychosis, anxiety, mood disorder and status post traumatic brain injury as evidenced by physical aggression towards others. The goal included the resident will have fewer episodes of behaviors. Interventions were to administer medications as ordered; assist the resident to develop more appropriate methods of coping and interacting with other dementia residents; encourage the resident to express feelings appropriately and if reasonable, discuss the	F 600		

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F 600	Continued From page 16 resident's behavior; explain/reinforce why behavior is inappropriate and/or unacceptable; intervene as necessary to protect the rights and safety of others; approach/speak in a calm manner; divert attention; remove from situation and take to alternate location as needed; monitor behavior episodes and attempt to determine underlying cause; and when resident is sitting next to other peers, ensure appropriate space to prevent physical aggression towards peers. Review of a Nursing Note dated September 30, 2018 revealed "...Resident began having a verbal altercation with another resident and he went up to the other resident and struck her in the face on the right cheek. The other resident retaliated and struck this resident on both arms. Both residents were immediately separated. No visible injuries noted to this resident..." Review of the annual MDS assessment dated November 1, 2018 revealed resident #61 had a BIMS (Brief Interview for Mental Status) score of 9, which indicated moderate impaired cognition. A Nursing Note dated November 16, 2018 revealed a CNA reported to this writer that resident #61 and resident #275 were swinging their arms with closed fists. Both residents were separated. Resident #61 stated that resident #275 hit him in the face. Reddened area noted to resident face. -Resident #275 was admitted to the facility on June 27, 2017, with diagnoses that included unspecified dementia with behavioral disturbance, schizophrenia, major depressive disorder and anxiety disorder.	F 600		

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F 600	Continued From page 17 Review of a Nursing Note dated May 17, 2018 revealed called into room by staff at 5:55 p.m., observed resident #275 laying in bed, and another resident was sitting on floor mat with blood on his face. The other resident was unable to explain what happened due to cognitive deficit. Resident #275 stated the resident woke him up and was messing with his bed and he "hit peer in the face..." A Nursing Note dated July 11, 2018 revealed that resident #275 "started hitting a resident from another room with a wire waste basket in the hallway. Resident #275 was upset that another resident was wearing his hoodie. Resident #275 has shown that he is very territorial and aggressive with male residents that might wander into his room, let's not forget that this is a unit where many of the residents suffer from dementia..." A Behavior care plan dated August 20, 2018 revealed that resident #275 has a history of initiating physical aggression. The goal was resident will not initiate aggression towards other residents. Resident should have a quiet area to stay in after dinner. He is sensitive to noise and busyness. Interventions to prevent the behaviors were to anticipate and prevent new incidents of violence towards another resident; provide snack, provide activities that promote non-aggressive interactions with other residents like one to one social activity; and provide activity so resident is not focused on busyness after meal times, as it is becoming evident he is not able to tolerate noise. Review of the quarterly MDS assessment dated November 6, 2018, revealed a BIMS score of 1, which indicated the resident had severe cognitive	F 600		

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impairment.

A Nursing Note dated November 16, 2018 revealed this writer was notified by a CNA that resident #275 and resident #61 were swinging their arms with closed fists. Residents were quickly separated by CNA. Reddened area noted on resident #61's face.

Further review of resident#275's clinical record revealed he had two more altercations with other residents on December 14 and 19, 2018 in which he was the aggressor. Resident #275 was discharged from the facility on December 19, 2018.

An interview was conducted with a CNA who stated that the facility usually staffed three CNA's on this unit for 20-24 high acuity behavioral residents. The CNA stated that one CNA is supposed to monitor the hallway at all times to ensure that resident to resident altercations do not occur, but that doesn't always happen when staff call in.

An interview was conducted with another CNA who stated that we are supposed to have someone monitor the hallway at all times, but that does not always happen. The CNA stated we do the best we can but if there is a call in we often do not have someone to monitor the hallway and that's when the residents get in to it. The CNA stated that resident #275 got into a lot of incidents with other residents and would laugh afterwards. The CNA stated that resident #61 does not like loud noises and doors slamming and that was usually when he got into altercations with other residents, because it upset him. The CNA stated that when resident #61 got upset he clapped his

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F 600	Continued From page 19 hands and said "shhh" and that irritated a lot of residents. The CNA further stated that a lot of the resident to resident altercations usually occurred when the facility did not have someone to monitor the hallway. An interview was conducted with a LPN who stated that resident #61 runs up and down the hall and resident #275 is paranoid. The LPN stated that staffing was recently cut on this high acuity behavioral unit and that they do the best they can. An interview was conducted with the administrator (staff #20) on January 10, 2019 at 9:25 a.m. Staff #20 stated that there should be a monitor on the hallway at all times on that unit. -Resident #117 was admitted to the facility on January 27, 2017, with diagnoses that included schizophrenia, anxiety disorder and dementia with behavioral disturbance. A care plan revised on June 28, 2018, included the resident required a secured unit due to diagnoses of schizophrenia and dementia, behaviors of being non-compliant with care and attempts to provoke peers. Interventions included redirecting the resident when having behaviors. A quarterly MDS assessment dated September 17, 2018 revealed the resident had short-term and long-term memory problems and was moderately impaired with daily decision making. The assessment also included the resident required supervision with set up help only for most activities of daily living and utilized a walker. Review of the clinical record revealed multiple	F 600		

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nursing notes for September 2018 describing the resident as being verbally aggressive toward staff and laughing loudly at other residents.

A nursing note dated September 30, 2018 revealed that at approximately 9:53 a.m., resident #117 began having a verbal altercation with another resident (#61), and the other resident struck resident #117 in the face on the right cheek. Resident #117 then struck resident #61 back, hitting him on the arms. Both residents were immediately separated. No visible injuries noted. Both residents will not be in the same dining hall as each other.

Review of the facility's investigative documentation dated September 30, 2018, revealed that resident #117 was in the hallway by her room, which was across the hall from resident #61's room. Resident #117 began cursing in the hallway, as she has a history of this behavior. Resident #61 was sitting in his wheelchair in the doorway to his room and got up and confronted resident #117 in the hallway outside their rooms. They began yelling back and forth and before staff could intervene, resident #61 hit resident #117 and then resident #117 hit resident #61. The residents were separated and resident #117 was moved to another room. No injuries were noted. When resident #117 was asked about the incident, she stated "He hit me!" Per the report, a housekeeping staff (#135) witnessed the incident. She reported that resident #117 was cursing at her and resident #61 told resident #117 to be quiet. Resident #117 kept cursing, and then resident #61 got up, went to resident #117 and they both made contact with each other. A statement from a licensed practical nurse (LPN/staff #166) included that she did not witness

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F 600	Continued From page 21 the incident but was at the nurses' station and heard resident #117 yelling that resident #61 hit her. She immediately went to the hallway and found resident #61 standing in front of resident #117 with his fists up. The residents were separated immediately. In an interview with staff #135 on January 9, 2019 at 9:32 a.m., she stated she had worked at the facility for over three years and is usually on the secured behavioral unit. She said that resident #117 is constantly being verbally aggressive and intimidates a lot of people. In an interview with a LPN (staff #148) on January 9, 2019 at 9:41 a.m., she stated that resident #61 usually hangs out in the hallway and is not one to instigate things. Staff #148 said he has a behavior of yelling out, which sometimes sets other residents off inadvertently, and he is easily triggered by noises. She stated when resident #117 used to be on her hall, her loud laughing and yelling would irritate resident #61. She stated staff tried to redirect resident #117 by asking her to stop or taking her to an activity or to a different area. In an interview with a LPN (staff #156) on January 9, 2019 at 9:49 a.m., he stated resident #117's behaviors include laughing out loud at random and yelling at others. He stated the other residents sometimes get agitated and they think resident #117 may be doing it on purpose. He stated sometimes she yells racial slurs and the other residents tell her to shut up. Additionally, he stated resident #117 is easily redirectable, but that does not work all the time. The LPN stated she is followed by the behavioral health team but for the most part, her behavior does not change.	F 600		

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An observation was conducted on January 9, 2018 at 10:35 a.m., during a resident smoke break. Resident #117 was observed to be laughing loudly and sticking her tongue out, which appeared to be directed at no one in particular. The staff present redirected the resident who then sat back down and continued to smoke her cigarette without further incident.

In an interview with the administrator (staff #20) on January 10, 2019 at 1:17 p.m., he stated when he receives an allegation of a resident to resident altercation, he will get more information about what happened, report to appropriate parties and begin an investigation.

-Resident #21 was admitted to the facility on January 18, 2018, with diagnoses that included schizophrenia, depression and Parkinson's disease.

A quarterly Minimum Data Set (MDS) assessment dated 10/08/2018 included the resident had a BIMS score of 15, indicating no cognitive impairment. The MDS assessment also included the resident had verbal behavioral symptoms directed toward others.

Review of the care plan regarding antipsychotic medication related to schizophrenia included the following interventions: when the resident becomes agitated intervene before agitation escalates; guide the resident away from the source of distress; engage calmly in conversation; and if the response is aggressive remove other residents from the area and approach later.

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F 600	Continued From page 23 A nursing note dated 11/29/2018 revealed that at approximately 10:50 a.m., resident #21 was witnessed sitting towards the end of the hall in front of another resident's (#62) room. Resident #21 began to yell and curse in Spanish. Resident #62 approached the doorway and told resident #21 to "move." Both residents were yelling and swinging their arms at each other. The residents were immediately separated and redirected into opposite directions. No injuries noted at this time. -Resident #62 was admitted on November 06, 2015, with diagnoses that included schizophrenia, dementia and depression. A quarterly MDS assessment dated 11/01/2018 included a BIMS score of 15, which indicated the resident had no cognitive impairment. The MDS assessment also included the resident had verbal behavioral symptoms directed toward others. Review of the current behavior care plan revealed the resident had the potential to be physically aggressive and threatening toward other residents and staff. Interventions included for staff to escort the resident from room to destination and from destination to room, and keep him a safe distance from other residents. A nurse's note dated 11/29/2018 included that at approximately 10:50 a.m., resident #62 was witnessed standing in front of resident #21. Resident #21 was sitting in front of his doorway in a wheelchair and resident #62 told him to move. Resident #21 started to yell and curse at him in Spanish. Resident #62 then raised his left hand and with a closed fist, hit resident #21. Both residents were swinging their arms at each other. They were immediately separated and redirected	F 600		

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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 600	Continued From page 24 into opposite directions. No Injuries were noted. Review of the facility's investigative report revealed that on November 29, 2018 at 10:50 a.m., resident #21 was sitting in his wheelchair in front of the door to resident #62's room. Resident #62 asked resident #21 to move, and angry words were exchanged. The residents struck out at each other and no injuries were noted. The report also included a witness statement from the housekeeper (staff #135) that she heard the residents arguing in front of resident #62's door who was telling resident #21 to move. The statement included that resident #21 hit resident #62 in the face and that both residents were hitting each other. The report revealed that resident #21 was unable to recall the incident and resident #62 reported that "He kept cussing at me and I told him to stop. I told him if he didn't stop I would hit him, and he didn't stop, so I hit him." During an interview conducted with resident #62 on 1/8/19 at 2:29 p.m., the resident stated that resident #21 was sitting in front of his door and that he asked him to leave. Resident #62 stated that the resident called his mother names in Spanish and that he hit him. During an interview conducted with resident #21 on 1/8/2019 at 2:43 p.m., the resident stated that resident #62 yelled at him and he yelled back. Resident #21 stated that resident #62 hit him and that he hit him back and that they punched each other until they were separated. An interview was conducted with a LPN (staff #148) on 1/09/19 at 10:01 a.m. The LPN stated that she heard yelling and saw the housekeeper separating resident #21 and resident #62. She	F 600		

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F 600	Continued From page 25 stated that she helped separate the residents and then assessed them for injuries. The LPN stated that both residents do occasionally yell and "blow off steam," but that resident #62 is often more verbal and physically threatening. Review of the facility's policy regarding Abuse Prevention Program revealed "Our residents have the right to be free from abuse, neglect..." Our facility is committed to protecting our residents from abuse by anyone including, but not necessarily limited to "staff and other residents..." The facility's policy regarding Unmanageable Residents revealed that each resident will be provided with a safe place of residence. The policy included that should a resident's behavior become abusive in any way that would jeopardize his or her safety or the safety of others, the Nurse Supervisor/Charge Nurse must immediately provide for the safety of all concerned. The policy also included unmanageable residents may not be retained by the facility. Review of a facility policy titled, "Resident-to-Resident Altercations" included that staff will monitor residents for aggressive/inappropriate behavior towards other residents. The policy included that all altercations, including those that may represent resident-to-resident abuse, shall be investigated and reported to the Administrator/Director of Nursing.	F 600		
F 607 SS=E	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that:	F 607		

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F 607	Continued From page 26 §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, facility documents and policy review, the facility failed to include in their Abuse policy that all alleged violations of abuse and neglect, must be reported to the State Survey Agency within two hours after the allegation is made, as manifested by an allegation of neglect for one resident (#225). Findings include: Resident #225 was admitted on July 22, 2015, with diagnoses that included dementia with behavioral disturbance, mental disorder due to known physiological condition, delusional disorder and altered mental status. A nursing note dated April 5, 2018 at 10:05 a.m. revealed the resident was discovered missing at 8:15 a.m. The note included the resident was not discovered in her room and that a "code yellow" had been initiated. Review of the facility's investigative report dated April 5, 2018 revealed that on the morning of April 5, 2018, it was determined that the resident had not reported for breakfast, so missing person	F 607	What corrective action will be accomplished for those residents found to have been affected by the alleged deficiency. 1. The facility Policy and Procedure for Abuse reporting has been updated to reflect the required reporting will be done within the two hour time frame. *see attached policy that indicates the required 2 hour reporting time for abuse/neglect allegations. 2. All residents could be affected by this alleged deficiency. 3. The new administrator hired as of 1/11/19 will ensure all required reporting of abuse and neglect will be done within 2 hours by submitting the report on line to the Arizona Department of Health Services. Staff will be re-inserviced on this policy on 3/29/19 4. The Administrator will review all required incidents that should be reported at the QAA Committee on a monthly basis. This will be ongoing.	3/3/19

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F 607	Continued From page 27 procedures were immediately implemented. The report included the resident "was able to leave the facility" obtain transportation, cross the border into Mexico, and after entering Mexico obtained transportation to a family home, arriving unharmed. Continued review of the investigative report revealed that although the resident was discovered missing on April 5, 2018 at 8:30 a.m., the facility did not notify the State Survey Agency until 3:30 p.m. on April 5. An interview was conducted with the Administrator (staff #20) on January 8, 2019 at 2:46 p.m. The Administrator stated that the facility had two hours to report all allegations of abuse, including neglect to the State Agency. The Administrator also stated that he was unable to explain why the elopement of resident #225 was reported late to the State Agency. Review of the facility's policy and procedure titled, Reporting Abuse to State Agencies and other Entities/Individuals revealed that all suspected violations and all substantiated incidents of abuse will be immediately reported to appropriate state agencies and other entities as may be required by law. The policy included that should a suspected violation or substantiated incident of mistreatment, neglect or abuse be reported, the facility Administrator or his/her designee, will promptly notify the State licensing/certification agency. The verbal/written notice to agencies will be made within twenty-four hours of the occurrence (not two hours as required).	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4)	F 609		

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F 609	Continued From page 28 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, facility documents and policies and procedures, the facility failed to ensure that an allegation of neglect for one resident (#225) was reported to the State Survey Agency within two hours after the allegation. Findings include:	F 609	1. The facility hired a new administrator as of 1/11/19. The Administrator will process required reports with in the two hour time frame by submitting the report through the AZDHS portal. Policy will updated on 3/4/19 to reflect the correct reporting time 2. All residents have the potential to be affected by this alleged deficiency. 3. New Administrator hired effective 01/11/2019. The administrator will report all allegations of abuse or neglect in accordance with state and federal regulations to required agencies. The online portal with the Arizona Department of Health Services will be utilized for the day one report. *see attached policy* 4. All incidents that are required to be reported to state and local agencies will be reviewed at the monthly QAPI meeting for three months.	3/3/19

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Resident #225 was admitted on July 22, 2015, with diagnoses that included dementia with behavioral disturbance, mental disorder due to known physiological condition, delusional disorder and altered mental status.

A nursing note dated April 5, 2018 at 10:05 a.m. revealed the resident was discovered missing at 8:15 a.m. The note included the resident was not discovered in her room and that a "code yellow" had been initiated.

Review of the facility's investigative report dated April 5, 2018 revealed that on the morning of April 5, 2018, it was determined that the resident had not reported for breakfast, so missing person procedures were immediately implemented. The report included the resident "was able to leave the facility" obtain transportation, cross the border into Mexico, and after entering Mexico obtained transportation to a family home, arriving unharmed. The report also included that the resident had been residing on a behavioral health (secured) unit, and that exit seeking and wandering behaviors were being monitored.

Continued review of the facility investigative report revealed that although the resident was discovered missing on April 5, 2018 at 8:30 a.m., the facility did not notify the State Survey Agency until 3:30 p.m. on April 5.

An interview was conducted with the Administrator (staff #20) on January 8, 2019 at 2:46 p.m. The Administrator stated that the facility had two hours to report all allegations of abuse, including neglect to the State Agency. The Administrator also stated that he was unable to

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F 609	Continued From page 30 explain why the elopement of resident #225 was reported late to the State Agency. A facility's policy and procedure titled Recognizing Signs and Symptoms of Abuse/Neglect included a definition of neglect as the failure to provide goods and services as necessary to avoid physical harm, mental anguish, or mental illness. The policy also listed signs of actual physical neglect that included inadequate provision of care and leaving someone unattended who needs supervision. Review of the facility's policy and procedure titled, Reporting Abuse to State Agencies and other Entities/Individuals revealed that all suspected violations and all substantiated incidents of abuse will be immediately reported to appropriate state agencies and other entities as may be required by law. The policy included that should a suspected violation or substantiated incident of mistreatment, neglect or abuse be reported, the facility Administrator or his/her designee, will promptly notify the State licensing/certification agency. The verbal/written notice to agencies will be made within twenty-four hours of the occurrence (not two hours as required).	F 609		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a	F 623		

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F 623	Continued From page 31 representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is	F 623	What corrective action will be accomplished for those residents found to be affective by the deficient practice. 1 On 1/10/19, an updated discharged list was sent to the local Ombudsman for the month of December. *See attached December discharge list that was sent to the Ombudsman. 2. All residents discharged from the facility have the potential to be affected by this alleged deficiency. 3. The Business Office Manager will send a Monthly Admissions/Discharge report to the local Ombudsman by the 5th business day of the month via email. *See attached verification email that the discharges for January and February were sent to the Ombudsman. 4. The Business Office Manager will report the QAA Committee monthly for three months. The Administrator will monitor for compliance	3/3/19

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F 623	Continued From page 32 transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide	F 623		

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F 623	Continued From page 33	F 623		

written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
Based on clinical record reviews, staff interviews and review of policies and procedures, the facility failed to notify the State Long Term Care Ombudsman when one resident (#50) was transferred/discharged to the hospital on two separate occasions, and when one resident (#175) was discharged to home.

Findings include:

-Resident #50 was readmitted to the facility on October 26, 2018, with diagnoses that included acute respiratory failure with hypoxia, adult failure to thrive and a pressure ulcer in sacral region.

A progress note dated July 26, 2018 revealed the resident was sent to the emergency room, due to difficulty breathing. A progress note dated July 29, 2018 revealed the resident was readmitted to the facility.

Review of a quarterly MDS (Minimum Data Set) assessment dated October 31, 2018, revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact.

A progress note dated October 23, 2018 revealed that the resident was admitted to Banner South Hospital Intensive Care Unit. Another progress

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note dated October 26, 2018 revealed that the resident was readmitted to the facility.

However, there was no documentation that the State Long Term Care Ombudsman was sent a copy of the notice of discharges for each hospitalization.

An interview was conducted with a licensed practical nurse (LPN/staff #150) on January 8, 2019 at 1:08 p.m., who stated that when she gets a patient ready to be transferred, she does not notify the Ombudsman and said the case manager (#190) completes the paperwork when a patient is being discharged.

An interview was conducted on January 8, 2019 at 1:19 p.m. with case manager (staff #190), who stated that she completes the paperwork when a resident is being discharged and staff #193 notifies the Ombudsman about the discharge.

Staff #193 was interviewed on January 8, 2019 at 2:42 p.m. He stated that the facility had a meeting last fall to talk about a better way to make sure the Ombudsman is notified. He said that he called the Ombudsman and asked if he could notify her by email, when a resident is discharged. He said that she told him that she doesn't want to be notified, because they don't need the information and they are being inundated with notifications. He said that Social Services was handling the notifications at that time.

An interview was conducted on January 8, 2019 at 3:06 p.m. with the Director of Social Services (staff #204), who stated that there was a meeting with the Ombudsman on August 6, 2018,

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because she wanted to verify the process for notifying the Ombudsman when a resident is discharged. She said the Ombudsman didn't want to be notified when a resident is discharged. She acknowledged that the facility has not been notifying the Ombudsman when a resident is discharged and stated that she will be notifying the Ombudsman in writing on a monthly basis from this point forward.

-Resident #175 was admitted to the facility on October 1, 2018, with a diagnosis of shortness of breath.

Review of the discharge care plan initiated on October 4, 2018 revealed resident #175 was to discharge to her previous residence an assisted living facility, after skilled nursing services were completed.

A physician's order dated October 9, 2018 indicated the resident may be discharged on October 13, 2018, with physical therapy home health.

A review of the Minimum Data Set (MDS) assessment discharge/return not anticipated dated October 13, 2018, revealed the resident was discharged to the community.

Review of the clinical record revealed there was no documentation that the State long term care ombudsman had been sent a copy of the notice of discharge.

An interview was conducted with the Director of Social Services (staff #204) on January 9, 2019 at 9:21 AM. She stated the facility has not been notifying the ombudsman when a resident is

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F 623	Continued From page 36 discharged. She stated that she is aware that the facility is responsible for notifications, but the ombudsman did not want to be notified of discharges. An interview with the Director of Nursing (DON/staff #125) was conducted on January 10, 2019 at 11:04 AM. The DON stated that she had been told the ombudsman did not want to be notified of discharges, but that the facility must notify her anyway. She stated the facility will be sending a list of discharges to the ombudsman at the end of every month. Review of a facility policy regarding Transfer or Discharge Notice revealed the resident an/or representative will be notified of an impending transfer or discharge from the facility as soon as it is practicable but before the transfer or discharge, when the transfer is necessary for the resident's welfare and the resident's needs cannot be met in the facility or when an immediate transfer or discharge is required by the resident's urgent medical needs. The policy also stated that a copy of the discharge notice will be sent to the Office of the State Long-Term Care Ombudsman.	F 623		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews, and the Resident Assessment Instrument (RAI) manual, the facility failed to ensure a Minimum	F 641		

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F 641	Continued From page 37 Data Set (MDS) assessment was accurate regarding antibiotic use and refusal of care for one resident (#62). Findings include: Resident #62 was admitted on November 06, 2015, with diagnoses that included schizophrenia, hypertension, dementia, and depression. Review of the physician's orders revealed the following: -Bactrim 400-80 milligrams (mg) by mouth once a day by mouth for prophylaxis for chronic UTI dated October 16, 2018 -Ipratropium Bromide HFA aerosol solution 17 micrograms (mcg) one puff orally every 6 hours for COPD (chronic obstructive pulmonary disease) dated August 24, 2018 -Metoprolol 25 mg by mouth once a day for hypertension dated August 25, 2018 -Levothyroxine 75 mcg by mouth once a day for hypothyroidism dated August 25, 2018. A review of the MAR for October 2018 revealed that the resident was administered Bactrim from October 16-31. The MAR also revealed the resident refused Ipratropium Bromide from October 27- 31 multiple times, refused Metoprolol on October 27, 28, and 29, and refused Levothyroxine on October 27 and 30. However, review of the quarterly MDS assessment dated November 1, 2018, revealed the resident did not receive an antibiotic and displayed no refusal of care during the 7 day look-back period. The MDS assessment also included a Brief Interview for Mental Status score	F 641	What corrective action will be accomplished for those residents found to be affected by this deficient practice: 1. Resident #62 medical records and MDS were reassessed. A modification was submitted to CMS with correct information by 2/24/19. 2. An audit of 25% of all residents on antibiotics will have their MDS reevaluated for accuracy and coding. 3. The MDS Director in-serviced the Coordinator on accurately completing the MDS on 2/25/19. The MDS Director will audit a random sample of MDS for antibiotics on a monthly basis for three months. The MDS Director will monitor for compliance and report to QA for three months.	3/3/19

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F 641	Continued From page 38 of 15 which indicated the resident had no cognitive impairment and that the resident displayed verbal behaviors directed towards others. An interview was conducted with a MDS Coordinator (staff #182) on 01/09/19 at 11:31 AM. Staff #182 stated that information obtained from the nurses' notes and the medication records are used to code a MDS assessment. She also stated that information is obtained from speaking with the residents and the staff. She acknowledged that the quarterly MDS assessment dated November 1, 2018 was an error in documentation regarding refusal of care. During an interview conducted with the Director of Nursing (DON/staff #125) on 01/09/19 at 11:44 AM., the DON stated that her expectation is that the MDS assessments are accurate, and that incorrect information on the MDS assessment is not acceptable. An interview was conducted with a MDS Coordinator (staff #181) on 01/10/19 at 01:18 PM. She stated that her hand written notes for November included the resident was on antibiotics through the end of October 2018. She agreed that the MDS assessment was marked incorrectly and stated that it was an oversight. The RAI manual for the MDS assessment states that the importance of accurately completing and submitting the MDS assessment cannot be over emphasized. The manual also included that the MDS assessment is the basis for the development of an individualized care plan. The RAI manual instructs to review the clinical record for documentation regarding any antibiotics that	F 641		

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F 641	Continued From page 39 were received by the resident during the 7 day look-back period and record the number of days it was received. The RAI manual also instructs to review the clinical record and interview staff for any refusal of care (e.g. taking medications) during the 7 day look-back period and code the behavior if it occurred.	F 641		
F 645 SS=E	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of	F 645		

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F 645	Continued From page 40 services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews,	F 645		

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F 645	Continued From page 41 and review of facility policies and procedures, the facility failed to ensure one resident (#61) was referred to the appropriate state-designated authority for Level II PASARR (pre-admission screening and resident review) evaluation and determination. Findings include: Resident #61 was admitted to the facility on February 20, 2014 with diagnoses that included unspecified psychosis not due to a substance or known physiological condition, Parkinson's disease, and schizoaffective disorder. Review of the resident's clinical record revealed a Level I PASARR dated June 4, 2015 which revealed the resident had a primary diagnosis of a serious mental illness (SMI) and required a referral for a Level II determination for mental illness. Further review of the clinical record revealed no evidence that the facility referred the resident to the appropriate state-designated authority for a Level II PASARR. An interview was conducted with a social worker (staff #203) on January 9, 2019 at 9:00 a.m. Staff #203 stated that if a resident had a primary diagnoses of a SMI that a referral for a Level II PASARR should be done. Staff #203 stated that she was unsure if a referral for a Level II PASARR was completed for this resident. An interview was conducted with another social worker (staff #204) on January 9, 2019 at 10:26 a.m. Staff #204 stated that the facility did an audit about a month ago and the resident qualified for a	F 645	1. For Resident #61 a Level II screening was obtained on 1/10/19, see attached copy of the PASARR 2. All residents who need a Level II screening could be affected by this alleged deficiency. 3. The facility conducted an in-service on 2/4/19 regarding the process for Level II PASAAR for all Social Services staff. This in-service will repeat on 2/28/19 and include the nurse managers, Admission Department,Medical Records and the MDS Director. The Social Services Director will review all new admissions to determine if a Level II screening is needed. The Behavioral Health Program Director will review the PASAAR during the admission process to ensure the appropriate Level II referral. 4. A tracking log was developed to ensure that if a Level II is needed it has been submitted. *See attached log for Level II tracking. This will monitored by the Behavioral Health Program Director and the Administrator. Results submitted monthly to the QAA Committee.	3/3/19

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F 645	Continued From page 42 referral for a Level II PASARR. Staff #204 stated that the referral was not completed yet. Review of the facility's policy Admission Criteria revealed "...Nursing and medical needs of individuals with mental disorders or intellectual disabilities will be determined by coordination with the Medicaid Pre-Admission Screening and Resident Review program (PASARR) to the extent possible..."	F 645		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the	F 657		

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F 657	Continued From page 43 comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, and policy and procedure, the facility failed to ensure a care plan was revised for one resident (#74). Findings include: Resident #74 was admitted to the facility on December 7, 2017 with diagnoses that included multiple sclerosis and quadriplegia. A physician's order dated July 23, 2018, revealed the order to apply splints to both arms at night at bedtime and take off in the morning to prevent contractures was discontinued. The quarterly Minimum Data Set (MDS) assessment dated November 8, 2018 revealed the resident was cognitively intact and required extensive/total assist with activities of daily living (ADLS). Review of the care plan for mobility dated November 24, 2018 revealed the resident had limited physical mobility related to current co-morbidities including multiple sclerosis (MS). Interventions included applying splints to both arms at night and removing in the morning. Further review of the care plan revealed it was not revised to reflect the splints had been discontinued. An interview was conducted with the Assistant Director of Nursing (ADON/staff #21) on January	F 657	1.	

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F 657	Continued From page 44 9, 2019 at 3:46 PM. Staff #21 stated the resident's splints had been discontinued. She stated that she did not know why the care plan had not been updated. The ADON stated all departments are responsible for updating the care plan, including nursing. She said the nursing management meets every morning to discuss residents' care plans, change of condition, etc. An interview was conducted with the Director of Nursing (DON/staff #125) on January 10, 2019 at 9:29 AM. The DON stated anything in the care plan related to nursing is updated daily. She said they have an interdisciplinary team (IDT) meeting every morning. She stated they are good at adding to the care plan but need to get better at discontinuing things. The DON said the splints should have been resolved in the care plan. Review of the facility's policy titled "Care Plans - Comprehensive" revealed assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change.	F 657	1. The Care Plan for Resident #74 has been updated to reflect the discontinuance of the splints on 2/24/19. The resident care plan is scheduled for review on 2/28/19. *Please see attached update care plan. 2. Residents with adaptive equipment have the potential to be affected by this practice. 3. The IDT team will review new orders from the previous 24 hours and on Monday from the weekends and update care plans when change of condition occur. Education will be provided to the IDT on 2/25/2019 to ensure understanding and compliance. 4. The DON/Designee will monitor for compliance and report to the QAA Committee for three months.	3/3/19
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and	F 689		

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F 689	Continued From page 45 review of policies and procedures, the facility failed to ensure that a public restroom accessible to residents was free from accident hazards. Findings include: During an observation conducted on January 7, 2019 at 10:30 a.m., two unlocked restrooms were observed near the front entrance of the facility. When the door to restroom #1 was opened and released, the door rapidly slammed shut causing a potential accident hazard to residents who may use the restroom. Multiple residents passed by this area to go to the front lobby and to go outside of the facility. An interview was conducted with a receptionist (staff #191) on January 8, 2019 at 9:25 a.m. Staff #191 stated that they asked the residents not to use the public restrooms but that some of them go in there anyway. Staff #191 stated that the residents probably use the public restrooms at night when no one is at the receptionist desk. Staff #191 further stated the public bathroom doors used to be locked. Additional observations conducted on January 8, 9, and 10, 2019 revealed the area near the public restrooms and front lobby continued to be a high traffic area with residents going to the front lobby or out of the facility. An interview was conducted with another receptionist (staff #194) on January 10, 2019 at 11:00 a.m. Staff #194 stated that the residents were asked to not use the public restrooms. Staff #194 further stated the doors used to be locked. An interview was conducted with the managing	F 689	1. On January 10, 2019 the door closure for Restroom #1 was repaired to prevent the door from slamming shut. The locks to both restrooms were changed to require a key from the receptionist in order to enter the restroom. This was effective 1/10/2019. 2. All residents who enter the lobby area and request a restroom could be affected. 3. The Maintenance Director will ensure the doors to the restroom are in working, safe condition. The receptionist will report any concerns to the Maintenance Director. 4. The Maintenance Director will include door operations as part of his preventive maintenance program. The Administrator shall monitor for compliance and report to QAPI for three months.	3/3/19

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F 689	Continued From page 46 partner of the facility (staff #220) on January 10, 2019 at 12:35 p.m. Staff #220 stated that the facility will be repairing the door today so that it does not slam shut. Review of the facility's policy Safety and Supervision of Residents revealed "Our facility strives to make the environment as free from accident hazards as possible". The policy included resident safety and supervision and assistance to prevent accidents are facility-wide priorities.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews and policy and procedures, the facility failed to ensure one resident (#50) was provided respiratory care consistent with the physician's order. Findings include: Resident #50 was readmitted to the facility on October 26, 2018, with diagnoses that included acute respiratory failure with hypoxia, adult failure to thrive and paraplegia.	F 695	1. The Policy and Procedure for Oxygen Administration was updated on 2/26/19 to include weekly tube change and date. *See attached updated policy and procedure. 2. Residents who receive oxygen could be affected by this alleged deficiency. The facility will audit all residents with oxygen orders to ensure that the orders reflect the policy change with the correct oxygen order and tubing change order. 3. Admission orders will be updated to include tube change and date. Nurse management audit of all new admissions will include reviewing all residents with oxygen orders to ensure accuracy. Attached is the audit of the oxygen tubing for February and as of March 21st. 4. The DON/Designee will monitor for compliance and report to QAA for three months.	3/3/19

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F 695	Continued From page 47 Review of the current summary of physician's orders revealed an order for oxygen continuously at 2 liters per minute via nasal cannula dated October 26, 2018 and an order to change the oxygen tubing every Wednesday on the night shift dated January 10, 2019. Review of the quarterly MDS (Minimum Data Set) assessment dated October 31, 2018 revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. The assessment also included the resident was receiving oxygen therapy. The current care plan revealed the resident had altered respiratory status related to respiratory failure with hypoxia. The interventions included administering medication/puffers as ordered and monitoring for effectiveness and side effects and monitoring/documenting/reporting abnormal breathing patterns to the physician. During an interview conducted with the resident on January 7, 2019 at 3:23 p.m., the oxygen concentrator was observed to be set at 2.5 liters, however, the resident did not have on the nasal cannula, as it was lying on the resident's tray. Observation of the tubing revealed no date when the tubing had been changed. On January 9, 2019 at 12:28 p.m., the resident was observed sleeping in his wheelchair with the oxygen tubing on and the concentrator was set at 2.5 liters. The tubing was not observed to have a date to reflect when the tubing had been last changed. An interview was conducted with a certified	F 695		

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F 695	Continued From page 48	F 695		

nursing assistant (CNA/staff #58) on January 10, 2019 at 9:14 a.m., who stated that the CNA's on the overnight shift change the tubing on the oxygen concentrators every Sunday, and tape the date on the tubing to show when the tubing was changed. She stated that if there is no date on the tubing or if the date indicates that it is overdue, she changes the tubing. After observing the oxygen tubing, she confirmed that there was no date on the resident's tubing or anywhere on the oxygen machine. She also confirmed that the level of oxygen was set at 2.5 liters per minute.

An interview was conducted on January 10, 2019 at 9:22 a.m. with a licensed practical nurse (LPN/staff #159), who stated that the CNA's on the night shift change and date the oxygen tubing every Sunday and document the tubing was changed in the computer in the task section. She stated that if she did not see a date on the tubing, she would change the tubing. She also stated that it is the nurse's responsibility to monitor the amount of oxygen received per a minute. After reviewing the orders, she stated the order is for oxygen at 2 liters.

Review of the resident's electronic record including in the task section, revealed there was no documentation that the tubing was changed in November and December 2018.

During an interview conducted with the Director of Nursing (DON/staff #125) on January 10, 2019 at 11:05 a.m., she stated the expectation is that the oxygen tubing is to be changed by the CNA's on the night shift every Sunday.

The facility's policy regarding "Oxygen Administration" included the following:

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F 695	Continued From page 49 -The purpose of this procedure is to provide guidelines for safe oxygen administration. -Verify that there is a physician's order for this procedure. -Review the physician's order or facility protocol for oxygen administration. The policy did not address a process for monitoring when oxygen equipment is to be changed.	F 695		
F 698 SS=E	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews, and policy review, the facility failed to ensure physician orders were in place for one resident (#151) regarding dialysis. Findings include: Resident #151 was admitted to the facility on November 16, 2018 with diagnoses that included end stage renal disease, sepsis, and bacteremia. An admission Minimum Data Set (MDS) assessment dated November 23, 2018 included the resident had short-term and long-term memory problems and had severe impairment with daily decision making. The MDS assessment	F 698	1. Physician order for dialysis was obtained on 1/10/19. See attached copy of this order. 2. All residents who receive dialysis could be affected by this alleged deficiency. An audit was conducted on 2/27/19 for all residents receiving dialysis to ensure orders are in place.100% audited had the correct orders. 3. The admission audit process will identify residents needing dialysis to ensure there are current physician orders. *See attached audits for February and as of March 21st. for dialysis orders. 4. The DON/Designee will monitor for compliance and report to the QAA Committee for three months.	3/3/19

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F 698	Continued From page 50 also included the resident was receiving dialysis. A nursing note dated November 23, 2018 revealed the resident had a right sided vascular catheter. Review of the clinical record revealed the resident went out to dialysis appointments on several occasions in November and December 2018 and January 2019. A care plan dated December 21, 2018 included the resident needs dialysis related to end stage renal disease. Interventions included checking and changing the dressing daily at access site and document. However, review of the clinical record revealed no evidence that there was a physician's order for dialysis treatments, to monitor the dialysis site, or to check and change the access site dressing daily. In an interview with a licensed practical nurse (LPN/staff #165) on January 10, 2019 at 10:31 a.m., he stated that for a resident receiving dialysis, there should be an order for the dialysis treatment to include the days for dialysis and an order to monitor the dialysis site. He stated that if the resident has a port site then it should be monitored every day for bleeding. The nurse reviewed resident #151's electronic record and was unable to locate an order for the resident's dialysis treatment. During an interview conducted with the LPN (staff #153) caring for this resident on January 10, 2019 at 10:38 a.m., she stated the resident was currently at the dialysis center. She stated she	F 698		

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F 698	Continued From page 51 knows when the resident is scheduled for dialysis based on an appointment log that is reviewed every day and her report sheet that has the dialysis days and time. The LPN also stated that when the resident returns from dialysis an assessment is done which includes checking the site. She stated the site should be assessed and documented every shift, and that there should be an order to monitor the site. In an interview with the Director of Nursing (DON/staff #125) on January 10, 2019 at 10:43 a.m., she stated there should be a physician's order in place for dialysis treatments which includes the location, day and time. She also stated there should be an order to monitor the resident's dialysis site, whether it is a fistula or a port. Review of the facility's policy titled "Hemodialysis Access Care" did not include physician's orders regarding a resident receiving dialysis treatment. Per the DON, there was no other policy specific to dialysis.	F 698		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required	F 725		

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F 725	Continued From page 52 at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, facility documentation and policies and procedures, the facility failed to have sufficient nursing staff to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. Findings include: Multiple resident interviews were conducted on January 7, 2018 regarding facility staffing. Ten random residents stated that there was not enough staff and that they have to wait too long for staff assistance and for their call lights to be answered. An interview was conducted with a CNA (certified nursing assistant). The CNA stated that the A-1 unit for high acuity behavioral residents was usually staffed with 3 CNA's to care for 20-24	F 725	1. The facility updated the call-in policy to reflect a more structured procedure for those who call in resulting in staff shortages. This policy was presented to staff on 2/22/19.*See attached policy regarding call-in's. There has been an increase in the hiring of C.N.A.'s and nurses to fill open positions. This will reduce the number of outside agency usage resulting in better and consistent patient care. The staffing patterns were reviewed to reflect a need for increased staffing on the Behavioral Unit. 2. All residents could be affected by this alleged deficiency. 3. The Resident Council Minutes are reviewed by the Administrator and monitored to ensure a response and action plan will be addressed for all concerns. An additional Guest Services Coordinator has been hired as of 3/1/19 to also address resident concerns and assist with any grievances. 4. The Administrator will monitor for compliance and report to the QAA Committee for three months.	3/3/19

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F 725	Continued From page 53 residents. The CNA stated that one CNA is supposed to be in the hall at all times to monitor to prevent resident to resident altercations, but that does not always happen because of call ins. An interview was conducted with another CNA, who stated that someone is always supposed to be monitoring the hallway on the A-1 unit, but that does not always happen and it's kind of irritating. The CNA stated we do the best we can, but if there is a call in there is no one to monitor the hallway and the residents get in to altercations. An interview was conducted with another CNA who stated that it is challenging to care for the residents when there are call ins. An interview was conducted with a fourth CNA, who stated that sometimes it is hard to care for the residents when there are call ins. An interview was conducted with another CNA, who stated that care and showers do not get done when there is not enough staff. The CNA further explained that care gets done but not like it should and showers get missed. An interview was conducted with another CNA, who stated that the facility attempts to staff adequately, but some days they are short. An interview was conducted with a seventh CNA, who stated that they used to have four CNA's for this hallway and now they have three. The CNA stated that it was hard to monitor the hallway, because most of the residents on this hallway require two staff to provide care. An interview was conducted with another CNA,	F 725		

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F 725	Continued From page 54 who stated that she thought the afternoon shift could use more staff especially on the weekends. The CNA stated that they used to have a hall monitor, but do not anymore. An interview was conducted with a CNA, who stated that sometimes they only have two CNA's on 2nd shift for this hallway and it's hard because most of the residents on this hallway require two staff to provide care. The CNA stated that the facility is trying to staff adequately because they are now using agency staff. An interview was conducted with a LPN (licensed practical nurse). The LPN stated they could use more staff. The LPN stated that when they are short, I do not focus on my medications or paperwork and help the CNAs. An interview was conducted with another LPN, who stated that they used to have enough staff, but when the new management company took over they cut staff. The LPN stated we do the best we can. The LPN further stated that there are more CNAs scheduled today, because the surveyors are here for the annual survey. Review of the Resident Council Minutes from February 2018 through December 2018 revealed the following concerns from residents: -February 26: "Not enough staff all shifts." -May 8: "The residents are concerned with ratio of staff and residents. The lights are not being answered promptly." -July 9: "Many say there's not enough staff (pending concern already)." -August 30: "Residents are concerned with lights not being answered promptly. Concerns with 7:00	F 725		

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a.m. - 3:00 p.m. B2 (long term care unit)."
-September 13: "Residents feel like they lack staff."
-October 12: "Call lights are not answered quick and residents and family are waiting more than 15 minutes on B2."
-November 8: "Overworked and understaffed was stated by one resident. B2 (all shifts). CNA's do a very good job but most are exhausted."
-December 6: "B2 resident stated there have been 2 CNA's to 30 patients and needs are not being met. Residents stated staffing issues for the dining room have happened three times this week. Residents need help with feeding and passing food."

According to the resident council meeting documentation, a meeting was held on January 9, 2019 at 2:10 p.m., with six residents. Per the documentation, four of the six residents stated that there was not enough staff and that they had to wait extended periods of time for staff assistance.

On the last page of the Resident Council Minutes for the above months was a section titled, "Interventions to be implemented" however, each month this section was blank.

An interview was conducted with the activity director (staff #2) on January 9, 2019 at 2:45 p.m. Staff #2 stated that she has been the activity director since April 2018, and that she took the minutes for the resident council meeting. Staff #2 stated that she gave the staffing concerns to nursing and they are supposed to respond to the residents' concerns so that we could let the resident council know. Staff #2 stated that she had not received responses from nursing yet

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F 725	Continued From page 56 regarding staffing. An interview was conducted with the administrator (staff #20) on January 10, 2019 at 9:25 a.m. Staff #20 stated that there should be a monitor in the hallways of the A1 and B1 units. Staff #20 stated that the facility is aware of the residents concerns regarding staffing. An interview was conducted with the managing partner of the facility (staff #220) on January 10, 2018 at 10:40 a.m. Staff #220 stated that different units have different staffing needs. Staff #220 stated the facility has never had a resident to resident altercation that resulted in a serious injury, because of staffing. Staff #220 stated that ratio wise, there was enough staff and the concern could be the accountability of the staff. Staff #220 stated that he was not aware of the residents and staff concerns regarding staffing. Review of the facility's policy regarding Staffing revealed, "Our facility provides sufficient numbers of staff with the skill and competency necessary to provide care and services for all residents in accordance with resident care plans and the facility assessment...Inquiries or concerns relative to our facility's staffing should be directed to the Administrator or his/her designee."	F 725		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:	F 758		

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F 758	Continued From page 57 (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or	F 758	The following actions have been taken for those residents noted to be affected by this alleged deficient practice. 1. Resident #135 was discharged on 12/26/18. 2. All residents could be affected by this alleged deficiency. The Behavioral Health nurse manager conducted an audit between 1/28/19-2/1/19 to determine correct diagnosis for use of psychotropic drugs. 3. The Behavioral Health nurse manager will conduct ongoing random audits on orders for psychotropic medications for the correct diagnosis. *see attached audit of correct diagnosis for psychotropic medications. For all new admissions the orders will be reviewed by nurse managers to check for appropriate diagnosis. All other orders for in-house residents will be reviewed at daily clinical meeting. 4. The DON/Designee will monitor for compliance and report any issues to the QAA Committee for three months.	3/3/19

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prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
Based on closed clinical record review, staff interviews, and policies and procedures, the facility failed to ensure that one resident (#135) who was prescribed an antipsychotic medication upon admission, had indications for its use.

Findings include:

Resident #135 was admitted on November 7, 2018 with diagnoses that included Alzheimer's disease, toxic encephalopathy, and major depressive disorder. The resident was discharged December 26, 2018.

Review of hospital records prior to the resident's admission, revealed a H&P (History and Physical) report dated November 5, 2018 that the resident had a significant history of Alzheimer's dementia and traumatic brain injury and was cooperative with normal mood and cognition. The hospital H&P included a list of medications that the resident was receiving in the hospital. The list did not include the Risperidone (antipsychotic) or any other antipsychotic medication.

Continued review of the hospital records revealed a discharge summary dated November 7, 2018 that included an order for the resident to receive Risperidone 0.5 mg (milligram) tablet every 12 hours upon transfer to the facility. The discharge summary included the diagnoses dementia and depression but did not include a diagnosis of psychosis.

Review of the closed clinical record revealed a

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physician's order dated November 7, 2018 for Risperidone 0.5 mg tablet two times daily for dementia.

The Medication Administration Record for November 2018 revealed the resident was administered Risperidone as ordered.

A discharge MDS (Minimum Data Set) assessment dated December 26, 2018 included a BIMS (Brief Interview for Mental Status) score of 11 which indicated the resident had moderately impaired cognition. The assessment included the resident felt tired, depressed, had difficulty sleeping, and verbal behaviors directed at others. The assessment also included the resident received antipsychotic medications. However, the assessment did not include the resident had a psychiatric mood disorder.

Further review of the closed record did not reveal any additional documented evidence that the diagnosis of dementia for the use of the antipsychotic medication Risperidone had been clarified.

An interview was conducted on January 10, 2019 at 9:17 a.m. with the Director of Nursing (DON/staff #125). The Director stated that a diagnosis is needed to support the use of specific medications and that if the physician prescribes a medication for which the resident does not have a diagnosis, the nurse is to question the doctor about the diagnosis. The DON stated that when a resident is admitted from the hospital, the medications that are prescribed must verify with the physician by the nurse. The DON stated that an antipsychotic drug cannot be prescribed for dementia unless there is a diagnosis to support

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F 758	Continued From page 60 the use of the antipsychotic drug. The DON further stated that the use of the antipsychotic drug for resident #135 should have been clarified with the physician. During an interview conducted on January 10, 2019 at 9:35 a.m. with a RN (Registered Nurse/staff #165), the nurse stated that if a diagnosis is inappropriate for an ordered medication, the nurse would bring it to the physician's attention. The facility's policy and procedure titled Antipsychotic Medication Use included a policy statement that antipsychotic medications may be considered for residents with dementia but only after medical, physical, functional, psychological, emotional psychiatric, social and environmental causes of behavioral symptoms have been identified and addressed. The policy included residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective.	F 758		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §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.	F 842		

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F 842	Continued From page 61 §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. §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	F 842	The facility does have a policy that allows access to all electronic medical records. The current owners of this facility took over August 2018. During the certification survey conducted 1/7-1/10 the facility made multiple attempts to obtain the electronic medical records for Resident #225 from the previous owners. The previous owners (Avalon) would not send electronically to PCC (Point Click Care) but did send through email therefore allowing Sapphire of Tucson to print the medical record for the survey team. 2. The residents who are affected by this alleged deficiency would be discharged residents that were under the control of the previous owners. 3. If there are future request for medical records under the control of the previous owners, this facility will make every effort to obtain the records for all entities and agencies that request them. 4. The Administrator will monitor and be the point person for this issue	3/3/19

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	035099	A. BUILDING ______ B. WING ______	01/10/2019

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F 842	Continued From page 62 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 record review, staff interviews and policies and procedures, the facility failed to ensure that electronic and paper health records for one resident (#225) were readily accessible to the State Survey Team. Findings include: Resident #225 was admitted on July 22, 2015 with diagnoses that included dementia with behavioral disturbance, mental disorder due to known physiological condition, delusional disorder, and altered mental status. Resident #225 was discharged on April 5, 2018. During random reviews of the facility electronic records conducted on January 7, 2019 it was revealed the electronic health records for resident #225 were not accessible in the data base provided by the facility. An interview was conducted with the administrator (staff #20) on January 7, 2019 at	F 842		

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F 842	Continued From page 63 10:15 a.m. The administrator stated that the facility did not have access to electronic records for resident #225, and that access to those records had been removed by the previous owner of the facility when the facility was purchased by the current owner in August 2018. The Administrator stated that he would notify the previous owner that access to the records was needed, and that the facility staff were aware that they were supposed to have access to all electronic health records for resident #225. An interview was conducted with a corporate staff member (staff #220) on January 7, 2019 at 1:45 p.m. Staff #220 stated that he was aware of the requirement that access to medical records was to be maintained for 7 years. Staff #220 also stated that staff were in communication with the previous owners of the facility to obtain access to the health records for resident #225. An interview was conducted on January 8, 2019 at 8:30 a.m. with medical records (staff #184). Staff #184 stated that the paper records and electronic health records for resident #225 were not accessible, because the records had been removed by the previous owner of the facility. Staff #184 stated that the previous owner was scanning records to the facility. She stated that the process of uploading the documents would take hours and that the documents would be printed after the upload. Staff #184 stated that she did not know whether or not the records for resident #225 were being pre-screened by the previous owner prior to being uploaded. During an interview conducted with the administrator on January 8, 2019 at 9:24 a.m., the administrator stated that they were unable to	F 842		

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F 842	Continued From page 64 obtain access to electronic health records from the previous owner of the facility. In a follow-up interview with staff #184 conducted on January 8, 2019 at 2:08 p.m., the staff #184 provided a stack of printed paper records for resident #225 and stated that there would be no access to electronic health records for resident #225. Review of the facility's policy and procedure titled Electronic Medical Records included a statement that authorized Federal and State survey agents as outlined in current regulations may be granted access to electronic medical records.	F 842		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on concerns identified during the survey, staff interview and policy review, the quality assessment and assurance (QAA) committee failed to identify quality concerns and implement appropriate plans of action to correct the quality deficiencies. Findings include: During the facility's annual recertification survey, multiple concerns were identified in the following areas:	F 867	1. A new administrator was hired effective 1/1/19. 2. All residents could be affected by this alleged deficiency. 3. The QAA Committee will ensure quality concerns are identified and implement appropriate plans of actions to correct the quality deficiencies. An inservice was conducted on 2/27/19 with the QAA Committee reviewing the requirements for systems to address care and management practices. 4. The Administrator will monitor to ensure quality concerns are being addressed and that the monthly QAA meetings are held as scheduled. This will be an ongoing process.	3/3/19

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F 867	Continued From page 65 -Pervasive odors throughout the facility. -Resident to resident abuse involving 5 residents. -One resident eloped from the facility. -Implement facility policy regarding reporting an allegation of neglect. -Report an allegation of neglect within two hours. -A physician's order was not obtained for dialysis. -Failed to maintain adequate staffing. -Failed to provide access to electronic records timely. An interview was conducted with the administrator (staff #20) on January 10, 2019 at 2:26 p.m. Staff #20 stated that when staff identify a quality concern they bring their concerns to the QAA committee. Staff #20 stated that if a performance improvement plan is developed the QAA committee monitors the progress. The administrator further acknowledged there were no action plans regarding the quality concerns identified during the survey and that the QAA process had not identified the above issues. Review of the facility's policy regarding Quality Assurance and Performance Improvement (QAPI) Committee revealed "...The primary goals of the QAPI Committee are to...Help identify actual and potential negative outcomes relative to resident care and resolve them appropriately..."	F 867		
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff	F 919		

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F 919	Continued From page 66 work area. §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to ensure that two public restrooms, which were unlocked, were equipped to allow residents to call for staff assistance. Findings include: During an observation conducted on January 7, 2019 at 10:30 a.m., two unlocked restrooms were observed near the front entrance of the facility. Neither restroom was equipped with a communication system to alert staff should a resident require assistance while in the restroom. Once inside of each restroom a deadbolt lock was observed on the doors. The deadbolt lock was unable to be unlocked from the outside of the door in the event of an emergency. Signs were posted on both of the restroom doors which stated "Lobby restrooms are for visitors and staff only. Residents, please utilize resident restrooms. Thank you for your cooperation. Kind regards, Sapphire Management." Multiple residents passed by this area to go to the front lobby or to go outside of the facility. An interview was conducted with a receptionist (staff #191) on January 8, 2019 at 9:25 a.m. Staff #191 stated that they ask the residents not to use the public restrooms but that some of the residents go in there anyway. Staff #191 stated that the residents probably use the public restrooms at night when no one is at the receptionist desk. Staff #191 further stated that the public bathroom doors used to be locked.	F 919		

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F 919	Continued From page 67 Observations conducted on January 8, 9, and 10, 2019 revealed the area near the public restrooms and front lobby continued to be a high traffic area with residents going to the front lobby or out of the facility. An interview was conducted with another receptionist (staff #194) on January 10, 2019 at 11:00 a.m. Staff #194 stated that the residents were asked to not use the public restrooms. Staff #194 stated that the facility put the signs on the doors of the public restrooms due to the fact that residents could go in there and fall and they would not know that they were in there because there is no call light. Staff #194 further stated the doors used to be locked. An interview was conducted with the managing partner of the facility (staff #220) on January 10, 2019 at 12:35 p.m. Staff #220 stated that the unlocked bathroom doors were his fault. Staff #220 stated that when he first came to the facility he thought it was a dignity issue to be in the restroom and have people knocking on the door when you were in there. Staff #220 stated that he felt installing the occupied/unoccupied deadbolts on the door would resolve the dignity issue. The facility did not have a policy regarding resident call systems.	F 919	The following action have been taken for those residents noted to be affected by this alleged deficient practice. 1. The locks to both public restrooms were changed to require a key from the receptionist in order to enter the restroom. The residents will not be allowed to use the public restroom as there is not a call system in place. This was effective 1/10/19. 2. All residents who enter the lobby area and request a restroom could be affected by this alleged deficiency. 3. The manging partner for the facility has confirmed that the restrooms will remain locked with accessibility only through the controlled method of obtaining a key from the receptionist. 4. The Administrator will monitor for compliance and report any issues to the QAA Committee for 3 months.	3/3/19

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F 000	INITIAL COMMENTS The annual recertification survey was conducted from January 7 through January 10, 2019, in conjunction with the following Complaint investigations: AZ00147662, AZ00152817, AZ00151707, AZ00153440 and AZ00152668. The following deficiencies were cited.	F 000	Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the Provider of the truth of the facts alleged of the convictions set forth in the statement of deficiencies. We have implemented the Plan of Correction as stated below and the facility is demonstrating compliance for the deficiencies cited.	
F 552 SS=D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is not met as evidenced by: Based on closed clinical record review, staff interviews and policies and procedures, the facility failed to ensure that one resident (#135) had been informed in advance of the risks and benefits of an antipsychotic medication. Findings include:	F 552	Arizona Department of Healt Division of Public Health Licensing Services MAR 26 2019 Reception Desk 150 N. 18th Ave #40(Phoenix, AZ 85007 RECEIVED MAR 26 2019 By	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE Administrator | (X6) DATE 3/25/19

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.

F552

SAPPHIRE OF TUCSON NURSING AND REHAB

OBTAINING CONSENTS FOR PSYCHOTROPIC MEDICATIONS

POLICY: Sapphire of Tucson Nursing and Rehab (SOT) will ensure residents have a right to be informed and make treatment decisions in advance regarding the use of psychotropic medications.

PROCEDURE:

1. All new admissions or new orders for in house residents are reviewed for psychotropic medications by the Behavioral Nurse Manager.
2. If there is an order for a psychotropic medication at the time of admission, the Behavioral Nurse shall delegate the task of obtaining the consent to the admitting nurse. The Behavioral Nurse Manager will be responsible to ensure the consent at the time of the order is received was obtained by auditing all new admissions.
3. The Behavioral Nurse Manager will place the order by the prescribing provider into the Electronic Health Record (EHR) and make an entry in the tracking log used to ensure accuracy of orders. This log also contains the correct diagnosis for the medication.
4. The Behavioral Nurse Manager or admitting nurse will explain the risks, benefits and side effects of the medications while obtaining the consents to either the resident or their legal representative authorized to give consent for the resident.
5. In the absence of the Behavioral Nurse Manager; the admitting nurse and or the Unit Managers will be responsible for overseeing the process of obtaining consents and all other necessary requirements related to this procedure.

7 578

NURSING INSERVICE 2/8/19

Admissions Process and Required documentation.

- Required Evaluations
- Obtain consents including consent to treat and code status/DNR
- Good customer service
- Q & A

Name- Please print	Title	Shift
[illegible]	LPN	6A-6P
Heidi Smith [illegible]	[illegible]	18-06
[illegible]	LPN	6A-6P
Tonya Williams	LPN	6P-6A
Angela Edwards	LPN	6A-6p
Stephanie M. Potter	RN	6p-6A
Charles Wylie	LPN	6a-6p
Barbara Bogard	LPN	6a-6p
Connie Morris	LPN	6A-6P
Claudia Gutierrez	LPN	6A-6p
Jena Panebianco.	RN	6A-6pm.
Manuela Bravo	LPN	6a-6pm
Mandee Kruse	LPN	6A-6pm
[illegible]	LPN	6A/6PM
[illegible]	LPN	6am-6pm

F518

Admissions Made Easy

Brought to you by:
Jean Cseley, RN, BSN, Director of Nursing.
Brittany Marble, RN, MSN, Nursing Supervisor
Carolyn Glover, LPN, Unit Manager
Maricela Nunez, LPN, Behavioral Health Director
Gila Deloya, RN,BSN, Unit Manager

February, 2019

First and Foremost

Greet the patient (You are the first face that they see and you represent Sapphire)

Empathize with the patient , they are in a new environment .

Make them feel at home . (Are you hungry ? Are you comfortable ?)

First Impressions are lasting and make a HUGE difference .

"THEY may forget your name, BUT they will never forget how you made them feel." Maya Angelou

Admission Checklist

- An admission checklist will come in every admission packet and must be completed within the **FIRST 24 HOURS** of admission.
- We are a 24 hour facility. This means that the checklist can and will be passed from one shift to the other.
- We MUST work as a team to ensure each part of the admission checklist is completed for EVERY admission.
- Each admission is audited by the unit managers.
  - Any part left off of the admission checklist will result in being called in to complete and disciplinary action for repeat occurrences.
- Any admission arriving after 1700 is the responsibility of the PM nurse.
  - To clarify - the AM nurse WILL INTRODUCE THEMSELVES to the resident and address any immediate concerns, admit the patient (quick ADT), write a detailed admission note (mode of arrival, status of resident upon arrival, any pertinent resident information), collect vitals, ensure equipment needs are met, and collect consents. Any additional parts of the admission they are able to complete is appreciated.
  - Any part of the checklist left from the AM shift is to be completed during the PM shift. The complete admission note is the responsibility of the PM nurse if resident is admitted after 1700.

"Necessary Nine"

- **Admit / Readmit Screener / Admission note (Computer)**
- **Braden Scale for Predicting Pressure Sore Risk (Computer)**
- **Dehydration Risk Screener (Computer)**
- **IMA Risk for Re Hospitalization Assessment Tool (LACE) (Computer)**
- **Morse Fall Scale (Computer)**
- **Pain Assessment (Computer)**
- **Smoking Evaluation (Computer) / Consent(Paper)**
- **Elopement Screen (Computer)**
- **IMA Baseline Care Plan (paper form) nursing part only leave open for other disciplines**

Admit / Readmit Screener

- Must be completed within 24 hours of admission to our facility.
- When doing skin check must look under dressings and count staples or sutures.
- Describe the wound (DO NOT STAGE) in your note.
- Check PICC dressings and change with-in 24 hours of admit.
  - PICC line presentation will come soon! ☺

Consent to Treat

- Please print!!!
- Have resident/appointed guardian/POA sign form upon admission and BEFORE ANY medications are administered or ANY cares are performed.
- THIS IS A PRIORITY!!!

Admission Note

- Admission notes are NOT OPTIONAL.
- Admission notes must include the following:
  - How resident arrived to our facility (wheelchair, stretcher, walking? Including transportation company).
  - Vital signs on arrival (completed by CNA).
  - Basic synopsis of assessment.
  - Any abnormal assessment findings.
  - Orientation status.
  - Mobility status.
  - Lines/Tubes.
  - Diet.
  - Wound Status if applicable.
  - Call light and bed locked and low.
  - Any other assessment information pertinent to care of resident.

Braden Scale for Prediction Pressure Sore Risk

- Must be completed within 24 hours of admission to our facility.

Dehydration Risk Screener

- Must be completed within 24 hours of admission to our facility.

IMA Baseline Care Plan

- Nursing is only responsible for the nursing part of the care plan, but feel free to fill in any areas that you have assessed.
- You may leave the other areas of the care plan open for other disciplines as it is their duty to complete their sections. When done place in unit managers box so we can take to the morning meeting for review
- THIS IS IMPARATIVE AND MUST BE COMPLETED WITHIN 24 HOURS PER STATE REGULATORY GUIDELINES.
- Failure to complete base line care plans may result in discplinary action as well as being called into the facility to finish the care plan documentation.
- It is NOT management responsibility to complete this.
- You know your resident, as you are the one that completed the assessments, as the resident's nurse, you have the most information, therefore the best person to fill out the care plan.
- A sample care plan is located in the nursing resource binder. This sample has each required section highlighted. Please refer to the resource binder for any quesitons you may have.

IMA Risk for Re Hospitalization Assessment Tool (LACE)

- Must be completed within 24 hours of admission to our facility.

Morse Fall Scale

- Must be completed within 24 hours of admission to our facility.

Pain Assessment

- Must be completed within 24 hours of admission to our facility.

Smoking Evaluation and Consent

- Must be completed within 24 hours of admission to our facility.
- (ASAP especially if they are a smoker!! Resident cannot smoke until this is done!!)

Elopement Screen

- Must be completed within 24 hours of admission to our facility.

Advanced Directives and DNR Sheet

- Advanced directives must be input for EACH RESIDENT!!!
- If the resident has a 'DNR' code status, an orange DNR sheet MUST be filled out and signed by the resident/appointed guardian/POA.
  - Without the orange form filled out correctly, the resident is considered a full code. Please take caution to ensure the facility has the correct forms.
  - Your resident depends on you!

Diet

- A diet order ***must*** be placed for each resident.
  - Without this order, the resident **MAY NOT RECEIVE A MEAL!**
- The diet order must include:
  - Diet
  - Consistency
  - Fluid Consistency
- Print out order and give to Kitchen. Also inform Kitchen staff of all new admits to ensure they receive the correct meals.

Weight

- Each resident is to have an admission weight recorded.
- Without this weight we CANNOT track weight loss/gain throughout their stay.
- Initial weight will determine how often the resident will be weighed.
  - Daily? Weekly? Monthly?
- Weight is to be collected by CNA. If CNA does not record weight, that responsibility will ultimately fall upon the admitting nurse.
  - If your CNA is unable to complete this task, please ensure you have assisted to get this weight.
- Each additional weight will be completed by the Restorative Aids unless otherwise noted.

Appointments and Transport

- Appointments are a PRIORITY, not an after thought.
- Appointment forms MUST be completed and placed in Donna's (Transportation Coordinator) box.
  - Without this form, transportation WILL NOT be set up; causing a delay in care.
- Donna's box/hanging file box is located next to the pharmacy fax machine on the second floor nurses station.
- The appointment/transportation form requires the following information:
  - Wheelchair or Stretcher
  - Height/Weight
  - Escort? Oxygen? Wound Vac? Fall risk?
  - DOB
  - Room Number
  - Appointment requested
  - Name of Doctor that will be seeing the resident
  - Reason for appointment
  - Address for appointment
  - Phone number for facility of appointment

Wound Orders and Consult

- Any resident with wounds MUST HAVE A WOUND CARE CONSULT.
- Place the order in PCC and also send Monica a PCC message .***Follow up*** to ensure that consult has been completed within 24 hours.
- If a patient comes in with a wound and there are no orders for the wound (i.e skin tear, sheering, open areas) need to put in an order on admit it is a delay in care if there is not an order.
- Monica can change if needed after she sees the patient
- Any wound questions or new wounds not previously documented shall be addressed by Monica, LPN Wound Care Nurse.
- Any wound orders must be input into PCC.
  - All orders subject to change after wound care consult and Monica's assessment. Please review orders each day and post each assessment.

Medication Orders and Faxing to PharMerica

- Once orders are ***verified*** by physician, print out medication order sheets, and fax to PharMerica.
- Once faxed, please call PharMerica and verify that fax has been received, this is especially important after 1600 as the pharmacy no longer fills medication orders after ***1630*** each night! (Some medications will require an authorization code from the pharmacist.)
- Must call pharmacy if faxed after 1900 to verify they got the fax and that they will stat over any other meds
- Please tell them you want it on the sweep run, if you miss this run must call them in to be sent over STAT.
- For emergent and urgent meds, PLEASE PULL ANYTHING AVAILABLE in the RxNow cabinet. If you have ANY questions call Brittany Marble at any time. 520-907-59281
- We have IV E-kits to mix IV medication use them, Can not be missing IV doses
- We will soon have a list of EACH medication that is stocked in the cabinet.
  - Once we have the list it will be laminated and placed next to the RxNow cabinet.

- **IF YOU DO NOT HAVE ACCESS TO THE RXNOW CABINET PLEASE SEE BRITTANY MARBLE AFTER THIS MEETING!!!**

Immunization Consents

- Have resident or appointed guardian/POA sign form upon admission and BEFORE any immunizations are given.
- Please ask resident or appointed guardian/POA if immunizations were received previously and document/administer immunizations accordingly.
- After having the immunization consents signed, please update the immunization tab in PCC. This does not trigger and needs to be input manually.
- After March we do not offer FLU.
- If they consent to PNA and don't want flu need two different consents.
- If they consent to immunization please notify MD and admin Immunization and document in note and Immunization tab.

Psychiatric Medication Consents

- Have resident or appointed guardian/POA sign form upon admission and BEFORE any medications are administered!!!
- We cannot administer these medications until a consent is signed.
- All psych medications can be placed on one consent .
- Please do no put dose on the consent
- AIMS is to be done on all antipsychotics and Reglan
- Need to have monitor behaviors for these psychiatric and adverse reactions in the orders

Inventory

- Please print!!!
- It is acceptable to ask a CNA to fill out inventory list.
- Have resident sign that all inventory is correct.
- Please update with new inventory that is brought into the facility as well as with any items taken out of the building.
- Have resident sign EVERY update to inventory list to ensure accuracy and alleviate any discrepancies to inventory list during their stay.

Labs

- Please review all lab orders and order labs accordingly.
- Pay close attention to residents with Coumadin/Warfarin orders.
  - IS THE PT/INR ORDER IN PLACE?
- Vancomycin orders need to include Vanco Troughs.
- All residents with IV antibiotic orders need to have follow up labs until D/C of meds. (If patient is followed by ID they will need weekly labs)
  - Check with admitting physician to determine which labs they would like.

Standing Orders

- MOM 30cc PO qday PRN for constipation
- Bisacodyl 5mg tabs 2 tabs (10mg) PO PRN q24h for bowel care not relieved by MOM
- Dulcolax suppository 10mg- one rectally Q24 hours prn bowel care
- Fleet Enema 1 every 24 hours PRN if Dulcolax Suppository is ineffective
- Acetaminophen table 650mg for pain 1-3 and fever 100.1 and higher
- May crush crushable meds in applesauce or another carrier PRN
- Maalox 30cc PO q4h prn for GI upset

- FOR RESIDENTS ON DIALYSIS, DO NOT ORDER ENEMA OR MOM

Questions, Comments, and Concerns?

- We would love your input and suggestions!
- Please place all input and suggestions in writing so that we can address them accordingly!

THANK YOU

- Thank you all for everything you do each day for each of our residents and our facility!
- Without each one of you, we could not give the care that our residents deserve.

YOU MAKE A DIFFERENCE IN EACH OF OUR RESIDENTS LIVES!!!

YOU ARE IMPORTANT!!!

WE APPRECIATE EACH AND EVERY ONE OF YOU!!!!

Quality of Life – Homelike Environment

Policy Statement

Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible.

Policy Interpretation and Implementation

1. Staff shall provide person-centered care that emphasizes the residents' comfort, independence and personal needs and preferences.
2. The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include:
   a. Cleanliness and order;
   b. Comfortable (minimum glare) yet adequate (suitable to the task) lighting;
   c. Inviting colors and décor;
   d. Personalized furniture and room arrangements;
   e. Pleasant, neutral scents;
   f. Plants and flowers, where appropriate;
   g. Comfortable temperatures; and
   h. Comfortable noise levels.
3. The facility staff and management shall minimize, to the extent possible, the characteristics of the facility that reflect a depersonalized, institutional setting. These characteristics include:
   a. Overhead paging;
   b. Institutional odors;
   c. Institutional signage (for example, labeled storage closets and work rooms in common areas);
   d. Medication carts; and
   e. Chair and bed alarms.
4. Comfortable and adequate lighting is provided in all areas of the facility to promote a safe, comfortable and homelike environment. The lighting design emphasizes:
   a. Sufficient general lighting in resident-use areas;
   b. Task lighting as needed;
   c. Reduction in glare (through use of light filters, no wax floors);
   d. Even light levels;
   e. Maximum use of daylight;
   f. Night lighting to promote safety and independence; and
   g. Dimming switches, where feasible.
5. Contrasting colors (for example, plates that contrast with the table linens and toilets that contrast with the bathroom wall color) may be used to promote a homelike environment and to aid visually impaired residents.

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F584

ATTENDANCE FORM

In-service Title: Annual Survey Results, Quality of Life Policy Review

Topics Discussed (May Attach Outline): Employee Hand Book / Attendance Policy, Nursing / Admission Overview, Life Safety Codes, Customer Service, Answering Call Bells — Odors, Care Rounds

Instructor's Name & Title: Sheila Wiggins, Administrator + Jean Csely - DON

Required Departments: All Staff

Date: 2/8/19

Name – Please Print	Title	Hours Earned
Ingried Perraiz	LPN	
Jillian LaCroix	Operations	
Amber Stogner	CNA	
Marily Maldonado	LPN	
Heidi Smith	LPN	
IRINE ZAKAYO	LPN	
Janet Onchimbo	LPN	
DONNA BROOM	SLP	
IRENE ARRIERO	CNA	
MARY ELLEN WOZNIAK	MDS RN	
Dana Greenlee	Cota/L	
Meaghan Hernandez	LPN	
Jennifer Rodgers	LPN	
Guadalupe Johnson	HOUSEKEEPING	
Mary Clay	HOUSEKEEPING	
Angela Edwards	LPN	
Roselen Medina	Laundry	
Charles Wylie	LPN	
MC [illegible]	CNA	
Leonsio Uriarte	cna	
[illegible]	LNA	
[illegible]	CNA	
Nicheola Oaten	CNA	

[illegible] Midesena A1

Riley [illegible] CNA

Meena Verghese LPN

1

ATTENDANCE FORM

In-service Title: Annual Survey Results Quality of Life Policy Review

Topics Discussed (May Attach Outline):

Employee Hand Book, Quality of Life, odors, answering Call Bells, Care Rounds, Life Safety

Instructor's Name & Title: Sheila Wiggins, Administrator, Jean Oseley-Director of Nursing

Required Departments:

Date: 2/8/19

Name – Please Print	Title	Hours Earned
Manuela Bravo	[illegible]	
Corinne Pineda	LPN	
Lonnie Morris	LPN	
Jaime Dicochea	floortech	
Phuong Ferguson	LPN	
JEFF ARMSTRONG	DIET AID	
Samantha Mallin	LPN CM	
Cindy Boehme	HR	
CLAUDIA Gutierrez	LPN	
Brittany Marble	RN Unit Manager	
Debbie Burham	RD	
Kendall Kellersman	CNA	
Jamie Hadley	CNA	
AMY Watsabaugh	CNA	
Rita Y. Romero	CNA	
LAVOCTEE Winn	CNA	
Libby Martinez	Diet tech	

2

ATTENDANCE FORM

In-service Title: Annual Survey Outcomes, Quality of Life, Policy Review

Topics Discussed (May Attach Outline):

Instructor's Name & Title: Sheila Wiggins, Administrator, Jean Cseley - Director of Nursing

Required Departments:

Date: 2/8/19

Name – Please Print	Title	Hours Earned
Verlene Antone	Housekeeping	
Desirae Whitehead	Housekeeping	
Lilia Downs	Nursing	
Kyra Wiggins	[illegible]	
Irma [illegible]		
Ana Rosas	ACT	
Irma Bell	Med Rec	
Marylou Aguirre	HIM	
Mariah Arenivas	CNA	
Ernansy Flemings	CNA	

F600

How the facility is reducing the resident to resident abuse allegations necessary to be put back in compliance:

1. The facility hired an experienced Behavioral Health Program Manager who is a LMSW. Her position is to oversee and coordinate services for the residents on the Behavioral Secured Unit. She also reviews and makes recommendations for any incidents or behaviors for other residents not residing on the secured unit.
2. The facility obtained a contract with a new psychiatric provider group. Their presence on the unit is more frequent and they are more available to do onsite evaluations with medication recommendations.
3. The facility hired hall monitors for 16 hours per day for the secured unit, A1. This position will be on the halls monitoring for any behaviors that may be escalating or to monitor for any increased behaviors that may cause an incident. The hall monitor will round throughout the unit and report to the nurse assigned to the unit.
4. The Activity Department increased the hours for the A1 secured unit to 10 hours per day.
5. There is ongoing education to all staff regarding escalating behaviors, and other potential issues that could cause a resident to resident altercation.
6. The care plan team is focusing more on ways to keep residents calm and less agitated. For instance, more physical activities, specific music geared for the resident, stuffed animals for comfort, getting residents off the unit for more activities and or dining.
7. The new LMSW is doing more counseling and listening sessions, redirecting as appropriate.
8. The Behavioral Nurse Manager and Program Director has an office located on the unit thus making them more accessible for support to the staff and nurses for consultation.

F600

NURSING

IN-SERVICE ATTENDANCE FORM

IN-SERVICE TITLE: De-escalating Technique

Presented by Patty Soto/Maricela Munoz LCSW / Beh health PM / VP Beh Nurse Director

Required department: All
Instructor: Date: 8/15/19
Mandatory In-service:

Name- Please print	Title	Shift
Eileen Acosta	Activities/CNA	9am-7pm
Angie Quintero	Act/CNA	9-7
jillian LaCroix	Operations	24 HRS
Zea Martinez	CNA	7-3pm
Ida Trier	LNa	11-7 3pm
Alex Salar	LNA	7-3 AM
Rosemary Roybal	LPN	6A-6P
Cecilia McCauley	LPN	6A 6P
Jose Cedillo	LPN	6am 6pm
Monica Vazquez	CNA	7-3pm
Valeria Escobar	CNA/GR	12-8pm.
Aaron Green	Activities	9-7pm

Lorena Pesquiria = Also needs Certificate

De Escalation

Training

3/22/19

2pm

Harriette Antee CNA

Irene Lopez CNA

Angie Quintero CNA

Marina Duarte Activities

Corinne Pineda Cl-Nurse

12/21/18

In service -
De-escalating Techniques
with Harve Morris PHD

12/12/18

[illegible signature]
[illegible signature]
Monica Vazquez
Rosemary [illegible]
Ana LaBlue [illegible]
Luna Gutierrez LPN.
Mary Erdmann-Belz
Valeria Escobar.
Petra Reyes
Harriette Antone
V. Fein
LAVoctore Winn

4:30pm-4:45pm 4/9/18

IN-SERVICE ATTENDANCE FORM

In-service Title: De-Escalation How to When to

Topics Discussed (May Attach Outline):

Instructor's Name & Title:, Amelia Gabusi MSW, SSP

Required Departments: CNA's + Nursing

Date: 4-9-18

Name – Please Print	Title	Hours Earned
Melissa Bonero	CNA	
Petra Reyes	CNA	
Debra Jurado	CNA	
Kyla Cazares	CNA	
Maria Crawford	CNA	
Sharon Walter	DON	
Ana Rosas	ACT / CNA	
Angie Quintero	CNA / Act	
[illegible]	CNA	
Valeria Escobar	CNA	
Karilea Padilla	CNA	
Belen Bonifacio	LNA	
[illegible]	CNA	
Angeline Gradus	CNA	
Lindsey McMinn		
Arlene Hall	CNA	
KACH Lilley	CNA	
Tra Allen	CNA	
Mariah Lawton	CNA	
CHARLES Horn	CNA	
Jennifer Arnett	CNA	
Dan [illegible]	CNA	
Harriette Antone	CNA	
Delia Frew	RNA	
Haredo Mohamed	CNA	
Ana Hernandez	CNA	
Enriqua Nesbitt	CNA	
Vanessa [illegible]	CNA	

F600

DE ESCALATION TRAINING

Verbal De Escalation

Goals of training:

How to identify and de escalate an agitated person while keeping yourself safe.

In any conflict, you have a choice.

Escalate the incident further

De escalate the situation

Verbal De escalation

- Verbal De escalation is an intervention for use with individuals who are at risk for aggression.
- Approach is to use calm language, along with other communication techniques, to diffuse, re-direct, or de-escalate a conflict situation
- De escalation does not utilize physical force. Physical force is a last resort to prevent injury to yourself or to the individual.

Establish your safety

- First, calm yourself prior to interacting with the individual. If you are upset, this will escalate the situation.
- Take a deep breath.
- Ensure your own safety, safety of others, and safety of the individual. Who else is in the room? Observe objects such as chairs, tables, etc.
- Remove potentially harmful objects.
- Get assistance from others to keep safe.

6 stages of behavioral escalation

- Calm- Person relatively calm/cooperative
- Trigger- Person experiences unresolved conflicts. This triggers the person's behavior to escalate
- Agitation- Person increasingly unfocused/upset
- Peak- Person out of control/exhibits severe behavior
- De-escalation- Vents in the peak stage, person displays confusion. Severity of peak behaviors subsides
- Recovery- Person displays willingness to participate in activities

Characteristics and factors that may trigger aggression

- Psychiatric Illness
- Substance abuse
- Prior history of violence
- Highly stressful situations- acuity on the unit
- Feelings- powerlessness, fear, grief, feeling of injustice, boredom, humiliation
- Chronic pain

Signs of Agitation

- Raised voice
- Rapid speech
- Pacing
- Excessive sweating
- Excessive hand gestures
- Fidgeting
- Shaking
- Balled fists
- Erratic movements
- Aggressive movements
- Verbally abusive

Style of Communication

- Body language
- Tone
- Word Choice

Body language, non verbal approach has the most influence when interacting with an individual.

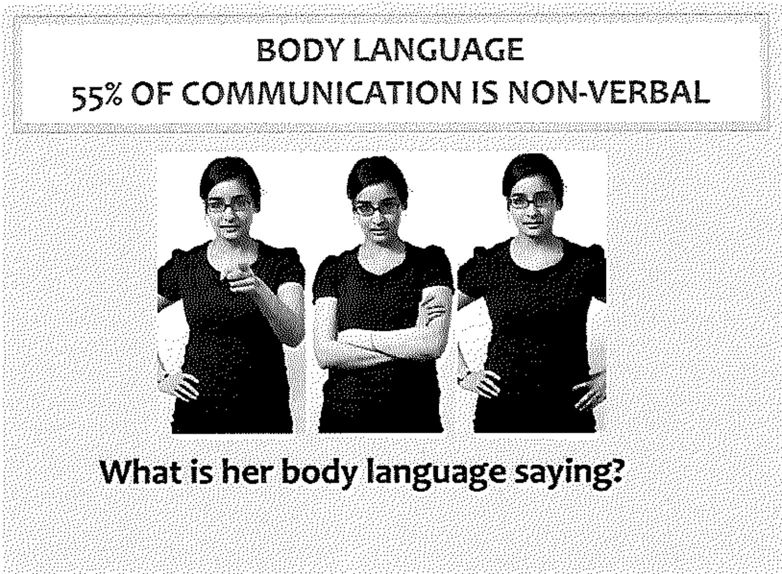
Types of non verbal behaviors:

- *eye contact*
- *Posture*
- *Gestures*
- *Facial expression*

Tone is secondary in importance when communicating:

- *Pitch*
- *Pace*
- *Volume*
- *Emotion*
- *Detail/High level*

Body Language



BODY LANGUAGE CAN ESCALATE TENSION

Match the body language to its message.

1. Shoulder shrugging
2. Jaw set with clenched teeth
3. Finger pointing
4. A fake smile
5. Excessive gesturing, pacing, fidgeting, or weight shifting
6. Touching, even when culturally appropriate

A. Mocking or uncaring
B. Accusing or threatening
C. Anxiety
D. Hostility or threatening
E. Not open- minded or listening
F. Uncaring or unknowing

Also avoid: Turning your back
Quick actions
Aggressive postures

Non Threatening techniques

- Appear calm and self assured
- Maintain limited eye contact
- Maintain a neutral facial expression
- Place your hands in front of your body in an open and relaxed position.
- Stance- at an angle, feet hips width apart, one foot in front. This promotes greater balance and mobility and exposes less of the body as a target.
- Stay far enough away so that the individual cannot hit, kick or grab you.

Behaviors to avoid

- Do not approach the individual head on or from the back.
- Approaching at an angle is perceived as less confrontational
- Never turn your back during a hostile situation

Importance of Tone

- Tone expresses your feelings or attitudes
- The listener interprets your message through tone.
- 38% of communication depends on tone
- https://www.youtube.com/watch?v=xD7rVRlnrJI

It is not just the words you use......

It is how you say it.....

Tone:

- Stern
- Timid
- Lowered
- Raised

Volume:

- Loud
- Soft

Rate of Speech:

- Slow but rhythmic rate
- Controlled- both calm and firm

Politeness:

- Be respectful- use “please” and “thank you”

Communication style

- Do not get loud or yell over an individual who is screaming. Wait until he/she takes a breath, speaking calmly at normal volume.
- Respond simply. Repeat if necessary. Answer informational questions, no matter how rudely asked.
- Help the individual talk out angry feelings rather than act on them.
- Do not become defensive if the individual curses, insults you. The statements are not about you.
- Be honest.
- Explain limits, rules in an authoritative, firm, but respectful tone. Give choices, when possible, in which both alternatives are safe.
- Empathize with feelings – not the behavior: "I understand that you feel angry…."
- Suggest alternative behaviors when appropriate: "Would you like to take a break and sit on the couch?"

Active Listening

Reasoning with an enraged induvial is not possible. Goal is to reduce the level of emotion.

The following techniques demonstrate to the individual you are listening and paying attention:

- *Brief nonverbal statements- nod head*
- *Simple verbal responses: Ok, Uh-huh, I see, I am listening*
- *Repeat what the individual has said*
- *Do not interrupt*

- https://www.youtube.com/watch?v=-4EDhdAHrOg

Trust your instincts

- If De escalation is not working, STOP!!
- If the situation feels unsafe: CALL FOR HELP
- De escalation Don'ts:
  - Threaten
  - Argue
  - Challenge
  - Order
  - Shame

Post De escalation

- Post de escalation and calming- stress and tension is decreased. There is a decrease in physical and emotional energy. The individual has regained control of behavior
- Attempt to re establish communication and return to calm/normal routines.
- Document incident- Provide all significant details accurately. Be objective- do not record your opinions. Example: incorrect: "Joe is acting crazy today." Correct: "Joe is talking about going to the store and shaking his fist in writer's face." Correct: "Joe states he 'feels crazy' today. He is pacing in his room with his shoes and jacket on."

Sapphire of Tucson

F600

Position	Shift	Hours	A1	B1	C1	A2	B2	C2
Activities	9:00AM-7:00PM	10	1	1	1	1		
Hall Monitor	7:00AM-3:00PM	8	1	-	-	-	-	-
Hall Monitor	3:00PM-11:00PM	8	1	-	-	-	-	-
CNA	7:00AM-3:00PM	8	3	3	3	4	3	3
CNA	3:00PM-11:00PM	8	3	3	3	3	3	3
CNA	11:00PM-7:00AM	8	2	2	2	2	2	2
LPN/RN	6:00AM-6:00PM	12	1	1	1	2	1	1
LPN/RN	6:00PM-6:00AM	12	1	1	1	2	1	1

Staffing Patterns

Closed-Circuit TVs

F600

Policy Statement

Our facility uses closed-circuit TVs in hallways, employee work areas, outside areas, etc., to monitor the safety and well-being of our staff and residents. The facility will use any video cameras in accordance with applicable laws and regulations.

Policy Interpretation and Implementation

1. All employees are informed about our facility's use of closed-circuit TVs to monitor the safety and well-being of our staff and residents. Employees must sign consent forms allowing the facility to tape them during duty hours.
2. Prior to or upon admission, residents are informed of the facility's use of closed-circuit TVs throughout the building. Consent forms are obtained allowing the facility to tape residents while in common areas of the building (e.g., dining/activity rooms, hallways, nurses' station, etc.).
3. If a video camera is installed in a resident's room, all residents, visitors, employees, etc., shall be informed of the use of the camera. The staff shall obtain signed consent from the resident's roommate, staff assigned duties to the resident, visitors, etc.
4. Facility management and the QA Committee may review any videos for content and to identify ways to improve care and services. Videotapes will be kept for 30 days and reused unless the content is needed. The Administrator will ensure that any tapes are stored in an appropriately secure location with limited access.
5. Only the Administrator may authorize copying of any videotapes. If a copy is made, there should be documentation as to why the copy was made, to whom the copy was provided, date provided, etc.
6. Inquiries concerning the use of closed-circuit TVs, obtaining copies of videotapes, security concerns, consents, etc., should be referred to the Administrator.

References	
OBRA Regulatory Reference Numbers	§483.10(e) Privacy and Confidentiality; §483.25(h) Accidents
Survey Tag Numbers	F164; F323
Other References	
Related Documents	Videotaping, Photographing, and Other Imaging of Residents
Version	1.1 (H5MAPL0134)

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F600

SAPPHIRE OF TUCSON NURSING AND REHAB

OBSERVING OF RESIDENTS BY CERTIFIED NURSING ASSISTANTS

POLICY: Sapphire of Tucson Nursing and Rehab (SOT) will ensure the needs of the residents are met by nursing personnel by checking and monitoring as determined by the care plan and physician orders.

PROCEDURE:

1. The C.N.A.'s are given a daily assignment to deliver care and services to residents.
2. The C.N.A.'s will check and monitor residents according to their needs and as directed by the nurse in charge.
3. The C.N.A.'s will report any changes or any significant issues to the nurse on a timely basis.

ELOPEMENT

1. When a resident is an elopement risk, the facility will take appropriate action for the safety of the resident. The actions include but not limited to one to one care until further orders by the attending physician.
2. The Interdisciplinary Team (IDT) will make recommendations for those that have been assessed as elopement risks.

F607

Abuse Investigation and Reporting

Policy Statement

All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source ("abuse") shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported.

Policy Interpretation and Implementation

Role of the Administrator:

1. If an incident or suspected incident of resident abuse, mistreatment, neglect or injury of unknown source is reported, the Administrator will assign the investigation to an appropriate individual.
2. The Administrator will provide any supporting documents relative to the alleged incident to the person in charge of the investigation.
3. The Administrator will keep the resident and his/her representative (sponsor) informed of the progress of the investigation.
4. The Administrator will suspend immediately any employee who has been accused of resident abuse, pending the outcome of the investigation.
5. The Administrator will ensure that any further potential abuse, neglect exploitation or mistreatment is prevented.
6. The Administrator will inform the resident and his/her representative of the status of the investigation and measures taken to protect the safety and privacy of the resident..

Role of the Investigator:

1. The individual conducting the investigation will, as a minimum:
   a. Review the completed documentation forms;
   b. Review the resident's medical record to determine events leading up to the incident;
   c. Interview the person(s) reporting the incident;
   d. Interview any witnesses to the incident;
   e. Interview the resident (as medically appropriate);
   f. Interview the resident's Attending Physician as needed to determine the resident's current level of cognitive function and medical condition;
   g. Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident;
   h. Interview the resident's roommate, family members, and visitors;
   i. Interview other residents to whom the accused employee provides care or services; and
   j. Review all events leading up to the alleged incident.
2. The following guidelines will be used when conducting interviews:
   a. Each interview will be conducted separately and in a private location.

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b. The purpose and confidentiality of the interview will be explained thoroughly to each person involved in the interview process.
c. Should a person disclose information that may be self-incriminating, that individual will be informed of his/her rights to terminate the interview until such time as his/her rights are protected (e.g., representation by legal counsel).
d. Witness reports will be obtained in writing. Either the witness will write his/her statement and sign and date it, or the investigator may obtain a statement, read it back to the member and have him/her sign and date it.

3. The investigator will notify the ombudsman that an abuse investigation is being conducted. The ombudsman will be invited to participate in the review process.
   a. If the ombudsman declines the invitation to participate in the investigation, that information will be noted in the investigation record. The ombudsman will be notified of the results of the investigation as well as any corrective measures taken.
4. The investigator will consult daily with the Administrator concerning the progress/findings of the investigation.
5. Upon conclusion of the investigation, the investigator will record the results of the investigation on approved documentation forms and provide the completed documentation to the Administrator.

Reporting

1. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the facility Administrator, or his/her designee, to the following persons or agencies:
   a. The State licensing/certification agency responsible for surveying/licensing the facility;
   b. The local/State Ombudsman;
   c. The Resident's Representative (Sponsor) of Record;
   d. Adult Protective Services (where state law provides jurisdiction in long-term care);
   e. Law enforcement officials;
   f. The resident's Attending Physician; and
   g. The facility Medical Director.
2. ✓ An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than:
   a. Two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury; or
   b. Twenty-four (24) hours if the alleged violation does not involve abuse AND has not resulted in serious bodily injury.
3. Verbal/written notices to agencies may be submitted via special carrier, fax, e-mail, or by telephone.
4. Notices will include, as appropriate:
   a. The name of the resident;
   b. The number of the room in which the resident resides;
   c. The type of abuse that was committed (i.e., verbal, physical, sexual, neglect, etc.);
   d. The date and time the alleged incident occurred;
   e. The name(s) of all persons involved in the alleged incident; and
   f. What immediate action was taken by the facility

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Sapphire of Tucson Nursing and Rehab

F 607

The facility will re-inservice employees on the Abuse/Neglect Reporting policy on 3/29/19

F609

Abuse Investigation and Reporting

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   e. Interview the resident (as medically appropriate);
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   g. Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident;
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c. Should a person disclose information that may be self-incriminating, that individual will be informed of his/her rights to terminate the interview until such time as his/her rights are protected (e.g., representation by legal counsel).

d. Witness reports will be obtained in writing. Either the witness will write his/her statement and sign and date it, or the investigator may obtain a statement, read it back to the member and have him/her sign and date it.

3. The investigator will notify the ombudsman that an abuse investigation is being conducted. The ombudsman will be invited to participate in the review process.
   a. If the ombudsman declines the invitation to participate in the investigation, that information will be noted in the investigation record. The ombudsman will be notified of the results of the investigation as well as any corrective measures taken.

4. The investigator will consult daily with the Administrator concerning the progress/findings of the investigation.

5. Upon conclusion of the investigation, the investigator will record the results of the investigation on approved documentation forms and provide the completed documentation to the Administrator.

Reporting

1. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the facility Administrator, or his/her designee, to the following persons or agencies:
   a. The State licensing/certification agency responsible for surveying/licensing the facility;
   b. The local/State Ombudsman;
   c. The Resident's Representative (Sponsor) of Record;
   d. Adult Protective Services (where state law provides jurisdiction in long-term care);
   e. Law enforcement officials;
   f. The resident's Attending Physician; and
   g. The facility Medical Director.

✔ 2. An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than:
   a. Two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury; or
   b. Twenty-four (24) hours if the alleged violation does not involve abuse AND has not resulted in serious bodily injury.

3. Verbal/written notices to agencies may be submitted via special carrier, fax, e-mail, or by telephone.

4. Notices will include, as appropriate:
   a. The name of the resident;
   b. The number of the room in which the resident resides;
   c. The type of abuse that was committed (i.e., verbal, physical, sexual, neglect, etc.);
   d. The date and time the alleged incident occurred;
   e. The name(s) of all persons involved in the alleged incident; and
   f. What immediate action was taken by the facility

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F 695

updated

Oxygen Administration

Level III

Purpose

The purpose of this procedure is to provide guidelines for safe oxygen administration.

Preparation

1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration.
2. Review the resident's care plan to assess for any special needs of the resident.
3. Assemble the equipment and supplies as needed.

General Guidelines

1. Oxygen therapy is administered by way of an oxygen mask, nasal cannula, and/or nasal catheter.
   a. The oxygen mask is a device that fits over the resident's nose and mouth. It is held in place by an elastic band placed around the resident's head.
   b. The nasal cannula is a tube that is placed approximately one-half inch into the resident's nose. It is held in place by an elastic band placed around the resident's head.
   c. The nasal catheter is a piece of tubing inserted through the resident's nostrils into the back of his/her mouth. It is held in place by a piece of skin tape attached to the resident's forehead and/or cheek.

Equipment and Supplies

The following equipment and supplies will be necessary when performing this procedure.

1. Portable oxygen cylinder (strapped to the stand);
2. Nasal cannula, nasal catheter, mask (as ordered);
3. Humidifier bottle;
4. "No Smoking/Oxygen in Use" signs;
5. Regulator; and
6. Personal protective equipment (e.g., gowns, gloves, mask, etc., as needed).

Assessment

Before administering oxygen, and while the resident is receiving oxygen therapy, assess for the following:

1. Signs or symptoms of cyanosis (i.e., blue tone to the skin and mucous membranes);
2. Signs or symptoms of hypoxia (i.e., rapid breathing, rapid pulse rate, restlessness, confusion);
3. Signs or symptoms of oxygen toxicity (i.e., tracheal irritation, difficulty breathing, or slow, shallow rate of breathing);
4. Vital signs;
5. Lung sounds;
6. Arterial blood gases and oxygen saturation, if applicable; and
7. Other laboratory results (hemoglobin, hematocrit, and complete blood count), if applicable.

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Steps in the Procedure

1. Wash and dry your hands thoroughly.
2. Place an "Oxygen in Use" sign on the outside of the room entrance door. Close the door.
3. Place an "Oxygen in Use" sign in a designated place on or over the resident's bed.
4. Remove all potentially flammable items (e.g., lotions, oils, alcohol, smoking articles, etc.) from the immediate area where the oxygen is to be administered.
5. Unless otherwise instructed, unplug and/or relocate all electrical devices (e.g., radios, televisions, electric shavers, etc.) in the immediate area where oxygen is to be administered.
6. Remove any woolen blankets, nylon and/or rayon clothing, etc., from the immediate area where oxygen is to be administered.
7. Check the tubing connected to the oxygen cylinder to assure that it is free of kinks.
8. Turn on the oxygen. Unless otherwise ordered, start the flow of oxygen at the rate of 2 to 3 liters per minute.
9. Place appropriate oxygen device on the resident (i.e., mask, nasal cannula and/or nasal catheter).
10. Adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered.
11. Securely anchor the tubing so that it does not rub or irritate the resident's nose, behind the resident's ears, etc.
12. Check the mask, tank, humidifying jar, etc., to be sure they are in good working order and are securely fastened. Be sure there is water in the humidifying jar and that the water level is high enough that the water bubbles as oxygen flows through.
13. Observe the resident upon setup and periodically thereafter to be sure oxygen is being tolerated (see "Assessment").
14. Periodically re-check water level in humidifying jar.
15. Discard used supplies into designated containers.
16. Discard personal protective equipment in designated receptacles. Wash and dry your hands thoroughly.
17. Reposition the bed covers. Make the resident comfortable.
18. Place the call light within easy reach of the resident.
19. If the resident desires, return the curtains to the open position and if visitors are waiting, tell them that they may now enter the room.
20. Instruct the resident, his/her family, visitors and roommate (if any) of the oxygen safety precautions. Provide the resident with a written copy of the *Oxygen Safety* handout.
21. Wash and dry your hands thoroughly.

Documentation

After completing the oxygen setup or adjustment, the following information should be recorded in the resident's medical record:

1. The date and time that the procedure was performed.
2. The name and title of the individual who performed the procedure.
3. The rate of oxygen flow, route, and rationale.
4. The frequency and duration of the treatment.
5. The reason for p.r.n. administration.
6. All assessment data obtained before, during, and after the procedure.
7. How the resident tolerated the procedure.

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8. If the resident refused the procedure, the reason(s) why and the intervention taken.
9. The signature and title of the person recording the data.

Reporting

1. Notify the supervisor if the resident refuses the procedure.
2. Report other information in accordance with facility policy and professional standards of practice.

Equipment Maintenance

1. All oxygen tubing including nasal cannula, nasal catheter, mask and tubing must be changed once weekly and as needed.
2. Date all tubing when it is changed weekly.

References	
MDS Items (CAAs)	Section O
Survey Tag Numbers	F328
Other References	
Related Documents	Oxygen Safety Pulse Oximetry (Assessing Oxygen Saturation)
Version	1.1 (H5MAPR0207)

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F 725

The Sapphire of Tucson Attendance Policy is as follows in a rolling 90- day period:

1st unscheduled absence	Verbal Warning
2nd unscheduled absence	Written Warning
3rd unscheduled absence	Suspension of up to 3 shifts
4th unscheduled absence	Termination

Subject to individual need/ case-by-case basis.

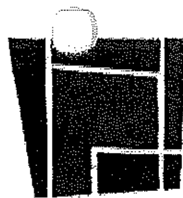
Employees are expected to be at their workstation at the designated start time of their shift. An employee is considered "tardy" if they are one (1) minute late for their shift. Employees required to clock-out exactly at the end of their shift unless approved by their supervisor.

Introductory Period Employees
Employees in their introductory period, the first (90 days) of employment, who have two (2) or more absences or tardies, may have their employment with Sapphire terminated for absenteeism.

D. NO CALL/ NO SHOW
An absence will be considered a no call/ no show after 1 hour into start of working shift. Employees are required to call out of their scheduled shift 4 hours prior to the start time. This will result in possible termination of employment from Sapphire of Tucson Nursing and Rehab. Exceptions to this rule may be considered on a case-by-case basis.

E. CALLING IN DURING HOLIDAYS/ PTO
Calling off work on the day before a Sapphire of Tucson designated holiday, the day of a holiday, or the day after a holiday will be treated as two (2) absences, and will move the employee to the next appropriate step in the disciplinary process. If you call in the day before, day of, day after a holiday- an employee will also not be paid holiday pay as explained above. This rule will also apply to paid time off and vacation time. Patterns of absences such as Fridays/ Mondays may be subject to disciplinary actions beyond those listed above. The above guidelines may be limited by, and will be administered consistent with, the FMLA, ADA, and/ or other state/ federal leave laws.

F. CELL PHONE USE
While at work, employees are expected to exercise the same discretion in using personal cellular phones as they would in use of company phones. Excessive personal calls during the workday, regardless of the phone used, can interfere with an employee's productivity. To promote a productive work environment and increase the safety of our staff and residents,



ARIZONA DEPARTMENT
OF HEALTH SERVICES

LICENSING

February 20, 2019

Receipt Of This Notice Is Presumed To Be -02/20/2019
Important Notice - Please Read Carefully

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

Dear Ms. Wiggins:

On **January 10, 2019**, a Medicare recertification 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 **March 2, 2019**. You must include all pages of the Statement of Deficiencies when submitting your PoC.
Failure to submit an acceptable PoC by **March 2, 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 **02/24/19 .**

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 January 10, 2019
Recommending to CMS Denial of Payment for New Admission

Mandatory Remedies

Your current period of noncompliance began on January 10, 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 .

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 07/10/19. 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: Effective July 1, 2007, 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 **March 2, 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.

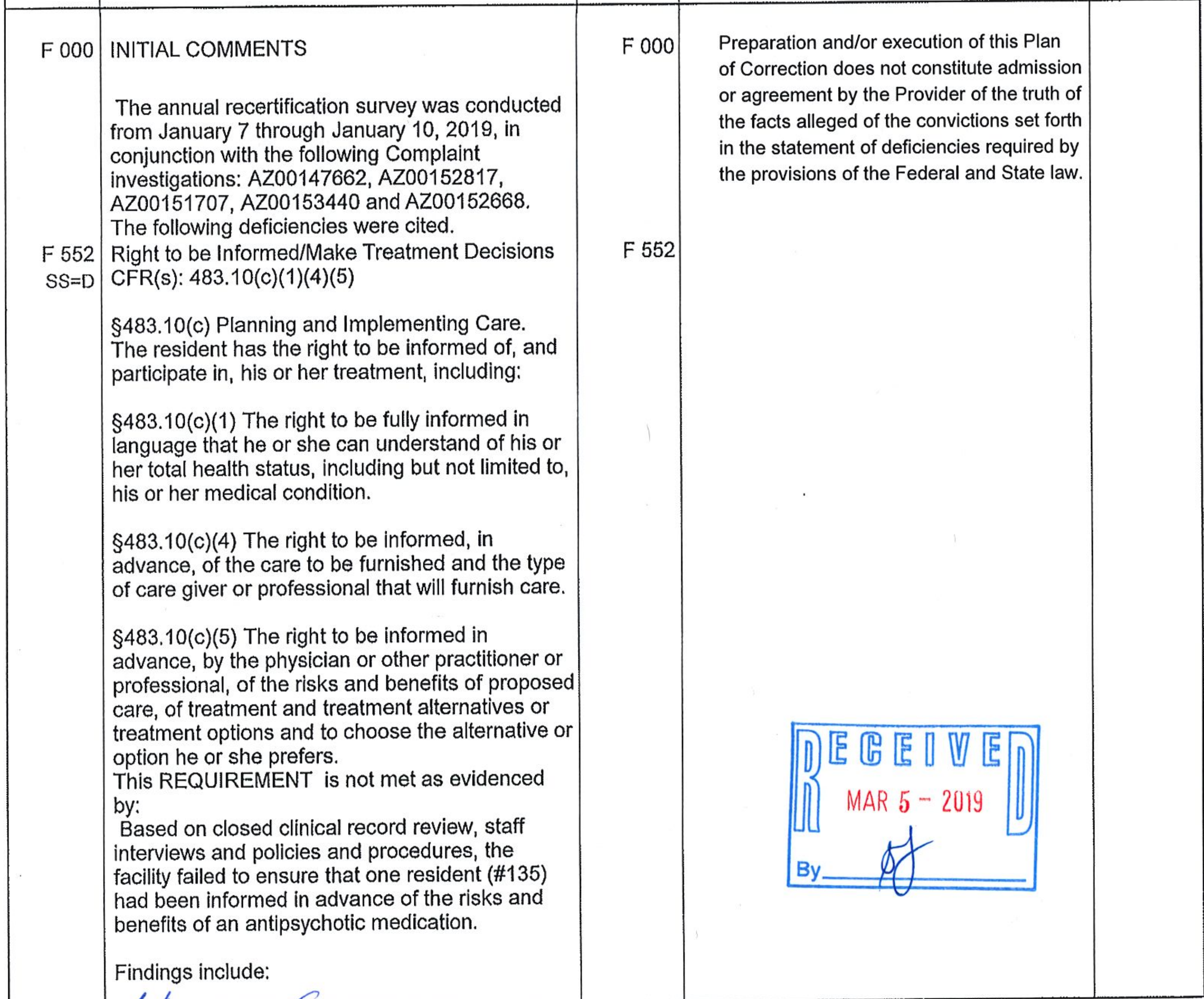
Sincerely,

Diane Eckles
Bureau Chief

DE:sf

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 ____	01/10/2019

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 annual recertification survey was conducted from January 7 through January 10, 2019, in conjunction with the following Complaint investigations: AZ00147662, AZ00152817, AZ00151707, AZ00153440 and AZ00152668. The following deficiencies were cited.	F 000	Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the Provider of the truth of the facts alleged of the convictions set forth in the statement of deficiencies required by the provisions of the Federal and State law.	
F 552 SS=D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is not met as evidenced by: Based on closed clinical record review, staff interviews and policies and procedures, the facility failed to ensure that one resident (#135) had been informed in advance of the risks and benefits of an antipsychotic medication. Findings include:	F 552	RECEIVED MAR 5 - 2019 By	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 3/2/19

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
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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

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F 552	Continued From page 1 Resident #135 was admitted on November 7, 2018, with diagnoses that included Alzheimer's disease, toxic encephalopathy and major depressive disorder. Review of the closed clinical record revealed a form titled Admission Record dated November 7, 2018, which included the resident was self-responsible. A form titled, Consent to Admit and Treat dated November 7, 2018 included a statement that the signer of the form was the responsible party for medical decision making. The form was signed by resident #135. A physician's order dated November 7, 2018 included for the resident to receive Risperdone 0.5 mg (antipsychotic medication) two times daily for dementia. A written care plan initiated on November 10, 2018 for the use of psychotropic medications related to behavioral management included an intervention for staff to educate the resident/family/caregivers about the risks, benefits and side effects and toxic symptoms of the medication. Further review of the clinical record revealed no evidence that the resident was informed of the risks, benefits and side effects of Risperdone. An interview was conducted on January 10, 2019 at 9:17 a.m., with the Director of Nursing (DON/staff #125). The DON stated that when an antipsychotic drug is prescribed, the use of the medication is explained to the resident, and they	F 552	1. Resident had been discharged from the facility on 12/26/18. Going forward a nurse was delegated to be the point person to obtain all the psychotropic consents for all residents. 2. All residents who have orders for anti-psychotropic medications have the potential to be affected by this deficient practice. 3. A complete audit was done to identify if there were any missing consents on 2/27/19. One person will be responsible to obtain all consents. This nurse will review the new orders daily to determine if new orders require consents. 4. The DON/Designee will review weekly to ensure all consents have been obtained and present to QAPI for 3 months.	3/3/19

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 552	Continued From page 2 have a form which includes the risks and benefits of the medications. The DON stated that they are to obtain informed consent. The DON said that after the risks and benefits are explained, the resident signs the form. An interview was conducted on January 10, 2019 at 9:35 a.m. with a RN (Registered Nurse/staff #165). During the interview, the nurse stated that there are consent forms for antipsychotic medications. Staff #165 said if the resident is unable to sign the consent form, consent is obtained from the resident's responsible party. Staff #165 stated they are required to obtain informed consent, prior to providing an antipsychotic medication to a resident. An interview was conducted on January 10, 2019 at 10:04 a.m. with medical records staff (#183), who stated that there was no informed consent for the use of Risperdone for resident #135. A policy regarding resident rights included that Federal and State laws guarantee certain basic rights to all residents of the facility. These rights include the resident's right to choose a treatment and participate in decisions and care planning.	F 552		
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical	F 578		

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F 578	Continued From page 3	F 578		

services deemed medically unnecessary or inappropriate.

§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).
(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.
(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.
(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.
(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.
(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.
This REQUIREMENT is not met as evidenced by:
Based on clinical record reviews, staff interviews and policy review, the facility failed to ensure that two residents (#164 and #121) were afforded the right to formulate advance directives.

Findings include:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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SAPPHIRE OF TUCSON NURSING AND REHAB, LLC	2900 EAST MILBER STREET TUCSON, AZ 85714

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F 578	Continued From page 4	F 578		

-Resident #164 was admitted to the facility on December 18, 2018, with diagnoses that included sepsis, end stage renal disease and type 2 diabetes mellitus.

Review of an Admission Minimum Data Set (MDS) assessment dated 12/25/18, revealed the resident scored a 9 on the Brief Interview for Mental Status (BIMS), which indicated moderate cognitive impairment.

Review of the resident's clinical record revealed no evidence of any advance directives for resident #164. There was also no documentation that the resident declined formulating advance directives.

Further review of the clinical record revealed there was no code status listed on the resident's face sheet or in the available space specific for code status in the electronic record.

According to the current physician's orders, there was no order for a code status for this resident.

In an interview with a Licensed Practical Nurse (LPN/staff #153) on January 10, 2019 at 9:30 a.m., she stated if she needed to find out a resident's code status, she would look in the electronic record, as there is a place where the code status is easily viewable. Further, she stated the resident's code status is listed on their report sheet. She stated the code status should be updated, as soon as the resident is admitted.

An interview with medical record staff (staff #184) was conducted on January 10, 2019 at 9:34 a.m. At this time, she reviewed resident #164's

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F 578	Continued From page 5 scanned documents and was unable to find any advance directives. She stated it could be in a stack of documents that are waiting to be scanned, however, no advanced directives were located. She also stated it could be in the physician's binder waiting to be signed by the physician, however, no advanced directives were found in the binder. In an interview with the Director of Nursing (DON/staff #125) on January 10, 2019 at 1:31 p.m., she stated an audit had just been done in late December, ensuring that all residents had advanced directive forms filled out. -Resident #121 was admitted to the facility on September 13, 2018, with diagnoses that included chronic osteomyelitis and quadriplegia. Review of the admission MDS assessment dated September 20, 2018, revealed the resident was cognitively intact. A physician's order dated November 20, 2018 indicated the resident was a full code. However, review of the clinical record revealed there were no advance directives which were signed by the resident. Also, the code status was not listed on the resident's face sheet or in the available space specific for code status in the resident's electronic record. An interview was conducted with a LPN (staff #150) on January 8, 2019 at 1:25 PM. The LPN stated that upon admission all consent forms are signed including advance directives. She stated that a resident's code status could be found on the face sheet or in the document section of the	F 578	The following actions have been taken for those residents noted to be affected by this alleged deficient practice: 1. The facility obtained a consent for code status for resident #164 on 1/10/2019. For resident #121 the facility located the signed consent for code status (dated and signed by the resident on 11/20/2018). The consents are located in PCC (electronic medical record) under the documents section and the face sheet shows current code status. 2. All residents have the potential to be affected this alleged deficiency. 3. An inservice for nurses was conducted on 2/22/19 that included the instructions on obtaining mandatory consents upon admission including signed code status consents. The DON has instituted a system whereby all nurse managers will be assigned to review new admissions to determine that there is a signed consent for code status. This will be completed within 24 hours of admission. 4. The DON/Designee will monitor for compliance and be reviewed at monthly QAPI for 3 months	3/3/19

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F 578	Continued From page 6 electronic medical record. Staff #150 was unable to locate any advanced directives which were signed by the resident. An interview was conducted with Medical Records (staff #183) on January 8, 2019 at 1:46 PM. She stated there was no record of advance directives on file for resident #121. She said the advance directives should be filled out upon admission or a few days later. An interview with the DON (staff #125) was conducted on January 10, 2019 at 11:40 AM. She stated the floor nurse is responsible for obtaining signed consents, including advance directives when the resident is admitted to the facility. She said if there is a problem social services should be notified. The DON stated she could not answer for what happened in September, as she was not employed by the facility at that time. The facility policy for Interpretation and Implementation for Advance Directives indicated that upon admission, the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive, if he or she chooses to do so. The policy stated that the information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record. The Director of Nursing or designee will notify the attending physician of advance directives, so that appropriate orders can be documented in the resident's medical record and plan of care.	F 578		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)	F 584		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 584	Continued From page 7 §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable	F 584	1. The facility does have a policy for Quality of Life - Homelike Environment that addresses cleanliness and institutional odors. (see attached). The Housekeeping department will begin using a urine odor neutralizer when cleaning all mattresses. The shower drain on the second floor that had an odor is not regularly used. It was determined that because of that, the housekeeping department will flush the drain periodically to prevent odors. It was not a urine odor. 2. All residents could be affected by this alleged deficiency. 3. Staff was in-serviced on 2/8/19 regarding answering call bells, preventing unnecessary odors, patient care rounds to ensure residents are clean and dry. The Housekeeping Supervisor will conduct environmental rounds and log any unusual occurrences of pervasive odors and report to the unit managers and address any housekeeping concerns. 4. The Housekeeping/Laundry Director will report to the management team on a daily basis if there are problems detected from the environmental rounds. The housekeeping weekend supervisor will conduct rounds and address with the supervisor concerns noted from the weekend and report to the Director. The DON/Designee and the Administrator will for compliance and report findings the QA Committee for 3 months.	3/3/19

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F 584	Continued From page 8 sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, and family, resident and staff interviews, the facility failed to maintain an environment that was free of odors. Findings include: During a family interview conducted on January 7, 2019 at 11:07 a.m., the family member of a resident stated that the hallways on the second floor always smell like urine. An interview with a resident who resided on the second floor was conducted on January 7, 2019 at 11:49 a.m. The resident stated that he keeps his door to the bathroom shut, because of the sewage odor. During an interview conducted on January 7, 2019 at 1:28 p.m. with another resident who resided on the second floor, a strong pervasive urine odor was detected in this resident's room and in the bathroom. During the survey from January 7 through 10, 2019, pervasive urine odors were frequently smelled in the hallways on the second floor. An environmental tour was conducted on January 10, 2019 at 12:30 p.m., with the maintenance director (staff #180) and the administrator (as of January 12/staff #222). At this time, there was still a slight sewage odor in the first resident's bathroom on the second floor. An interview was conducted with the maintenance director (staff #180) on January 10, 2019 at 12:40	F 584		

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F 584	Continued From page 9 p.m. Staff #180 stated that he would call a plumber to address the odor in the bathroom. An interview was conducted with staff #222 on January 10, 2019 at 12:45 p.m. Staff #222 stated that she thought she smelled urine yesterday, when the resident was being changed. The facility did not have policy regarding the prevention of odors throughout the facility.	F 584		
F 600 SS=E	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation 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 observation, clinical record reviews, staff and resident interviews, facility documents and policies and procedures, the facility failed to ensure that one resident (#225) with dementia and behaviors was free from neglect, failed to ensure that one resident (#61) was free from abuse by resident (#275), failed to ensure that one resident (#117) was free from abuse by	F 600		

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F 600	Continued From page 10 resident (#61), and that one resident (#21) was free from abuse by resident (#62). Findings include: -Resident #225 was admitted on July 22, 2015 and readmitted on April 16, 2018, with diagnoses that included dementia with behavioral disturbance, mental disorder due to known physiological condition, delusional disorder and altered mental status. Review of the clinical record revealed a written care plan initiated on July 11, 2016, with a revision date of April 16, 2018, which identified that the resident was an elopement risk/wanderer, related to escapist behavior and history of attempts to leave the facility unattended. A goal included the resident would not leave the facility unattended. Interventions included identifying a pattern of wandering and intervening as appropriate, monitoring the resident's location every 30 minutes and documenting wandering behavior. A quarterly MDS (Minimum Data Set) assessment dated January 25, 2018 included a BIMS (Brief Interview for Mental Status) score of 9, which indicated the resident had moderate cognitive impairment. The MDS also included the resident was delusional, had physical and verbal behavioral symptoms directed at others, refused care, wandered daily and had dementia and psychotic disorder. A nurse practitioner assessment dated February 2, 2018, revealed the resident had dementia, wandering, delirium, anxiety, adjustment disorder and depression. The assessment included the	F 600	The following actions have been taken for those noted to be affected by this alleged deficient practice: Resident # 225 discharged on 4/5/18 Resident # 275 discharged on 12/19/18 Resident #62 discharged on 2/7/19 The above residents did not return to the facility. Resident #117 was moved to another room on 9/30/18 to be further away from Resident #61. Residents were assigned different dining locations. Resident #117 was moved off the secured unit on 11/29/18 to unit C1, a separate behavioral unit. 2. All residents have the potential to be affected by this alleged deficiency. The Behavioral Health Nursing Director identified other residents to be affected through behavioral tracking. An audit was conducted for the Elopement Risk assessment to determine if there were other residents at risk for elopement and care plans update accordingly. 3. The facility conducted de-escalating techniques training to recognize the first signs of possible altercations on 4/10/18. Activities have been increased on the units. The facility hired a LCSW for Behavioral training and to address residents psychological needs. Reviewed staffing patterns to determine the needs of the unit. 4. The facility initiated a Behavioral Health Tracking log to analyze patterns of behaviors. that will enable the facility to identify residents at high risk for behaviors. This will be reviewed weekly with the Behavioral Health Team	3/3/19

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F 600	Continued From page 11 resident was residing on the behavioral unit "for safety" and received psychiatric services. The assessment also included the resident "desperately tries to escape if given the chance." She speaks Spanish mostly, but understands a lot of English. Under assessment and plan it included the following: wandering-provide a safe and nuturing environment. A nursing note dated March 17, 2018 at 6:34 a.m. included the resident had been exit seeking from the unit through the main locked door to the unit and also by a (locked) back door to the unit. A nursing note dated March 23, 2018 included the following: the resident had been exit seeking and had attempted to leave through the front door, and had struck a staff member when redirected back to the unit. A nursing note dated April 5, 2018 at 10:05 a.m. revealed the resident was discovered missing at 8:15 a.m. The note included the resident was not discovered in her room and that a "code yellow" had been initiated. Continued review of the closed record for resident #225 revealed that the resident did not return to the facility after she eloped. Review of the facility's investigative report dated April 5, 2018 revealed that on the morning of April 5, 2018, the resident had not reported for breakfast and the missing person procedures were immediately implemented. The investigation included the resident was able to leave the facility, obtain transportation, cross the border into Mexico, and after entering Mexico obtained transportation to a family home in Mexico, arriving	F 600	and presented at the monthly QAPI meetings ongoing.	

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unharmed. The report also included that the resident had been residing on a behavioral health (secured) unit, and that exit seeking and wandering behaviors were being monitored.

Continued review of the investigative report revealed a written staff statement obtained by a CNA (Certified Nursing Assistant/staff #222) dated April 5, 2018 at 2:45 p.m. The statement included that the resident was last seen in the resident dining room on April 4, 2018 between 8:30 p.m. and 9:00 p.m. The report further included that facility policies were not followed, as safety checks were missed.

An interview was conducted with the Administrator (staff #20) on January 7, 2019 at 10:15 a.m. The Administrator stated that it had been determined through the facility investigation that resident #225 had obtained an identification badge from a staff member (which the staff member thought had been misplaced) two weeks prior to her elopement from the facility, and had obtained money in small increments over time from her visitors, which enabled her to purchase bus fare. The Administrator also stated that the security camera footage, which had been examined during the investigation showed the resident had used a staff badge to open the exit door and then quickly exited the unit.

An interview was conducted on January 8, 2019 at 12:30 p.m. with a CNA (staff #97), who stated that she had been assigned to provide care to resident #225 on April 5, 2018 on the night shift (11:00 p.m. until 7:00 a.m.). She stated that when she arrived at 11:00 p.m., the previous CNA reported to her that all of the residents in her section were in bed, including resident #225 and

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that she observed the door to the resident's room was closed. Staff #97 stated that there were other residents in her section who were very ill and she was unable to check on resident #225, because she was busy caring for the residents who were ill. Staff #97 said the facility protocol was to check the residents every 15-30 minutes but not less than hourly, and that she did not check the resident that night. She stated that she assumed her co-worker (CNA/staff #49) who was assigned to another section was checking on all of the residents and assumed that resident #225 was in her room, because the door to her room was closed. She stated that she never actually saw the resident on her shift. She further stated that at approximately 2:00 a.m., she observed staff #49 enter the resident's room as he was passing water, and then exit the resident's room, and assumed that the resident was in her room. The CNA stated she was aware that the resident had a history of elopement attempts. The CNA also stated later that morning after it was discovered the resident was missing, staff #49 told her that although he entered the resident's room to pass ice water during the night shift, he did not see the resident in her room and did not know where she was.

During an interview conducted on January 8, 2019 at 12:35 p.m. with a CNA (staff #49), the CNA stated that he did not remember resident #225 and did not remember anything about a resident eloping from the facility.

An interview was conducted on January 8, 2019 at 1:15 p.m. with a LPN (Licensed Practical Nurse/staff #201). Staff #201 stated that she worked on the secured behavioral unit on the night shift on April 5, 2018. Staff #210 said that

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F 600	Continued From page 14 she did not see the resident on her shift and the door to the resident's room was closed all night. The nurse stated that she was aware that the resident had made frequent statements that she was going to leave the facility and go to Mexico where she owned a home. The facility was unable to provide a written policy regarding frequent resident safety checks on the behavioral unit. A policy and procedure titled, Recognizing Signs and Symptoms of Abuse/Neglect included the definition of neglect, as the failure to provide goods and services as necessary to avoid physical harm, mental anguish, or mental illness. The policy also listed signs of actual physical neglect that included inadequate provision of care and leaving someone unattended who needs supervision. Review of the Reporting Abuse policy revealed that all suspected violations or substantiated incidents of abuse/neglect will be immediately reported to the State licensing/certification agency. -Resident #61 was admitted to the facility on February 20, 2014, with diagnoses that included unspecified psychosis not due to a substance or known physiological condition, Parkinson's disease, and schizoaffective disorder. Review of a Nursing Note dated February 4, 2018 revealed "...Resident has had a few outbursts when there is an excessive amount of noise. Resident had three episodes of yelling out (using profanity) and two episodes of attempting to go down to the room of the resident who was yelling	F 600		

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out to shut him up. Staff was there to redirect resident immediately.

A Nursing Note dated May 3, 2018 revealed "Resident had several verbal outbursts during shift. Resident primarily has these outbursts when other residents are having an increase in behaviors by making loud noises and yelling..."

A Nursing Note dated May 21, 2018 revealed "Resident has episodes of yelling out when he is startled with other loud noises like other residents yelling or doors slamming..."

A quarterly MDS assessment dated August 6, 2018, revealed the resident had short-term and long-term memory problems and was severely impaired with daily decision making. The MDS also included the resident required extensive assistance with one staff assistance with activities of daily living.

A Behavior care plan dated August 20, 2018 revealed resident #61 has behavior problems (agitation, poor safety awareness, verbal aggression, repetitive statements, disruptive/intrusive, wandering, mood issues, pacing, exit seeking, refusal of care, disorganized thinking and physical aggression), related to psychosis, anxiety, mood disorder and status post traumatic brain injury as evidenced by physical aggression towards others. The goal included the resident will have fewer episodes of behaviors. Interventions were to administer medications as ordered; assist the resident to develop more appropriate methods of coping and interacting with other dementia residents; encourage the resident to express feelings appropriately and if reasonable, discuss the

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F 600	Continued From page 16 resident's behavior; explain/reinforce why behavior is inappropriate and/or unacceptable; intervene as necessary to protect the rights and safety of others; approach/speak in a calm manner; divert attention; remove from situation and take to alternate location as needed; monitor behavior episodes and attempt to determine underlying cause; and when resident is sitting next to other peers, ensure appropriate space to prevent physical aggression towards peers. Review of a Nursing Note dated September 30, 2018 revealed "...Resident began having a verbal altercation with another resident and he went up to the other resident and struck her in the face on the right cheek. The other resident retaliated and struck this resident on both arms. Both residents were immediately separated. No visible injuries noted to this resident..." Review of the annual MDS assessment dated November 1, 2018 revealed resident #61 had a BIMS (Brief Interview for Mental Status) score of 9, which indicated moderate impaired cognition. A Nursing Note dated November 16, 2018 revealed a CNA reported to this writer that resident #61 and resident #275 were swinging their arms with closed fists. Both residents were separated. Resident #61 stated that resident #275 hit him in the face. Reddened area noted to resident face. -Resident #275 was admitted to the facility on June 27, 2017, with diagnoses that included unspecified dementia with behavioral disturbance, schizophrenia, major depressive disorder and anxiety disorder.	F 600		

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F 600	Continued From page 17 Review of a Nursing Note dated May 17, 2018 revealed called into room by staff at 5:55 p.m., observed resident #275 laying in bed, and another resident was sitting on floor mat with blood on his face. The other resident was unable to explain what happened due to cognitive deficit. Resident #275 stated the resident woke him up and was messing with his bed and he "hit peer in the face..." A Nursing Note dated July 11, 2018 revealed that resident #275 "started hitting a resident from another room with a wire waste basket in the hallway. Resident #275 was upset that another resident was wearing his hoodie. Resident #275 has shown that he is very territorial and aggressive with male residents that might wander into his room, let's not forget that this is a unit where many of the residents suffer from dementia..." A Behavior care plan dated August 20, 2018 revealed that resident #275 has a history of initiating physical aggression. The goal was resident will not initiate aggression towards other residents. Resident should have a quiet area to stay in after dinner. He is sensitive to noise and busyness. Interventions to prevent the behaviors were to anticipate and prevent new incidents of violence towards another resident; provide snack, provide activities that promote non-aggressive interactions with other residents like one to one social activity; and provide activity so resident is not focused on busyness after meal times, as it is becoming evident he is not able to tolerate noise. Review of the quarterly MDS assessment dated November 6, 2018, revealed a BIMS score of 1, which indicated the resident had severe cognitive	F 600		

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F 600	Continued From page 18 impairment. A Nursing Note dated November 16, 2018 revealed this writer was notified by a CNA that resident #275 and resident #61 were swinging their arms with closed fists. Residents were quickly separated by CNA. Reddened area noted on resident #61's face. Further review of resident#275's clinical record revealed he had two more altercations with other residents on December 14 and 19, 2018 in which he was the aggressor. Resident #275 was discharged from the facility on December 19, 2018. An interview was conducted with a CNA who stated that the facility usually staffed three CNA's on this unit for 20-24 high acuity behavioral residents. The CNA stated that one CNA is supposed to monitor the hallway at all times to ensure that resident to resident altercations do not occur, but that doesn't always happen when staff call in. An interview was conducted with another CNA who stated that we are supposed to have someone monitor the hallway at all times, but that does not always happen. The CNA stated we do the best we can but if there is a call in we often do not have someone to monitor the hallway and that's when the residents get in to it. The CNA stated that resident #275 got into a lot of incidents with other residents and would laugh afterwards. The CNA stated that resident #61 does not like loud noises and doors slamming and that was usually when he got into altercations with other residents, because it upset him. The CNA stated that when resident #61 got upset he clapped his	F 600		

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F 600	Continued From page 19 hands and said "shhh" and that irritated a lot of residents. The CNA further stated that a lot of the resident to resident altercations usually occurred when the facility did not have someone to monitor the hallway. An interview was conducted with a LPN who stated that resident #61 runs up and down the hall and resident #275 is paranoid. The LPN stated that staffing was recently cut on this high acuity behavioral unit and that they do the best they can. An interview was conducted with the administrator (staff #20) on January 10, 2019 at 9:25 a.m. Staff #20 stated that there should be a monitor on the hallway at all times on that unit. -Resident #117 was admitted to the facility on January 27, 2017, with diagnoses that included schizophrenia, anxiety disorder and dementia with behavioral disturbance. A care plan revised on June 28, 2018, included the resident required a secured unit due to diagnoses of schizophrenia and dementia, behaviors of being non-compliant with care and attempts to provoke peers. Interventions included redirecting the resident when having behaviors. A quarterly MDS assessment dated September 17, 2018 revealed the resident had short-term and long-term memory problems and was moderately impaired with daily decision making. The assessment also included the resident required supervision with set up help only for most activities of daily living and utilized a walker. Review of the clinical record revealed multiple	F 600		

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F 600	Continued From page 20 nursing notes for September 2018 describing the resident as being verbally aggressive toward staff and laughing loudly at other residents. A nursing note dated September 30, 2018 revealed that at approximately 9:53 a.m., resident #117 began having a verbal altercation with another resident (#61), and the other resident struck resident #117 in the face on the right cheek. Resident #117 then struck resident #61 back, hitting him on the arms. Both residents were immediately separated. No visible injuries noted. Both residents will not be in the same dining hall as each other. Review of the facility's investigative documentation dated September 30, 2018, revealed that resident #117 was in the hallway by her room, which was across the hall from resident #61's room. Resident #117 began cursing in the hallway, as she has a history of this behavior. Resident #61 was sitting in his wheelchair in the doorway to his room and got up and confronted resident #117 in the hallway outside their rooms. They began yelling back and forth and before staff could intervene, resident #61 hit resident #117 and then resident #117 hit resident #61. The residents were separated and resident #117 was moved to another room. No injuries were noted. When resident #117 was asked about the incident, she stated "He hit me!" Per the report, a housekeeping staff (#135) witnessed the incident. She reported that resident #117 was cursing at her and resident #61 told resident #117 to be quiet. Resident #117 kept cursing, and then resident #61 got up, went to resident #117 and they both made contact with each other. A statement from a licensed practical nurse (LPN/staff #166) included that she did not witness	F 600		

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F 600	Continued From page 21 the incident but was at the nurses' station and heard resident #117 yelling that resident #61 hit her. She immediately went to the hallway and found resident #61 standing in front of resident #117 with his fists up. The residents were separated immediately. In an interview with staff #135 on January 9, 2019 at 9:32 a.m., she stated she had worked at the facility for over three years and is usually on the secured behavioral unit. She said that resident #117 is constantly being verbally aggressive and intimidates a lot of people. In an interview with a LPN (staff #148) on January 9, 2019 at 9:41 a.m., she stated that resident #61 usually hangs out in the hallway and is not one to instigate things. Staff #148 said he has a behavior of yelling out, which sometimes sets other residents off inadvertently, and he is easily triggered by noises. She stated when resident #117 used to be on her hall, her loud laughing and yelling would irritate resident #61. She stated staff tried to redirect resident #117 by asking her to stop or taking her to an activity or to a different area. In an interview with a LPN (staff #156) on January 9, 2019 at 9:49 a.m., he stated resident #117's behaviors include laughing out loud at random and yelling at others. He stated the other residents sometimes get agitated and they think resident #117 may be doing it on purpose. He stated sometimes she yells racial slurs and the other residents tell her to shut up. Additionally, he stated resident #117 is easily redirectable, but that does not work all the time. The LPN stated she is followed by the behavioral health team but for the most part, her behavior does not change.	F 600		

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F 600	Continued From page 22 An observation was conducted on January 9, 2018 at 10:35 a.m., during a resident smoke break. Resident #117 was observed to be laughing loudly and sticking her tongue out, which appeared to be directed at no one in particular. The staff present redirected the resident who then sat back down and continued to smoke her cigarette without further incident. In an interview with the administrator (staff #20) on January 10, 2019 at 1:17 p.m., he stated when he receives an allegation of a resident to resident altercation, he will get more information about what happened, report to appropriate parties and begin an investigation. -Resident #21 was admitted to the facility on January 18, 2018, with diagnoses that included schizophrenia, depression and Parkinson's disease. A quarterly Minimum Data Set (MDS) assessment dated 10/08/2018 included the resident had a BIMS score of 15, indicating no cognitive impairment. The MDS assessment also included the resident had verbal behavioral symptoms directed toward others. Review of the care plan regarding antipsychotic medication related to schizophrenia included the following interventions: when the resident becomes agitated intervene before agitation escalates; guide the resident away from the source of distress; engage calmly in conversation; and if the response is aggressive remove other residents from the area and approach later.	F 600		

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F 600	Continued From page 23 A nursing note dated 11/29/2018 revealed that at approximately 10:50 a.m., resident #21 was witnessed sitting towards the end of the hall in front of another resident's (#62) room. Resident #21 began to yell and curse in Spanish. Resident #62 approached the doorway and told resident #21 to "move." Both residents were yelling and swinging their arms at each other. The residents were immediately separated and redirected into opposite directions. No injuries noted at this time. -Resident #62 was admitted on November 06, 2015, with diagnoses that included schizophrenia, dementia and depression. A quarterly MDS assessment dated 11/01/2018 included a BIMS score of 15, which indicated the resident had no cognitive impairment. The MDS assessment also included the resident had verbal behavioral symptoms directed toward others. Review of the current behavior care plan revealed the resident had the potential to be physically aggressive and threatening toward other residents and staff. Interventions included for staff to escort the resident from room to destination and from destination to room, and keep him a safe distance from other residents. A nurse's note dated 11/29/2018 included that at approximately 10:50 a.m., resident #62 was witnessed standing in front of resident #21. Resident #21 was sitting in front of his doorway in a wheelchair and resident #62 told him to move. Resident #21 started to yell and curse at him in Spanish. Resident #62 then raised his left hand and with a closed fist, hit resident #21. Both residents were swinging their arms at each other. They were immediately separated and redirected	F 600		

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F 600	Continued From page 24 into opposite directions. No injuries were noted. Review of the facility's investigative report revealed that on November 29, 2018 at 10:50 a.m., resident #21 was sitting in his wheelchair in front of the door to resident #62's room. Resident #62 asked resident #21 to move, and angry words were exchanged. The residents struck out at each other and no injuries were noted. The report also included a witness statement from the housekeeper (staff #135) that she heard the residents arguing in front of resident #62's door who was telling resident #21 to move. The statement included that resident #21 hit resident #62 in the face and that both residents were hitting each other. The report revealed that resident #21 was unable to recall the incident and resident #62 reported that "He kept cussing at me and I told him to stop. I told him if he didn't stop I would hit him, and he didn't stop, so I hit him." During an interview conducted with resident #62 on 1/8/19 at 2:29 p.m., the resident stated that resident #21 was sitting in front of his door and that he asked him to leave. Resident #62 stated that the resident called his mother names in Spanish and that he hit him. During an interview conducted with resident #21 on 1/8/2019 at 2:43 p.m., the resident stated that resident #62 yelled at him and he yelled back. Resident #21 stated that resident #62 hit him and that he hit him back and that they punched each other until they were separated. An interview was conducted with a LPN (staff #148) on 1/09/19 at 10:01 a.m. The LPN stated that she heard yelling and saw the housekeeper separating resident #21 and resident #62. She	F 600		

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F 600	Continued From page 25 stated that she helped separate the residents and then assessed them for injuries. The LPN stated that both residents do occasionally yell and "blow off steam," but that resident #62 is often more verbal and physically threatening. Review of the facility's policy regarding Abuse Prevention Program revealed "Our residents have the right to be free from abuse, neglect..." Our facility is committed to protecting our residents from abuse by anyone including, but not necessarily limited to "staff and other residents..." The facility's policy regarding Unmanageable Residents revealed that each resident will be provided with a safe place of residence. The policy included that should a resident's behavior become abusive in any way that would jeopardize his or her safety or the safety of others, the Nurse Supervisor/Charge Nurse must immediately provide for the safety of all concerned. The policy also included unmanageable residents may not be retained by the facility. Review of a facility policy titled, "Resident-to-Resident Altercations" included that staff will monitor residents for aggressive/inappropriate behavior towards other residents. The policy included that all altercations, including those that may represent resident-to-resident abuse, shall be investigated and reported to the Administrator/Director of Nursing.	F 600		
F 607 SS=E	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that:	F 607		

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F 607	Continued From page 26 §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, facility documents and policy review, the facility failed to include in their Abuse policy that all alleged violations of abuse and neglect, must be reported to the State Survey Agency within two hours after the allegation is made, as manifested by an allegation of neglect for one resident (#225). Findings include: Resident #225 was admitted on July 22, 2015, with diagnoses that included dementia with behavioral disturbance, mental disorder due to known physiological condition, delusional disorder and altered mental status. A nursing note dated April 5, 2018 at 10:05 a.m. revealed the resident was discovered missing at 8:15 a.m. The note included the resident was not discovered in her room and that a "code yellow" had been initiated. Review of the facility's investigative report dated April 5, 2018 revealed that on the morning of April 5, 2018, it was determined that the resident had not reported for breakfast, so missing person	F 607	What corrective action will be accomplished for those residents found to have been affected by the alleged deficiency. 1. The facility Policy and Procedure for Abuse reporting has been updated to reflect the required reporting will be done within the two hour time frame. 2. All residents could be affected by this alleged deficiency. 3. The new administrator hired as of 1/11/19 will ensure all required reporting of abuse and neglect will be done within 2 hours by submitting the report on line to the Arizona Department of Health Services. 4. The Administrator will review all required incidents that should be reported at the QAA Committee on a monthly basis. This will be ongoing.	3/3/19

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F 607	Continued From page 27 procedures were immediately implemented. The report included the resident "was able to leave the facility" obtain transportation, cross the border into Mexico, and after entering Mexico obtained transportation to a family home, arriving unharmed. Continued review of the investigative report revealed that although the resident was discovered missing on April 5, 2018 at 8:30 a.m., the facility did not notify the State Survey Agency until 3:30 p.m. on April 5. An interview was conducted with the Administrator (staff #20) on January 8, 2019 at 2:46 p.m. The Administrator stated that the facility had two hours to report all allegations of abuse, including neglect to the State Agency. The Administrator also stated that he was unable to explain why the elopement of resident #225 was reported late to the State Agency. Review of the facility's policy and procedure titled, Reporting Abuse to State Agencies and other Entities/Individuals revealed that all suspected violations and all substantiated incidents of abuse will be immediately reported to appropriate state agencies and other entities as may be required by law. The policy included that should a suspected violation or substantiated incident of mistreatment, neglect or abuse be reported, the facility Administrator or his/her designee, will promptly notify the State licensing/certification agency. The verbal/written notice to agencies will be made within twenty-four hours of the occurrence (not two hours as required).	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4)	F 609		

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F 609	Continued From page 28 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, facility documents and policies and procedures, the facility failed to ensure that an allegation of neglect for one resident (#225) was reported to the State Survey Agency within two hours after the allegation. Findings include:	F 609	1. The facility hired a new administrator as of 1/11/19. The Administrator will process required reports with in the two hour time frame by submitting the report through the AZDHS portal. Policy will updated on 3/4/19 to reflect the correct reporting time 2. All residents have the potential to be affected by this alleged deficiency. 3. New Administrator hired effective 01/11/2019. The administrator will report all allegations of abuse or neglect in accordance with state and federal regulations to required agencies. The online portal with the Arizona Department of Health Services will be utilized for the day one report. 4. All incidents that are required to be reported to state and local agencies will be reviewed at the monthly QAPI meeting for three months.	3/3/19

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F 609	Continued From page 29	F 609		

Resident #225 was admitted on July 22, 2015, with diagnoses that included dementia with behavioral disturbance, mental disorder due to known physiological condition, delusional disorder and altered mental status.

A nursing note dated April 5, 2018 at 10:05 a.m. revealed the resident was discovered missing at 8:15 a.m. The note included the resident was not discovered in her room and that a "code yellow" had been initiated.

Review of the facility's investigative report dated April 5, 2018 revealed that on the morning of April 5, 2018, it was determined that the resident had not reported for breakfast, so missing person procedures were immediately implemented. The report included the resident "was able to leave the facility" obtain transportation, cross the border into Mexico, and after entering Mexico obtained transportation to a family home, arriving unharmed. The report also included that the resident had been residing on a behavioral health (secured) unit, and that exit seeking and wandering behaviors were being monitored.

Continued review of the facility investigative report revealed that although the resident was discovered missing on April 5, 2018 at 8:30 a.m., the facility did not notify the State Survey Agency until 3:30 p.m. on April 5.

An interview was conducted with the Administrator (staff #20) on January 8, 2019 at 2:46 p.m. The Administrator stated that the facility had two hours to report all allegations of abuse, including neglect to the State Agency. The Administrator also stated that he was unable to

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F 609	Continued From page 30 explain why the elopement of resident #225 was reported late to the State Agency. A facility's policy and procedure titled Recognizing Signs and Symptoms of Abuse/Neglect included a definition of neglect as the failure to provide goods and services as necessary to avoid physical harm, mental anguish, or mental illness. The policy also listed signs of actual physical neglect that included inadequate provision of care and leaving someone unattended who needs supervision. Review of the facility's policy and procedure titled, Reporting Abuse to State Agencies and other Entities/Individuals revealed that all suspected violations and all substantiated incidents of abuse will be immediately reported to appropriate state agencies and other entities as may be required by law. The policy included that should a suspected violation or substantiated incident of mistreatment, neglect or abuse be reported, the facility Administrator or his/her designee, will promptly notify the State licensing/certification agency. The verbal/written notice to agencies will be made within twenty-four hours of the occurrence (not two hours as required).	F 609		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a	F 623		

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F 623	Continued From page 31 representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is	F 623	What corrective action will be accomplished for those residents found to be affective by the deficient practice. 1 On 1/10/19, an updated discharged list was sent to the local Ombudsman for the month of December. 2. All residents discharged from the facility have the potential to be affected by this alleged deficiency. 3. The Business Office Manager will send a Monthly Admissions/Discharge report to the local Ombudsman by the 5th business day of the month via email. 4. The Business Office Manager will report the QAA Committee monthly for three months. The Administrator will monitor for compliance	3/3/19

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F 623	Continued From page 32 transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide	F 623		

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F 623	Continued From page 33 written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on clinical record reviews, staff interviews and review of policies and procedures, the facility failed to notify the State Long Term Care Ombudsman when one resident (#50) was transferred/discharged to the hospital on two separate occasions, and when one resident (#175) was discharged to home. Findings include: -Resident #50 was readmitted to the facility on October 26, 2018, with diagnoses that included acute respiratory failure with hypoxia, adult failure to thrive and a pressure ulcer in sacral region. A progress note dated July 26, 2018 revealed the resident was sent to the emergency room, due to difficulty breathing. A progress note dated July 29, 2018 revealed the resident was readmitted to the facility. Review of a quarterly MDS (Minimum Data Set) assessment dated October 31, 2018, revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. A progress note dated October 23, 2018 revealed that the resident was admitted to Banner South Hospital Intensive Care Unit. Another progress	F 623		

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F 623	Continued From page 34 note dated October 26, 2018 revealed that the resident was readmitted to the facility. However, there was no documentation that the State Long Term Care Ombudsman was sent a copy of the notice of discharges for each hospitalization. An interview was conducted with a licensed practical nurse (LPN/staff #150) on January 8, 2019 at 1:08 p.m., who stated that when she gets a patient ready to be transferred, she does not notify the Ombudsman and said the case manager (#190) completes the paperwork when a patient is being discharged. An interview was conducted on January 8, 2019 at 1:19 p.m. with case manager (staff #190), who stated that she completes the paperwork when a resident is being discharged and staff #193 notifies the Ombudsman about the discharge. Staff #193 was interviewed on January 8, 2019 at 2:42 p.m. He stated that the facility had a meeting last fall to talk about a better way to make sure the Ombudsman is notified. He said that he called the Ombudsman and asked if he could notify her by email, when a resident is discharged. He said that she told him that she doesn't want to be notified, because they don't need the information and they are being inundated with notifications. He said that Social Services was handling the notifications at that time. An interview was conducted on January 8, 2019 at 3:06 p.m. with the Director of Social Services (staff #204), who stated that there was a meeting with the Ombudsman on August 6, 2018,	F 623		

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F 623	Continued From page 35 because she wanted to verify the process for notifying the Ombudsman when a resident is discharged. She said the Ombudsman didn't want to be notified when a resident is discharged. She acknowledged that the facility has not been notifying the Ombudsman when a resident is discharged and stated that she will be notifying the Ombudsman in writing on a monthly basis from this point forward. -Resident #175 was admitted to the facility on October 1, 2018, with a diagnosis of shortness of breath. Review of the discharge care plan initiated on October 4, 2018 revealed resident #175 was to discharge to her previous residence an assisted living facility, after skilled nursing services were completed. A physician's order dated October 9, 2018 indicated the resident may be discharged on October 13, 2018, with physical therapy home health. A review of the Minimum Data Set (MDS) assessment discharge/return not anticipated dated October 13, 2018, revealed the resident was discharged to the community. Review of the clinical record revealed there was no documentation that the State long term care ombudsman had been sent a copy of the notice of discharge. An interview was conducted with the Director of Social Services (staff #204) on January 9, 2019 at 9:21 AM. She stated the facility has not been notifying the ombudsman when a resident is	F 623		

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

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F 623	Continued From page 36 discharged. She stated that she is aware that the facility is responsible for notifications, but the ombudsman did not want to be notified of discharges. An interview with the Director of Nursing (DON/staff #125) was conducted on January 10, 2019 at 11:04 AM. The DON stated that she had been told the ombudsman did not want to be notified of discharges, but that the facility must notify her anyway. She stated the facility will be sending a list of discharges to the ombudsman at the end of every month. Review of a facility policy regarding Transfer or Discharge Notice revealed the resident an/or representative will be notified of an impending transfer or discharge from the facility as soon as it is practicable but before the transfer or discharge, when the transfer is necessary for the resident's welfare and the resident's needs cannot be met in the facility or when an immediate transfer or discharge is required by the resident's urgent medical needs. The policy also stated that a copy of the discharge notice will be sent to the Office of the State Long-Term Care Ombudsman.	F 623		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews, and the Resident Assessment Instrument (RAI) manual, the facility failed to ensure a Minimum	F 641		

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F 641	Continued From page 37 Data Set (MDS) assessment was accurate regarding antibiotic use and refusal of care for one resident (#62). Findings include: Resident #62 was admitted on November 06, 2015, with diagnoses that included schizophrenia, hypertension, dementia, and depression. Review of the physician's orders revealed the following: -Bactrim 400-80 milligrams (mg) by mouth once a day by mouth for prophylaxis for chronic UTI dated October 16, 2018 -Ipratropium Bromide HFA aerosol solution 17 micrograms (mcg) one puff orally every 6 hours for COPD (chronic obstructive pulmonary disease) dated August 24, 2018 -Metoprolol 25 mg by mouth once a day for hypertension dated August 25, 2018 -Levothyroxine 75 mcg by mouth once a day for hypothyroidism dated August 25, 2018. A review of the MAR for October 2018 revealed that the resident was administered Bactrim from October 16-31. The MAR also revealed the resident refused Ipratropium Bromide from October 27- 31 multiple times, refused Metoprolol on October 27, 28, and 29, and refused Levothyroxine on October 27 and 30. However, review of the quarterly MDS assessment dated November 1, 2018, revealed the resident did not receive an antibiotic and displayed no refusal of care during the 7 day look-back period. The MDS assessment also included a Brief Interview for Mental Status score	F 641	What corrective action will be accomplished for those residents found to be affected by this deficient practice: 1. Resident #62 medical records and MDS were reassessed. A modification was submitted to CMS with correct information by 2/24/19. 2. An audit of 25% of all residents on antibiotics will have their MDS reevaluated for accuracy and coding. 3. The MDS Director in-serviced the Coordinator on accurately completing the MDS on 2/25/19. The MDS Director will audit a random sample of MDS for antibiotics on a monthly basis for three months. The MDS Director will monitor for compliance and report to QA for three months.	3/3/19

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F 641	Continued From page 38	F 641		

of 15 which indicated the resident had no cognitive impairment and that the resident displayed verbal behaviors directed towards others.

An interview was conducted with a MDS Coordinator (staff #182) on 01/09/19 at 11:31 AM. Staff #182 stated that information obtained from the nurses' notes and the medication records are used to code a MDS assessment. She also stated that information is obtained from speaking with the residents and the staff. She acknowledged that the quarterly MDS assessment dated November 1, 2018 was an error in documentation regarding refusal of care.

During an interview conducted with the Director of Nursing (DON/staff #125) on 01/09/19 at 11:44 AM., the DON stated that her expectation is that the MDS assessments are accurate, and that incorrect information on the MDS assessment is not acceptable.

An interview was conducted with a MDS Coordinator (staff #181) on 01/10/19 at 01:18 PM. She stated that her hand written notes for November included the resident was on antibiotics through the end of October 2018. She agreed that the MDS assessment was marked incorrectly and stated that it was an oversight.

The RAI manual for the MDS assessment states that the importance of accurately completing and submitting the MDS assessment cannot be over emphasized. The manual also included that the MDS assessment is the basis for the development of an individualized care plan. The RAI manual instructs to review the clinical record for documentation regarding any antibiotics that

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F 641	Continued From page 39 were received by the resident during the 7 day look-back period and record the number of days it was received. The RAI manual also instructs to review the clinical record and interview staff for any refusal of care (e.g. taking medications) during the 7 day look-back period and code the behavior if it occurred.	F 641		
F 645 SS=E	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of	F 645		

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F 645	Continued From page 40 services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews,	F 645		

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F 645	Continued From page 41 and review of facility policies and procedures, the facility failed to ensure one resident (#61) was referred to the appropriate state-designated authority for Level II PASARR (pre-admission screening and resident review) evaluation and determination. Findings include: Resident #61 was admitted to the facility on February 20, 2014 with diagnoses that included unspecified psychosis not due to a substance or known physiological condition, Parkinson's disease, and schizoaffective disorder. Review of the resident's clinical record revealed a Level I PASARR dated June 4, 2015 which revealed the resident had a primary diagnosis of a serious mental illness (SMI) and required a referral for a Level II determination for mental illness. Further review of the clinical record revealed no evidence that the facility referred the resident to the appropriate state-designated authority for a Level II PASARR. An interview was conducted with a social worker (staff #203) on January 9, 2019 at 9:00 a.m. Staff #203 stated that if a resident had a primary diagnoses of a SMI that a referral for a Level II PASARR should be done. Staff #203 stated that she was unsure if a referral for a Level II PASARR was completed for this resident. An interview was conducted with another social worker (staff #204) on January 9, 2019 at 10:26 a.m. Staff #204 stated that the facility did an audit about a month ago and the resident qualified for a	F 645	1. For Resident #61 a Level II screening was obtained on 1/10/19 2. All residents who need a Level II screening could be affected by this alleged deficiency. 3. The facility conducted an in-service on 2/4/19 regarding the process for Level II PASAAR for all Social Services staff. This in-service will repeat on 2/28/19 and include the nurse managers, Admission Department,Medical Records and the MDS Director. The Social Services Director will review all new admissions to determine if a Level II screening is needed. The Behavioral Health Program Director will review the PASAAR during the admission process to ensure the appropriate Level II referral. 4. A tracking log was developed to ensure that if a Level II is needed and it has been submitted correctly and timely. This will monitored by the Behavioral Health Program Director and the Administrator. Results submitted monthly to the QAA Committee.	3/3/19

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SAPPHIRE OF TUCSON NURSING AND REHAB, LLC	2900 EAST MILBER STREET TUCSON, AZ 85714

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F 645	Continued From page 42 referral for a Level II PASARR. Staff #204 stated that the referral was not completed yet. Review of the facility's policy Admission Criteria revealed "...Nursing and medical needs of individuals with mental disorders or intellectual disabilities will be determined by coordination with the Medicaid Pre-Admission Screening and Resident Review program (PASARR) to the extent possible..."	F 645		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the	F 657		

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F 657	Continued From page 43 comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, and policy and procedure, the facility failed to ensure a care plan was revised for one resident (#74). Findings include: Resident #74 was admitted to the facility on December 7, 2017 with diagnoses that included multiple sclerosis and quadriplegia. A physician's order dated July 23, 2018, revealed the order to apply splints to both arms at night at bedtime and take off in the morning to prevent contractures was discontinued. The quarterly Minimum Data Set (MDS) assessment dated November 8, 2018 revealed the resident was cognitively intact and required extensive/total assist with activities of daily living (ADLS). Review of the care plan for mobility dated November 24,-2018 revealed the resident had limited physical mobility related to current co-morbidities including multiple sclerosis (MS). Interventions included applying splints to both arms at night and removing in the morning. Further review of the care plan revealed it was not revised to reflect the splints had been discontinued. An interview was conducted with the Assistant Director of Nursing (ADON/staff #21) on January	F 657	1.	

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F 657	Continued From page 44 9, 2019 at 3:46 PM. Staff #21 stated the resident's splints had been discontinued. She stated that she did not know why the care plan had not been updated. The ADON stated all departments are responsible for updating the care plan, including nursing. She said the nursing management meets every morning to discuss residents' care plans, change of condition, etc. An interview was conducted with the Director of Nursing (DON/staff #125) on January 10, 2019 at 9:29 AM. The DON stated anything in the care plan related to nursing is updated daily. She said they have an interdisciplinary team (IDT) meeting every morning. She stated they are good at adding to the care plan but need to get better at discontinuing things. The DON said the splints should have been resolved in the care plan. Review of the facility's policy titled "Care Plans - Comprehensive" revealed assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change.	F 657	1. The Care Plan for Resident #74 has been updated to reflect the discontinuance of the splints on 2/24/19. The resident care plan is scheduled for review on 2/28/19. 2. Residents with adaptive equipment have the potential to be affected by this practice. 3. The IDT team will review new orders from the previous 24 hours and on Monday from the weekends and update care plans when change of condition occur. Education will be provided to the IDT on 2/25/2019 to ensure understanding and compliance. 4. The DON/Designee will monitor for compliance and report to the QAA Committee for three months.	3/3/19
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and	F 689		

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F 689	Continued From page 45 review of policies and procedures, the facility failed to ensure that a public restroom accessible to residents was free from accident hazards. Findings include: During an observation conducted on January 7, 2019 at 10:30 a.m., two unlocked restrooms were observed near the front entrance of the facility. When the door to restroom #1 was opened and released, the door rapidly slammed shut causing a potential accident hazard to residents who may use the restroom. Multiple residents passed by this area to go to the front lobby and to go outside of the facility. An interview was conducted with a receptionist (staff #191) on January 8, 2019 at 9:25 a.m. Staff #191 stated that they asked the residents not to use the public restrooms but that some of them go in there anyway. Staff #191 stated that the residents probably use the public restrooms at night when no one is at the receptionist desk. Staff #191 further stated the public bathroom doors used to be locked. Additional observations conducted on January 8, 9, and 10, 2019 revealed the area near the public restrooms and front lobby continued to be a high traffic area with residents going to the front lobby or out of the facility. An interview was conducted with another receptionist (staff #194) on January 10, 2019 at 11:00 a.m. Staff #194 stated that the residents were asked to not use the public restrooms. Staff #194 further stated the doors used to be locked. An interview was conducted with the managing	F 689	1. On January 10, 2019 the door closure for Restroom #1 was repaired to prevent the door from slamming shut. The locks to both restrooms were changed to require a key from the receptionist in order to enter the restroom. This was effective 1/10/2019. 2. All residents who enter the lobby area and request a restroom could be affected. 3. The Maintenance Director will ensure the doors to the restroom are in working, safe condition. The receptionist will report any concerns to the Maintenance Director. 4. The Maintenance Director will include door operations as part of his preventive maintenance program. The Administrator shall monitor for compliance and report to QAPI for three months.	3/3/19

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F 689	Continued From page 46 partner of the facility (staff #220) on January 10, 2019 at 12:35 p.m. Staff #220 stated that the facility will be repairing the door today so that it does not slam shut. Review of the facility's policy Safety and Supervision of Residents revealed "Our facility strives to make the environment as free from accident hazards as possible". The policy included resident safety and supervision and assistance to prevent accidents are facility-wide priorities.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews and policy and procedures, the facility failed to ensure one resident (#50) was provided respiratory care consistent with the physician's order. Findings include: Resident #50 was readmitted to the facility on October 26, 2018, with diagnoses that included acute respiratory failure with hypoxia, adult failure to thrive and paraplegia.	F 695	1. The Policy and Procedure for Oxygen Administration was updated on 2/26/19 to include weekly tube change and date. 2. Residents who receive oxygen could be affected by this alleged deficiency. The facility will audit all residents with oxygen orders to ensure that the orders reflect the policy change with the correct oxygen order and tubing change order. 3. Admission orders will be updated to include tube change and date. Nurse management audit of all new admissions will include reviewing all residents with oxygen orders to ensure accuracy. 4. The DON/Designee will monitor for compliance and report to QAA for three months.	3/3/19

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F 695	Continued From page 47 Review of the current summary of physician's orders revealed an order for oxygen continuously at 2 liters per minute via nasal cannula dated October 26, 2018 and an order to change the oxygen tubing every Wednesday on the night shift dated January 10, 2019. Review of the quarterly MDS (Minimum Data Set) assessment dated October 31, 2018 revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. The assessment also included the resident was receiving oxygen therapy. The current care plan revealed the resident had altered respiratory status related to respiratory failure with hypoxia. The interventions included administering medication/puffers as ordered and monitoring for effectiveness and side effects and monitoring/documenting/reporting abnormal breathing patterns to the physician. During an interview conducted with the resident on January 7, 2019 at 3:23 p.m., the oxygen concentrator was observed to be set at 2.5 liters, however, the resident did not have on the nasal cannula, as it was lying on the resident's tray. Observation of the tubing revealed no date when the tubing had been changed. On January 9, 2019 at 12:28 p.m., the resident was observed sleeping in his wheelchair with the oxygen tubing on and the concentrator was set at 2.5 liters. The tubing was not observed to have a date to reflect when the tubing had been last changed. An interview was conducted with a certified	F 695		

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F 695	Continued From page 48 nursing assistant (CNA/staff #58) on January 10, 2019 at 9:14 a.m., who stated that the CNA's on the overnight shift change the tubing on the oxygen concentrators every Sunday, and tape the date on the tubing to show when the tubing was changed. She stated that if there is no date on the tubing or if the date indicates that it is overdue, she changes the tubing. After observing the oxygen tubing, she confirmed that there was no date on the resident's tubing or anywhere on the oxygen machine. She also confirmed that the level of oxygen was set at 2.5 liters per minute. An interview was conducted on January 10, 2019 at 9:22 a.m. with a licensed practical nurse (LPN/staff #159), who stated that the CNA's on the night shift change and date the oxygen tubing every Sunday and document the tubing was changed in the computer in the task section. She stated that if she did not see a date on the tubing, she would change the tubing. She also stated that it is the nurse's responsibility to monitor the amount of oxygen received per a minute. After reviewing the orders, she stated the order is for oxygen at 2 liters. Review of the resident's electronic record including in the task section, revealed there was no documentation that the tubing was changed in November and December 2018. During an interview conducted with the Director of Nursing (DON/staff #125) on January 10, 2019 at 11:05 a.m., she stated the expectation is that the oxygen tubing is to be changed by the CNA's on the night shift every Sunday. The facility's policy regarding "Oxygen Administration" included the following:	F 695		

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F 695	Continued From page 49 -The purpose of this procedure is to provide guidelines for safe oxygen administration. -Verify that there is a physician's order for this procedure. -Review the physician's order or facility protocol for oxygen administration. The policy did not address a process for monitoring when oxygen equipment is to be changed.	F 695		
F 698 SS=E	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews, and policy review, the facility failed to ensure physician orders were in place for one resident (#151) regarding dialysis. Findings include: Resident #151 was admitted to the facility on November 16, 2018 with diagnoses that included end stage renal disease, sepsis, and bacteremia. An admission Minimum Data Set (MDS) assessment dated November 23, 2018 included the resident had short-term and long-term memory problems and had severe impairment with daily decision making. The MDS assessment	F 698	1. Physician order for dialysis was obtained on 1/10/19. 2. All residents who receive dialysis could be affected by this alleged deficiency. An audit was conducted on 2/27/19 for all residents receiving dialysis to ensure orders are in place.100% audited had the correct orders. 3. The admission audit process will identify residents needing dialysis to ensure there are current physician orders. 4. The DON/Designee will monitor for compliance and report to the QAA Committee for three months.	3/3/19

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F 698	Continued From page 50 also included the resident was receiving dialysis. A nursing note dated November 23, 2018 revealed the resident had a right sided vascular catheter. Review of the clinical record revealed the resident went out to dialysis appointments on several occasions in November and December 2018 and January 2019. A care plan dated December 21, 2018 included the resident needs dialysis related to end stage renal disease. Interventions included checking and changing the dressing daily at access site and document. However, review of the clinical record revealed no evidence that there was a physician's order for dialysis treatments, to monitor the dialysis site, or to check and change the access site dressing daily. In an interview with a licensed practical nurse (LPN/staff #165) on January 10, 2019 at 10:31 a.m., he stated that for a resident receiving dialysis, there should be an order for the dialysis treatment to include the days for dialysis and an order to monitor the dialysis site. He stated that if the resident has a port site then it should be monitored every day for bleeding. The nurse reviewed resident #151's electronic record and was unable to locate an order for the resident's dialysis treatment. During an interview conducted with the LPN (staff #153) caring for this resident on January 10, 2019 at 10:38 a.m., she stated the resident was currently at the dialysis center. She stated she	F 698		

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F 698 Continued From page 51

knows when the resident is scheduled for dialysis based on an appointment log that is reviewed every day and her report sheet that has the dialysis days and time. The LPN also stated that when the resident returns from dialysis an assessment is done which includes checking the site. She stated the site should be assessed and documented every shift, and that there should be an order to monitor the site.

In an interview with the Director of Nursing (DON/staff #125) on January 10, 2019 at 10:43 a.m., she stated there should be a physician's order in place for dialysis treatments which includes the location, day and time. She also stated there should be an order to monitor the resident's dialysis site, whether it is a fistula or a port.

Review of the facility's policy titled "Hemodialysis Access Care" did not include physician's orders regarding a resident receiving dialysis treatment. Per the DON, there was no other policy specific to dialysis.

F 725 SS=E

Sufficient Nursing Staff
CFR(s): 483.35(a)(1)(2)

§483.35(a) Sufficient Staff.
The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required

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F 725	Continued From page 52 at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, facility documentation and policies and procedures, the facility failed to have sufficient nursing staff to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. Findings include: Multiple resident interviews were conducted on January 7, 2018 regarding facility staffing. Ten random residents stated that there was not enough staff and that they have to wait too long for staff assistance and for their call lights to be answered. An interview was conducted with a CNA (certified nursing assistant). The CNA stated that the A-1 unit for high acuity behavioral residents was usually staffed with 3 CNA's to care for 20-24	F 725	1. The facility updated the call-in policy to reflect a more structured procedure for those who call in resulting in staff shortages. This policy was presented to staff on 2/22/19. There has been an increase in the hiring of C.N.A.'s and nurses to fill open positions. This will reduce the number of outside agency usage resulting in better and consistent patient care. The staffing patterns were reviewed to reflect a need for increased staffing on the Behavioral Unit. 2. All residents could be affected by this alleged deficiency. 3. The Resident Council Minutes are reviewed by the Administrator and monitored to ensure a response and action plan will be addressed for all concerns. An additional Guest Services Coordinator has been hired as of 3/1/19 to also address resident concerns and assist with any grievances. 4. The Administrator will monitor for compliance and report to the QAA Committee for three months.	3/3/19

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F 725	Continued From page 53 residents. The CNA stated that one CNA is supposed to be in the hall at all times to monitor to prevent resident to resident altercations, but that does not always happen because of call ins. An interview was conducted with another CNA, who stated that someone is always supposed to be monitoring the hallway on the A-1 unit, but that does not always happen and it's kind of irritating. The CNA stated we do the best we can, but if there is a call in there is no one to monitor the hallway and the residents get in to altercations. An interview was conducted with another CNA who stated that it is challenging to care for the residents when there are call ins. An interview was conducted with a fourth CNA, who stated that sometimes it is hard to care for the residents when there are call ins. An interview was conducted with another CNA, who stated that care and showers do not get done when there is not enough staff. The CNA further explained that care gets done but not like it should and showers get missed. An interview was conducted with another CNA, who stated that the facility attempts to staff adequately, but some days they are short. An interview was conducted with a seventh CNA, who stated that they used to have four CNA's for this hallway and now they have three. The CNA stated that it was hard to monitor the hallway, because most of the residents on this hallway require two staff to provide care. An interview was conducted with another CNA,	F 725		

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F 725	Continued From page 54	F 725		

who stated that she thought the afternoon shift could use more staff especially on the weekends. The CNA stated that they used to have a hall monitor, but do not anymore.

An interview was conducted with a CNA, who stated that sometimes they only have two CNA's on 2nd shift for this hallway and it's hard because most of the residents on this hallway require two staff to provide care. The CNA stated that the facility is trying to staff adequately because they are now using agency staff.

An interview was conducted with a LPN (licensed practical nurse). The LPN stated they could use more staff. The LPN stated that when they are short, I do not focus on my medications or paperwork and help the CNAs.

An interview was conducted with another LPN, who stated that they used to have enough staff, but when the new management company took over they cut staff. The LPN stated we do the best we can. The LPN further stated that there are more CNAs scheduled today, because the surveyors are here for the annual survey.

Review of the Resident Council Minutes from February 2018 through December 2018 revealed the following concerns from residents:

-February 26: "Not enough staff all shifts."
-May 8: "The residents are concerned with ratio of staff and residents. The lights are not being answered promptly."
-July 9: "Many say there's not enough staff (pending concern already)."
-August 30: "Residents are concerned with lights not being answered promptly. Concerns with 7:00

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SAPPHIRE OF TUCSON NURSING AND REHAB, LLC	2900 EAST MILBER STREET TUCSON, AZ 85714

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F 725	Continued From page 55	F 725		

a.m. - 3:00 p.m. B2 (long term care unit)."
-September 13: "Residents feel like they lack staff."
-October 12: "Call lights are not answered quick and residents and family are waiting more than 15 minutes on B2."
-November 8: "Overworked and understaffed was stated by one resident. B2 (all shifts). CNA's do a very good job but most are exhausted."
-December 6: "B2 resident stated there have been 2 CNA's to 30 patients and needs are not being met. Residents stated staffing issues for the dining room have happened three times this week. Residents need help with feeding and passing food."

According to the resident council meeting documentation, a meeting was held on January 9, 2019 at 2:10 p.m., with six residents. Per the documentation, four of the six residents stated that there was not enough staff and that they had to wait extended periods of time for staff assistance.

On the last page of the Resident Council Minutes for the above months was a section titled, "Interventions to be implemented" however, each month this section was blank.

An interview was conducted with the activity director (staff #2) on January 9, 2019 at 2:45 p.m. Staff #2 stated that she has been the activity director since April 2018, and that she took the minutes for the resident council meeting. Staff #2 stated that she gave the staffing concerns to nursing and they are supposed to respond to the residents' concerns so that we could let the resident council know. Staff #2 stated that she had not received responses from nursing yet

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F 725	Continued From page 56 regarding staffing. An interview was conducted with the administrator (staff #20) on January 10, 2019 at 9:25 a.m. Staff #20 stated that there should be a monitor in the hallways of the A1 and B1 units. Staff #20 stated that the facility is aware of the residents concerns regarding staffing. An interview was conducted with the managing partner of the facility (staff #220) on January 10, 2018 at 10:40 a.m. Staff #220 stated that different units have different staffing needs. Staff #220 stated the facility has never had a resident to resident altercation that resulted in a serious injury, because of staffing. Staff #220 stated that ratio wise, there was enough staff and the concern could be the accountability of the staff. Staff #220 stated that he was not aware of the residents and staff concerns regarding staffing. Review of the facility's policy regarding Staffing revealed, "Our facility provides sufficient numbers of staff with the skill and competency necessary to provide care and services for all residents in accordance with resident care plans and the facility assessment...Inquiries or concerns relative to our facility's staffing should be directed to the Administrator or his/her designee."	F 725		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:	F 758		

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F 758	Continued From page 57 (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or	F 758	The following actions have been taken for those residents noted to be affected by this alleged deficient practice. 1. Resident #135 was discharged on 12/26/18. 2. All residents could be affected by this alleged deficiency. The Behavioral Health nurse manager conducted an audit between 1/28/19-2/1/19 to determine correct diagnosis for use of psychotropic drugs. 3. The Behavioral Health nurse manager will conduct ongoing random audits on orders for psychotropic medications for the correct diagnosis. For all new admissions the orders will be reviewed by nurse managers to check for appropriate diagnosis. All other orders for in-house residents will be reviewed at daily clinical meeting. 4. The DON/Designee will monitor for compliance and report any issues to the QAA Committee for three months.	3/3/19

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F 758	Continued From page 58 prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on closed clinical record review, staff interviews, and policies and procedures, the facility failed to ensure that one resident (#135) who was prescribed an antipsychotic medication upon admission, had indications for its use. Findings include: Resident #135 was admitted on November 7, 2018 with diagnoses that included Alzheimer's disease, toxic encephalopathy, and major depressive disorder. The resident was discharged December 26, 2018. Review of hospital records prior to the resident's admission, revealed a H&P (History and Physical) report dated November 5, 2018 that the resident had a significant history of Alzheimer's dementia and traumatic brain injury and was cooperative with normal mood and cognition. The hospital H&P included a list of medications that the resident was receiving in the hospital. The list did not include the Risperidone (antipsychotic) or any other antipsychotic medication. Continued review of the hospital records revealed a discharge summary dated November 7, 2018 that included an order for the resident to receive Risperidone 0.5 mg (milligram) tablet every 12 hours upon transfer to the facility. The discharge summary included the diagnoses dementia and depression but did not include a diagnosis of psychosis. Review of the closed clinical record revealed a	F 758		

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F 758	Continued From page 59 physician's order dated November 7, 2018 for Risperidone 0.5 mg tablet two times daily for dementia. The Medication Administration Record for November 2018 revealed the resident was administered Risperidone as ordered. A discharge MDS (Minimum Data Set) assessment dated December 26, 2018 included a BIMS (Brief Interview for Mental Status) score of 11 which indicated the resident had moderately impaired cognition. The assessment included the resident felt tired, depressed, had difficulty sleeping, and verbal behaviors directed at others. The assessment also included the resident received antipsychotic medications. However, the assessment did not include the resident had a psychiatric mood disorder. Further review of the closed record did not reveal any additional documented evidence that the diagnosis of dementia for the use of the antipsychotic medication Risperidone had been clarified. An interview was conducted on January 10, 2019 at 9:17 a.m. with the Director of Nursing (DON/staff #125). The Director stated that a diagnosis is needed to support the use of specific medications and that if the physician prescribes a medication for which the resident does not have a diagnosis, the nurse is to question the doctor about the diagnosis. The DON stated that when a resident is admitted from the hospital, the medications that are prescribed must verify with the physician by the nurse. The DON stated that an antipsychotic drug cannot be prescribed for dementia unless there is a diagnosis to support	F 758		

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F 758	Continued From page 60 the use of the antipsychotic drug. The DON further stated that the use of the antipsychotic drug for resident #135 should have been clarified with the physician. During an interview conducted on January 10, 2019 at 9:35 a.m. with a RN (Registered Nurse/staff #165), the nurse stated that if a diagnosis is inappropriate for an ordered medication, the nurse would bring it to the physician's attention. The facility's policy and procedure titled Antipsychotic Medication Use included a policy statement that antipsychotic medications may be considered for residents with dementia but only after medical, physical, functional, psychological, emotional psychiatric, social and environmental causes of behavioral symptoms have been identified and addressed. The policy included residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective.	F 758		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §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.	F 842		

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F 842	Continued From page 61 §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. §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	F 842	The facility does have a policy that allows access to all electronic medical records. The current owners of this facility took over August 2018. During the certification survey conducted 1/7-1/10 the facility made multiple attempts to obtain the electronic medical records for Resident #225 from the previous owners. The previous owners (Avalon) would not send electronically to PCC (Point Click Care) but did send through email therefore allowing Sapphire of Tucson to print the medical record for the survey team. 2. The residents who are affected by this alleged deficiency would be discharged residents that were under the control of the previous owners. 3. If there are future request for medical records under the control of the previous owners, this facility will make every effort to obtain the records for all entities and agencies that request them. 4. The Administrator will monitor and be the point person for this issue	3/3/19

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F 842	Continued From page 62 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 record review, staff interviews and policies and procedures, the facility failed to ensure that electronic and paper health records for one resident (#225) were readily accessible to the State Survey Team. Findings include: Resident #225 was admitted on July 22, 2015 with diagnoses that included dementia with behavioral disturbance, mental disorder due to known physiological condition, delusional disorder, and altered mental status. Resident #225 was discharged on April 5, 2018. During random reviews of the facility electronic records conducted on January 7, 2019 it was revealed the electronic health records for resident #225 were not accessible in the data base provided by the facility. An interview was conducted with the administrator (staff #20) on January 7, 2019 at	F 842		

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

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F 842	Continued From page 63 10:15 a.m. The administrator stated that the facility did not have access to electronic records for resident #225, and that access to those records had been removed by the previous owner of the facility when the facility was purchased by the current owner in August 2018. The Administrator stated that he would notify the previous owner that access to the records was needed, and that the facility staff were aware that they were supposed to have access to all electronic health records for resident #225. An interview was conducted with a corporate staff member (staff #220) on January 7, 2019 at 1:45 p.m. Staff #220 stated that he was aware of the requirement that access to medical records was to be maintained for 7 years. Staff #220 also stated that staff were in communication with the previous owners of the facility to obtain access to the health records for resident #225. An interview was conducted on January 8, 2019 at 8:30 a.m. with medical records (staff #184). Staff #184 stated that the paper records and electronic health records for resident #225 were not accessible, because the records had been removed by the previous owner of the facility. Staff #184 stated that the previous owner was scanning records to the facility. She stated that the process of uploading the documents would take hours and that the documents would be printed after the upload. Staff #184 stated that she did not know whether or not the records for resident #225 were being pre-screened by the previous owner prior to being uploaded. During an interview conducted with the administrator on January 8, 2019 at 9:24 a.m., the administrator stated that they were unable to	F 842		

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F 842	Continued From page 64 obtain access to electronic health records from the previous owner of the facility. In a follow-up interview with staff #184 conducted on January 8, 2019 at 2:08 p.m., the staff #184 provided a stack of printed paper records for resident #225 and stated that there would be no access to electronic health records for resident #225. Review of the facility's policy and procedure titled Electronic Medical Records included a statement that authorized Federal and State survey agents as outlined in current regulations may be granted access to electronic medical records.	F 842		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on concerns identified during the survey, staff interview and policy review, the quality assessment and assurance (QAA) committee failed to identify quality concerns and implement appropriate plans of action to correct the quality deficiencies. Findings include: During the facility's annual recertification survey, multiple concerns were identified in the following areas:	F 867	1. A new administrator was hired effective 1/1/19. 2. All residents could be affected by this alleged deficiency. 3. The QAA Committee will ensure quality concerns are identified and implement appropriate plans of actions to correct the quality deficiencies. An inservice was conducted on 2/27/19 with the QAA Committee reviewing the requirements for systems to address care and management practices. 4. The Administrator will monitor to ensure quality concerns are being addressed and that the monthly QAA meetings are held as scheduled. This will be an ongoing process.	3/3/19

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F 867	Continued From page 65 -Pervasive odors throughout the facility. -Resident to resident abuse involving 5 residents. -One resident eloped from the facility. -Implement facility policy regarding reporting an allegation of neglect. -Report an allegation of neglect within two hours. -A physician's order was not obtained for dialysis. -Failed to maintain adequate staffing. -Failed to provide access to electronic records timely. An interview was conducted with the administrator (staff #20) on January 10, 2019 at 2:26 p.m. Staff #20 stated that when staff identify a quality concern they bring their concerns to the QAA committee. Staff #20 stated that if a performance improvement plan is developed the QAA committee monitors the progress. The administrator further acknowledged there were no action plans regarding the quality concerns identified during the survey and that the QAA process had not identified the above issues. Review of the facility's policy regarding Quality Assurance and Performance Improvement (QAPI) Committee revealed "...The primary goals of the QAPI Committee are to...Help identify actual and potential negative outcomes relative to resident care and resolve them appropriately..."	F 867		
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff	F 919		

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F 919	Continued From page 66 work area. §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to ensure that two public restrooms, which were unlocked, were equipped to allow residents to call for staff assistance. Findings include: During an observation conducted on January 7, 2019 at 10:30 a.m., two unlocked restrooms were observed near the front entrance of the facility. Neither restroom was equipped with a communication system to alert staff should a resident require assistance while in the restroom. Once inside of each restroom a deadbolt lock was observed on the doors. The deadbolt lock was unable to be unlocked from the outside of the door in the event of an emergency. Signs were posted on both of the restroom doors which stated "Lobby restrooms are for visitors and staff only. Residents, please utilize resident restrooms. Thank you for your cooperation. Kind regards, Sapphire Management." Multiple residents passed by this area to go to the front lobby or to go outside of the facility. An interview was conducted with a receptionist (staff #191) on January 8, 2019 at 9:25 a.m. Staff #191 stated that they ask the residents not to use the public restrooms but that some of the residents go in there anyway. Staff #191 stated that the residents probably use the public restrooms at night when no one is at the receptionist desk. Staff #191 further stated that the public bathroom doors used to be locked.	F 919		

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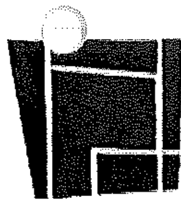
F 919	Continued From page 67 Observations conducted on January 8, 9, and 10, 2019 revealed the area near the public restrooms and front lobby continued to be a high traffic area with residents going to the front lobby or out of the facility. An interview was conducted with another receptionist (staff #194) on January 10, 2019 at 11:00 a.m. Staff #194 stated that the residents were asked to not use the public restrooms. Staff #194 stated that the facility put the signs on the doors of the public restrooms due to the fact that residents could go in there and fall and they would not know that they were in there because there is no call light. Staff #194 further stated the doors used to be locked. An interview was conducted with the managing partner of the facility (staff #220) on January 10, 2019 at 12:35 p.m. Staff #220 stated that the unlocked bathroom doors were his fault. Staff #220 stated that when he first came to the facility he thought it was a dignity issue to be in the restroom and have people knocking on the door when you were in there. Staff #220 stated that he felt installing the occupied/unoccupied deadbolts on the door would resolve the dignity issue. The facility did not have a policy regarding resident call systems.	F 919	The following action have been taken for those residents noted to be affected by this alleged deficient practice. 1. The locks to both public restrooms were changed to require a key from the receptionist in order to enter the restroom. The residents will not be allowed to use the public restroom as there is not a call system in place. This was effective 1/10/19. 2. All residents who enter the lobby area and request a restroom could be affected by this alleged deficiency. 3. The manging partner for the facility has confirmed that the restrooms will remain locked with accessibility only through the controlled method of obtaining a key from the receptionist. 4. The Administrator will monitor for compliance and report any issues to the QAA Committee for 3 months.	3/3/19



February 20, 2019

Receipt Of This Notice Is Presumed To Be -02/20/2019
Important Notice - Please Read Carefully

Ms. Sheila Wiggins, Administrator
Sapphire of Tucson Nursing and Rehab, L.L.C.
2900 East Milber Street
Tucson, AZ 85714

Dear Ms. Wiggins:

On January 15, 2019, a **Life Safety Code** 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.

[] 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).

[] 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).

[X] 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).

[] This survey found the most serious deficiency(ies) in your facility to be isolated deficiencies that constitute actual harm that is not immediate jeopardy as evidenced by the attached form 2567 whereby significant corrections are required (G).

[] This survey found the most serious deficiency(ies) in your facility to be a pattern of deficiencies that constitute actual harm that is not immediate jeopardy as evidenced by the attached form 2567 whereby significant corrections are required (H).

[] This survey found the most serious deficiency(ies) in your facility to be widespread deficiencies that constitute actual harm that is not immediate jeopardy, as evidenced by the attached form 2567 whereby significant corrections are required (I).

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 **March 2, 2019**. You must include all pages of the Statement of Deficiencies when submitting your PoC. Failure to submit an acceptable PoC by **March 2, 2019**, may result in the imposition of remedies.

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.

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 **03/01/19.**

If, upon the 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 continuing 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, per day, per tag, effective January 15, 2019

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.

Mandatory Remedies

Your current period of noncompliance began on January 15, 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 07/15/19.

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. **Please note: Effective July 1, 2007, facilities requesting an Informal Dispute Resolution must submit separate requests, one for State deficiencies cited and one for Federal deficiencies cited, if applicable.**

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.

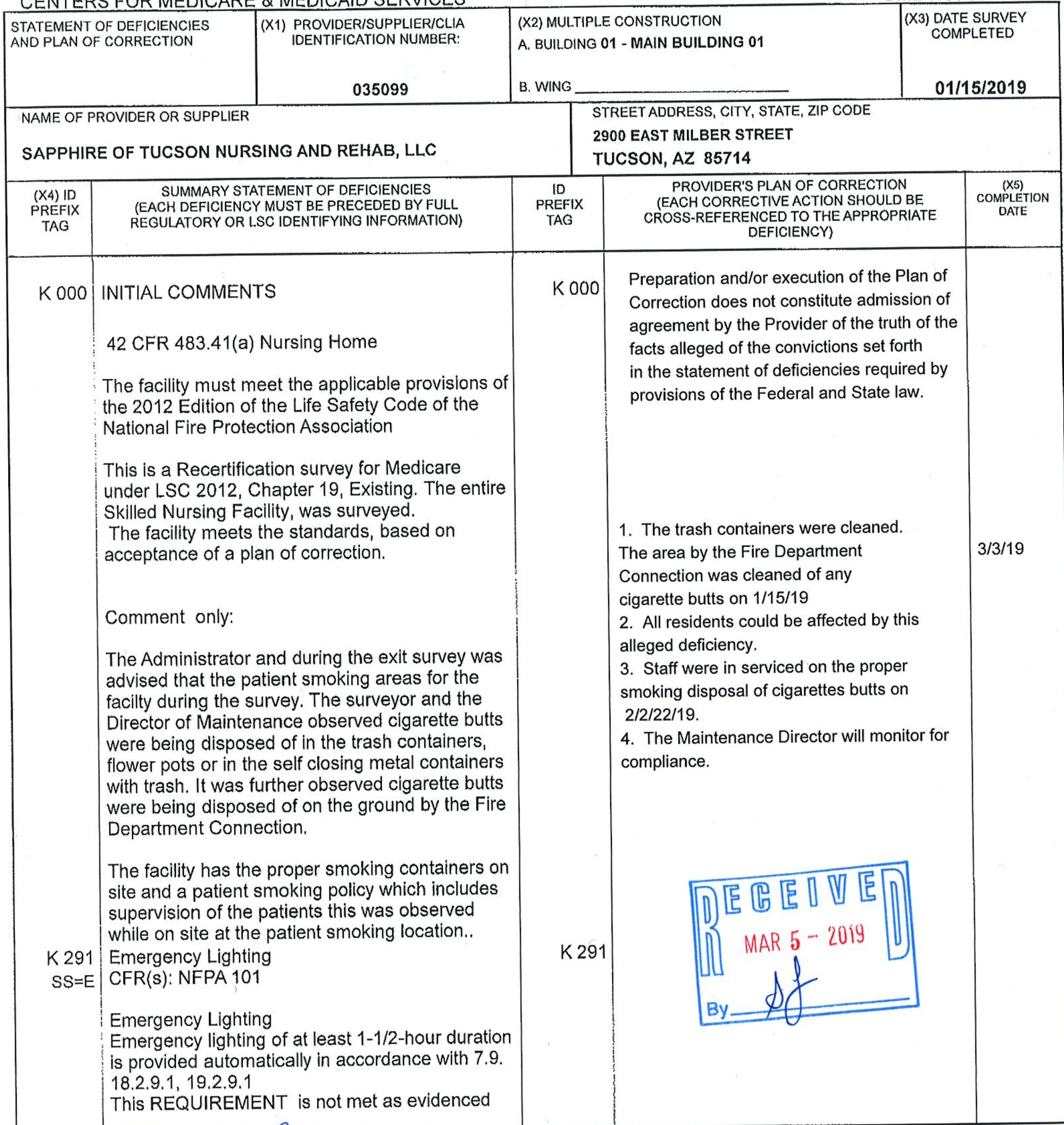
Retain a copy of the PoC for your files. If the PoC is not received by this Office by **March 2, 2019**, recertification may be denied. **Plans of correction sent by fax will not be accepted.** If you have any questions concerning the instructions contained in this letter, please contact the Bureau of Long Term Care at (602) 364-2690.

Sincerely,

Diane Eckles
Bureau Chief

DE\sf

Attachments



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035099	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	01/15/2019

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
K 000	INITIAL COMMENTS 42 CFR 483.41(a) Nursing Home The facility must meet the applicable provisions of the 2012 Edition of the Life Safety Code of the National Fire Protection Association This is a Recertification survey for Medicare under LSC 2012, Chapter 19, Existing. The entire Skilled Nursing Facility, was surveyed. The facility meets the standards, based on acceptance of a plan of correction. Comment only: The Administrator and during the exit survey was advised that the patient smoking areas for the facilty during the survey. The surveyor and the Director of Maintenance observed cigarette butts were being disposed of in the trash containers, flower pots or in the self closing metal containers with trash. It was further observed cigarette butts were being disposed of on the ground by the Fire Department Connection. The facility has the proper smoking containers on site and a patient smoking policy which includes supervision of the patients this was observed while on site at the patient smoking location..	K 000	Preparation and/or execution of the Plan of Correction does not constitute admission of agreement by the Provider of the truth of the facts alleged of the convictions set forth in the statement of deficiencies required by provisions of the Federal and State law. 1. The trash containers were cleaned. The area by the Fire Department Connection was cleaned of any cigarette butts on 1/15/19 2. All residents could be affected by this alleged deficiency. 3. Staff were in serviced on the proper smoking disposal of cigarettes butts on 2/2/22/19. 4. The Maintenance Director will monitor for compliance.	3/3/19
K 291 SS=E	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced	K 291	RECEIVED MAR 5 - 2019 By	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE Administrator

(X6) DATE 3/2/19

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 01 - **MAIN BUILDING 01** B. WING ______	**01/15/2019**

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**

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K 291	Continued From page 1 by: Based on record review of the battery backup lighting documentation and interview with the Director of Maintenance it was determined two of two battery back up emergency lighting units located in the in the main kitchen were not documented for the monthly 30 second tests for March 2018, June through December of 2018 for light one and March 2018 for light 2. NFPA 101, Life Safety Code, 2012, Chapter 19, Section 19.2.9.1 "Emergency lighting shall be provided in accordance with Section 7.9". Section 7.9.3 " Periodic Testing of Emergency Lighting Equipment" " Section 7.9.3.1 Testing of required emergency lighting systems shall be permitted to be conducted as follows: (1) Functional Testing shall be conducted monthly with a minimum of 3 weeks and a maximum of 5 weeks between tests. , for not less than 30 seconds except as otherwise permitted by 7.9.3.1.1.(2) The Test interval shall be permitted to be extended beyond 30 days with the approval of authority having jurisdiction.(3) Functional testing shall be conducted annually for a minimum of 1/1/2 hours if the emergency lighting system is battery powered. (4) The emergency lighting equipment shall be fully operational for the duration of the tests required by 7.9.3.1.1 (1) and (3). (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. Findings include: On January 15, 2019 the surveyor accompanied by the Director of Maintenance reviewed the battery backup emergency lighting documentation. Two of two battery back up	K 291	1. The facility has hired a new Maintenance Director as of 2/7/19. The new Director has a developed a Preventive Maintenance Testing system to monitor and schedule all testing of required emergency lighting equipment. 2. All residents could be affected by this alleged deficiency. 3. The Maintenance Director will ensure all required testing and inspections are done on a timely basis through his Preventive Maintenance system. 4. The Administrator will monitor for compliance and report to the QAA Committee for 3 months and will review all documentation related to required inspections.	3/3/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035099	A. BUILDING 01 - MAIN BUILDING 01 B. WING ________	01/15/2019

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K 291	Continued From page 2 emergency lighting units located in the in the main kitchen were not documented for the monthly 30 second tests for March 2018, June through December of 2018 for light one and March 2018 for light 2. During the exit conference on January 15, 2019 the above findings were again acknowledged by the Administrator and Director of Maintenance. Failing to test and document emergency lighting units once a month for 30 seconds could cause harm to the patients in an emergency power outage.	K 291		
K 325 SS=E	Alcohol Based Hand Rub Dispenser (ABHR) CFR(s): NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: * Corridor is at least 6 feet wide * Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols * Dispensers shall have a minimum of 4-foot horizontal spacing * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30 * Dispensers are not installed within 1 inch of an ignition source * Dispensers over carpeted floors are in sprinklered smoke compartments * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with	K 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 325	Continued From page 3 Section 18.3.2.6(11) or 19.3.2.6(11) * ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485 This REQUIREMENT is not met as evidenced by: Based on record review and observation it was determined the facilties Alcohol Based Hand Rub Dispensers were not tested in accordance with the manufactures care and use instructions each time a refill is installed. NFPA 101 Life Safety Code, 2012, Chapter 19, Section 19.3.2.6 ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: * Corridor is at least 6 feet wide * Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols * Dispensers shall have a minimum of 4-foot horizontal spacing * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30 * Dispensers are not installed within 1 inch of an ignition source * Dispensers over carpeted floors are in sprinklered smoke compartments * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11) * ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485	K 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035099	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	01/15/2019

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K 325	Continued From page 4 Operation of the dispenser(s) shall comply with the following criteria: (F) The dispenser shall be tested in accordance with the manufactures care and use instructions each time a refill is installed. Findings include: On January 15, 2019 the surveyor, accompanied by the Director of Maintenance it was determined the facility did not have documented evidence that the facilities Alcohol Based Hand Rub Dispensers were tested in accordance with the manufactures care and use instructions each time a refill is installed. There was no written documentation shown to the surveyor while on site that showed the ABHR dispensers were tested and documented in accordance with the manufactures care and use instructions. During the exit conference on Janaury 15, 2019 the above findings were again acknowledged by the Administrator and Director of Maintenance. ABHR dispensers not tested in accordance with the manufactures care and use instructions each time a refill is installed could cause the dispenser not to operate in an effective manner if needed.	K 325	1. The facility has developed a system to test the dispensers to ensure they are in compliance. 2. All residents could be affected by this alleged deficiency. 3. The Housekeeping Supervisor will in- service the staff on the proper techniques and procedures for changing the alcohol based dispensers on 3/3/19. 4. The Maintenance Director will monitor that the dispensers are being tested and changed	3/3/19
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire	K 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 353	Continued From page 5 Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked ______ b) Who provided system test ______ c) Water system supply source ______ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation it was determined that the facility failed to maintain the sprinkler heads in multiple areas in the facility. NFPA 101 Life Safety Code, 2012 edition, Chapter 19, Section 19.3.5.1 "Buildings containing nursing homes shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7." Chapter 9, Section 9.7.1 "Each automatic sprinkler system required by another section of this Code shall be in accordance with on of the following." " NFPA 13, Standard for the Installation of Sprinkler Systems." Chapter 26, Section 26.1 "General." "A sprinkler system installed in accordance with standard shall be properly inspected, tested, and maintained by the property owner or their authorized representative in accordance with NFPA 25. NFPA 25, Section 5.2.1 "Sprinklers, Section 5.2.1.1.1 "Sprinklers shall not show signs of leakage, shall be free of corrosion, foreign materials, paint and physical damage."	K 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 353	Continued From page 6 Findings Include: On January 15, 2019 the surveyor accompanied by the Director of Maintenance observed sprinkler heads with dust/lint, paint, corrosion or lint and grease on the sprinkler heads in the following locations: 1. Room 220 sprinkler head with dust/lint. 2. Shower room B-1 and B-2 sprinklers dust/lint. 3. Shower room C-1 sprinkler paint, stucco and appears corroded/rusted 4. Soiled Utility C-1 paint on sprinkler. 5. Bathroom in room 126 painted sprinkler and room 124 corroded/rusted sprinkler head. 6. Main Kitchen two sprinklers with lint and grease. These were one to three sprinklers in each location noted above: During the exit conference on January 15, 2019, the above findings were again acknowledged by the Administrator and Director of Maintenance. Failing to maintain sprinkler heads could cause harm to residents and staff by allowing a fire to spread before the temperature is reached to set of the sprinkler head. Based on record review and interview with the Director of Maintenance it was determined the facility did not have visual monthly sprinkler inspections to include gauges and control valves being completed by a sprinkler company or by the Director of Maintenance for seven of twelve months since the last survey.	K 353	1. Sprinkle heads in room 220 were cleaned with the removal of dust/lint. Sprinkler heads in B-1 and B-2 shower rooms were cleaned. This was done 1/18/19. The sprinkler heads with paint and or corrosion will be scheduled to be replaced by contractor no later than 3/8/19. A quote to perform the work was obtained on 3/1/19. 2. All resident have the potential to be affected by this alleged deficiency. 3. The Maintenance Director will schedule visual inspections by zones and note the visual inspections which will be performed throughout the month. 4. The Maintenance Director and Administrator will monitor for compliance and report to the QAA Committee for three months.	3/3/19

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K 353	Continued From page 7 NFPA 101 Life Safety Code, 2012, Chapter 19, Section 19.3.5.1. "Buildings containing health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7." Section 9.7.5 "All automatic sprinkler and standpipe systems required by this Code shall be inspected, tested, and maintained in accordance with NFPA 25, 2011 Edition, "Standard for the Inspection, Testing , and Maintenance of Water-Based Fire Protection Systems." NFPA 25, 2011 Edition, "Water Based Extinguishment Systems," requires monthly, quarterly and annual testing of automatic sprinkler systems. Findings include: On January 15, 2019 the surveyor, accompanied by the Director of Maintenance could not provide written visual sprinkler inspections of present or past visual sprinkler inspections of the sprinkler system or control valves since the last survey except for the quarterly inspection and tests completed by the sprinkler company for 5 of 12 months since the last survey. During the exit conference on January 15, 2019 the above findings were again acknowledged by the Administrator and Director of Maintenance. Failure to conduct inspections may result in unidentified sprinkler system problems with potential for fire sprinkler failure in the event of a fire placing all residents, staff, and visitors at risk for injury due to exposure to fire.	K 353		
K 511 SS=D	Utilities - Gas and Electric CFR(s): NFPA 101	K 511		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 511	Continued From page 8 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation it was determined the facility did not allow access to the main electrical equipment room electrical panels adjacent to the maintenance shop. NFPA 101 Life Safety Code, 2012, Chapter 19, Section 19.5.1.1 Utilities shall comply with the provisions of Section 9.1., Section 9.1.2 "Electrical wiring and equipment shall be in accordance with NFPA 70, 2011 Edition, "National Electrical Code, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction." NEC, 2011 ARTICLE 110, SECTION 110-26 Spaces About Electrical Equipment. "Sufficient access and working space shall be provided and maintained about all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons." Table 110-26(a) Working Space Minimum of three (3) feet in all directions.	K 511		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035099	A. BUILDING 01 - MAIN BUILDING 01 B. WING	01/15/2019

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
K 511	Continued From page 9 "(NO STORAGE ALLOWED IN THE WORKING SPACE)" Findings include: On January 15, 2019 the surveyor accompanied by the Director of Maintenance observed two generator/ compressors stored within three feet of the main electrical room electrical panel. During the exit conference on January 15, 2019 the above findings were again acknowledged by the Administrator and Director of Maintenance. Blocking of access to electrical panels or equipment may delay personnel from controlling an emergency situation. Patients could be harmed if a fire should start because of a delay.	K 511	1. The generator/compressor units were removed from within the main electrical panel 2. All residents could be affected by this alleged deficiency. 3. The Maintenance Director will ensure all electrical panels are not blocked and areas clean. The Maintenance Director will in-service the maintenance staff regarding keeping electrical panels clear from being blocked. 4. The Maintenance Director will monitor for compliance and report to QAA Committee for three months.	3/3/19
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by:	K 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035099	A. BUILDING 01 - MAIN BUILDING 01 B. WING	01/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 761	Continued From page 10 Based on interview with the Director of Maintenance it was determined the facility did not have written documentation of the Annual Inspection and Testing of Door openings in accordance with NFPA 80, 2010 Edition, "Standard for Fire doors and Other Opening Protective's " NFPA 101 2012 Life Safety Code Section 8.3.3. Fire door and Windows Section 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed labeled fire door assemblies and fire window assemblies and their accompanying hardware,including all frames, closing devices, anchorage and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening protective, except as otherwise specified in this code. NFPA 80 Section 5.2* Inspections Section 5.2.1* Fire door assemblies shall be inspected and tested not less than annually , and a written record of the inspection shall be signed and kept for the AHJ. Section 5.2.3 Functional Testing. Section 5.2.3.1 Functional testing of fire door and window assemblies shall be performed by individuals with knowledge and understanding of the operating components of the type of door being subject to testing. NFPA 80 Section 13.4 Automatic closing Section 5.2.5 Horizontal sliding , Vertically Sliding, and Rolling Doors. Section 5.2.14.3 All horizontal or vertical sliding or rolling fire doors shall be inspected and tested annually to check for proper operation at frequent intervals to ensure operation.	K 761	The Annual Door Inspection was scheduled on 2/28/19. This inspection will be performed on 3/11/19 by contractors Cintas. 2. All residents have the potential to be affected by this alleged deficiency. 3. The Maintenance Director has established a monitoring system to track all required Life Safety Inspections. 4. All required Life Safety inspections will be reported to the QAA Committee for three months and as needed. The Administrator will monitor for compliance.	3/3/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035099	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	01/15/2019

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SAPPHIRE OF TUCSON NURSING AND REHAB, LLC	2900 EAST MILBER STREET TUCSON, AZ 85714

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K 761	Continued From page 11 Findings include: On January 15, 2018 the surveyor accompanied by the Director of Maintenance it was determined the facility did not have written records of the Annual Inspection and Testing of Door Openings in accordance with NFPA 80 Standard for Fire Doors and Other Opening Protective's In addition: The following smoke barrier doors or corridor door did not close and latch or were not smoke tight when tested three of three times. 1. Smoke barrier doors adjacent to patient room 221 2. Smoke barrier doors in A-2 hallway. 3. Smoke doors in C-1 hallway adjacent to patient room 142. 4. Shower room corridor door in B-1 hallway adjacent to patient room 126. During the exit conference on January 15, 2019 the above findings were again acknowledged by the Administrator and Director of Maintenance. Failing to inspect and test fire rated door assemblies in accordance with NFPA 80 annually could cause harm to the patients.	K 761		
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not	K 914		

DEPARTMENT OF HEALTH AND HU[illegible]N SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 914	Continued From page 12 listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on interview with the Director of Maintenance it was determined that the facility failed to conduct, maintain and document electrical receptacle testing in patient care areas specifically to the patient care rooms throughout the facility. NFPA 101 Life Safety Code, 2012, Chapter 4, Section 4.6.12.4 Any device, equipment, system, condition, arrangement, level of protection, fire-resistive construction, or any other feature requiring periodic testing, inspection, or operation to ensure its maintenance shall be tested, inspected or operated as specified elsewhere in the Code or as directed by the authority having jurisdiction. NFPA 99, Health Care Facilities Code, 2012, Chapter 6, Section 6.3.4.1.3 Receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at intervals not exceeding 12 months.	K 914		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 914	Continued From page 13 Findings include: On January 15, 2019 the surveyor, accompanied by the Director of Maintenance advised the surveyor he could not provide any documentation on the receptacle testing for patient care areas were tested in all of 2017 since the last survey and no documentation was provided to review for 2018. The Maintenance Director advised there was no documentation being done for the receptacle testing. During the exit conference on January 15, 2019 the above finding was again acknowledged by the Administrator and Director of Maintenance. Failing to test the patient care areas electrical receptacles could lead to an ignition hazard in a patient care area resulting in fire and/or injury to the patients.	K 914	1. The new Maintenance Director began receptacle testing in February and will continue as required. 2. All residents have the potential to be affected by this alleged deficiency. 3. The Maintenance Director will ensure compliance by the implementation of the Preventive Maintenance Testing Program. 4. The Administrator will monitor for compliance and report to the QAA Committee for three months.	3/3/19
K 918 SS=E	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36	K 918	1. The facility has hired a new Maintenance Director as of 2/7/19. The new Director has developed a Preventive Maintenance Testing system to monitor and schedule all weekly testing of the emergency generator. 2. All resident could be affected by this alleged deficiency. 3. The Maintenance Director will ensure all required weekly testing of the generator occurs as required by the NFPA 101 Life Safety Code. This will be accomplished by utilizing the tracking system developed for all Preventive Maintenance systems. 4. The Administrator will monitor for compliance and report to the QAA Committee for three months.	3/3/19

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K 918	Continued From page 14 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on record review and interview with the Director of Maintenance it was determined the facility failed to document the required testing of the emergency generator for Weekly and Monthly Testing of the diesel generator for the facility. NFPA 101 Life Safety Code, 2012, Chapter 19, Section 19.7.6 "Maintenance and Testing (See 4.6.12) Section 4.6.12.2 " Equipment requiring periodic testing or operation to ensure its maintenance shall be tested or operated as specified elsewhere in this Code or as directed by the authority having jurisdiction." NFPA 99 "HEALTH CARE FACILITIES". Chapter 3, Section 3-5.4.1.1 (a) and Section 3-4.4.1.1 (b) "Generator sets shall be tested twelve (12) times a year... Generator sets serving emergency and	K 918		

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K 918	Continued From page 15 equipment systems shall be in accordance with NFPA 110, Chapter 6, Section 8.4.1 "Level 1 and Level 2 EPSSs, including all appurtenant components shall be inspected weekly and shall be exercised under load at least monthly. NFPA 110, Chapter 8, Section 8.4.2 "Generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes... Findings Include: On January 15, 2019 the surveyor, accompanied by the Director of Maintenance reviewed the generator test records since the last survey. No documentation of weekly or monthly load tests and transfer times within 10 seconds were documented for following periods. 1. Last week of February 2018 no weekly visual generator checks documented. 2. March 2018 the entire month no weekly inspections to include a monthly load bank test for 30 minutes and transfer time not documented. 2. April 2018 the first three weeks, no weekly visual generator checks documented. During the exit conference the above findings were again acknowledged by the Administrator and Director of Maintenance. Failure to inspect and test and document the emergency generator under load monthly and conduct weekly visual inspections and document time from normal power to emergency power could result in harm to patients during emergency system failures.	K 918		
K 920	Electrical Equipment - Power Cords and Extens	K 920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 920 SS=D	Continued From page 16 CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation it was determined the facility allowed the use of an extension cord to be used for a Christmas tree in room 152. NFPA 101, Life Safety Code, 2012. Chapter 2, Section 2.1 The following documents or portions thereof are referenced within this Code as mandatory requirements and shall be considered part of the requirements of this Code. Chapter 2 "Mandatory References" NFPA 99 "Standard for Health Care Facilities, " 2012 Edition. NFPA 99,	K 920	1. The extension cord was taken out of room 152. 2. All residents could be affected by this alleged deficiency. 3. Staff in serviced on 2/22/19 regarding extension cords usage. 4. The Maintenance Director will monitor for compliance.	3/3/19

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K 920	Continued From page 17 Chapter 6, Section 6.3.2.2.6.2 , "All Patient Care Areas," Sections 6.3.2.2..6.2 (A) through 6.3.2.2.6.2 (E) Receptacles (2)" Minimum Number of Receptacles." "The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters. Findings include: On January 15, 2019 the surveyor, accompanied by the Director of Maintenance observed the use of an extension cord to be used for a Christmas tree in room 152. The Christmas tree was not plugged directly into the wall outlet receptacle in the room. During the exit conference on January 15, 2019, the above findings were again acknowledged by the Administrator and Director of the Maintenance. The use of multiple outlet adapters could create an overload of the electrical system and could cause a fire or an electrical hazard. A fire could cause harm to the patients.	K 920		

ATTENDANCE FORM

In-service Title: All Staff

Topics Discussed (May Attach Outline):
Employee Hand Book / Attendance Policy
Nursing / Admission Overview, Life Safety Codes
Instructor's Name & Title: Sheila Wiggins, Administrator + Customer Service
Jean Psely - DON
Required Departments: All Staff — Answering Call Bells —
Date: 2/8/19 — Odors, Care Rounds

Name – Please Print	Title	Hours Earned
Tagried Pervaiz	LPN	
Jillian LaCroix	Operations	
Amber Stogner	CNA	
Marily Maldonado	LPN	
Heidi Smith	LPN	
IRINA ZAKAYO	LPN	
Janet Onchimbo	LPN	
DONNA BROOM	SLP	
IRENE ARRIERO	CNA	
MARY Ellen WOZNIAK	MDS RN	
Dana Greenlee	Cota/L	
Meaghan Hernandez	CNA	
Jennifer Rodgers	LPN	
Guadalupe Johnson	HOUSEKEEPING	
Mary Clay	HOUSEKEEPING	
Angela Edwards	LPN	
Roselen Medina	Laundry	
Charles Wylie	LPN	
MC [illegible]	CNA	
Leonsio Uriarte	cna	
[illegible]	LNA	
[illegible]	CNA	
Nicheola Oates	CNA	

[illegible] Midesena A I
Riley [illegible] CNA
Meena Verghese LPN

ATTENDANCE FORM

1

In-service Title: All Staff

Topics Discussed (May Attach Outline):

Instructor's Name & Title:

Required Departments:

Date: 2/8/19

Name – Please Print	Title	Hours Earned
Manuela Bravo	[illegible]	
Corinne Pineda	LPN	
Lonnie morris	LPN	
Jaime Dicochea	floortech	
Phung Ferguson	LPN	
JEFF ARMSTRONG	DIET Aid	
Samantha Mallin	LPN CM	
Cindy Boehme	HR	
Claudia Gutierrez	LPN	
Brittany Marble	RN Unit Manager	
Debby Burham	RD	
Kimeah Kellersman	CNA	
Jamie Hadley	CNA	
AMY Watsabaugh	CNA	
Rita Y. Romero	CNA	
LAVIOCTRE Winn	CNA	
Libby Martinez	Diet tech	

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ATTENDANCE FORM

In-service Title: All Staff

Topics Discussed (May Attach Outline):

Instructor's Name & Title:

Required Departments:

Date: 2/8/19

Name – Please Print	Title	Hours Earned
Verlene Antone	Housekeeping	
Desirae Whitehead	Housekeeping	
Lilia Downs	Nursing	
Tyra Wiggins	[illegible]	
Irma Tiwari	[illegible]	
Ana Rosas	ACT	
Irma Beck	Med Rec	
Marylou Aguirre	HIM	
Mariah Arenivas	CNA	
Ernansy Flemings	CNA	

Inservice & Training Sign-In Sheet

PASRR & Procedure — Amelia Gabusi MSW — 2/28/19

Name	Department/Title
Jean Caeley	RN DON
Irma Tinucci	RN MDS Director
Marylou T. Aguirre	HIM
Patricia Soto	BH Director
Karina Lopez	SS
Adriana Silva	SS
Samantha Mallin	CM
Gila Deloya	RN UM
Carolyn Glover	LVN Unit manager
Maricela Luna	LVN BCH Ofc
Christina Espinoza	Christina Espinoza
Brittany Waldbillig	B Waldbillig

ATTENDANCE FORM

In-service Title: Accurate Coding of MDS records

Topics Discussed (May Attach Outline):
Need for care and accuracy in completing MDS documentation

Instructor's Name & Title: IRMA TINUCCI, RN MDS DIRECTOR

Required Departments: MDS Coordinator

Date: 2/25/19

Name – Please Print	Title	Hours Earned
MARY ELLEN WOZNIAK	MDS COORDINATOR	1 HOUR

ATTENDANCE FORM

In-service Title: Care Plan Interventions Update

Topics Discussed (May Attach Outline): all new orders will be reviewed by the IDT team every morning @ clinical. Care plans & interventions updated at this time.

Instructor's Name & Title: Jean Cseley RN DON

Required Departments: Therapy, MDS, nursing, social services dietary, activities

Date: 2/25/19 0930

Name – Please Print	Title	Hours Earned
Deidre Pender	DOR [signature]	
Irma Tinucci	MDS Director [signature]	
Amelia Gabusi	Social Services Director [signature]	
Patricia Soto	BH Prog Director [signature]	
Gila Deloya	RN unit manager	
Libby Martinez	Diet tech	
Karina Lopez	SS	
Ana Rosas	ACT	
Jean Cseley	DON JMCseley RN	
Marcela Lent	LPN/PM	

ATTENDANCE FORM

In-service Title: QAA Committee

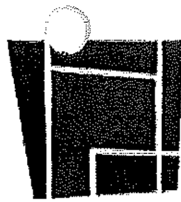
Topics Discussed (May Attach Outline):
Plan of Correction for Annual Survey
Requirements For Systems to address care and management Practices

Instructor's Name & Title: Sheila Wiggins, Administrator

Required Departments: All Department Managers

Date: 2/27/19

Name – Please Print	Title	
Maricela Nunez	Dir Nurs DON	[signature]
Timothy Roberts	Timothy Roberts	
Jean Csely	RN DON	[signature] RN
Samantha Mallin	LPN CM	[signature]
Eitan Morse	OPS	[signature]
C Boehme	HR	C Boehme
IRMA TINUCCI	MD Director	[signature]
Marylou T. Aguirre	HIM	[signature]
Patricia Soto	Behavioral Health Prog Direct	[signature]
Karina Lopez	CS	[signature]
Libby Martinez	Diet Tech	[signature]
Ana Rosas	ACT	[signature]
Abriana Silva	SS	Abriana Silva
Deidre Pender	DOR	[signature]
David Deloya	HSK. Director	David D
Gila Deloya	RN unit manager	GDeloya
Kyra Wiggins	HR	[signature]
Christina Espinoza	Admissions	[signature]
Ben Larson	Central Supply	[signature]
Jimmy Nunez	STAFFING	[signature]
Carolyn Glaver	LPN unit manager	[signature]



February 20, 2019

Receipt Of This Notice Is Presumed To Be 02/20/2019
Important Notice - Please Read Carefully

Sheila Wiggins, Administrator
Sapphire of Tucson Nursing and Rehab, L.L.C.
2900 East Milber Street
Tucson, Arizona 85714

Dear Ms. Wiggins:

On January 15, 2019, a Emergency Preparedness 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. Although the survey found that your facility was in substantial compliance with the participation requirements, some deficiencies exist.

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 **March 2, 2019.** You must include all pages of the Statement of Deficiencies when submitting your PoC. Failure to submit an acceptable PoC by **March 2, 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.

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.

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, #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: Effective July 1, 2007, 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 **March 2, 2019**, 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
Bureau Chief

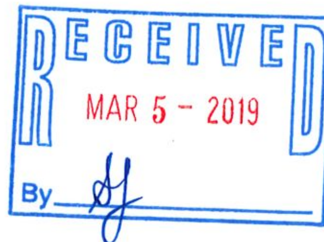
DE\sf

Attachments

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

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 ______	01/15/2019

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
E 000	Initial Comments 42 CFR 483.73 Long Term Care Facilities. The facility must meet all applicable Federal, State and local emergency preparedness requirements as outlined in the Medicare and Medicaid Programs: Emergency Preparedness Requirements of Medicare and Medicaid Participating Providers and Suppliers Final Rule (81 FR 63860) September 16, 2016. The facility meets the standards, based on acceptance of a plan of correction	E 000	Preparation and/or execution of the Plan of Correction does not constitute admission or agreement by the Provider of the truth of the facts alleged of the convictions set forth in he statement of deficiencies required by the provisions of the Federal and State law.	
E 009 SS=C	Local, State, Tribal Collaboration Process CFR(s): 483.73(a)(4) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. * [For ESRD facilities only at §494.62(a)(4)]: (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the dialysis facility's efforts to	E 009		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 3/2/19

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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E 009	Continued From page 1 contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. The dialysis facility must contact the local emergency preparedness agency at least annually to confirm that the agency is aware of the dialysis facility's needs in the event of an emergency. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials. Findings include: The surveyor, along with the Administrator and Director of Maintenance on January 15, 2019 reviewed the facility's Emergency Plan. The Emergency Plan did not indicate, with supportive documentation, a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials. The Administer and Director of Maintenance confirmed during their exit conference on January 15, 2019 that the facility emergency plan did not indicate a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials. Failure to include a process for cooperation and collaboration could lead to harm to both patients and staff.	E 009	1. The Administrator signed a Memorandum of Understanding (MOU) on 1/21/19 with the Southern Arizona Health Care Coalition. 2. All residents have the potential to be affected by this alleged deficiency. 3. The Administrator and Maintenance Director will be a part of all coalition activities and training. 4. The Administrator will be responsible to maintain active participation and membership in this coalition.	3/3/19
E 015 SS=C	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1)	E 015		

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E 015	Continued From page 2 [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies.	E 015		

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E 015	Continued From page 3 (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on interview and record review with the Administrator and Director of Maintenance it was determined the facility did not have a policy and procedure on sewage and waste policy in accordance with the emergency preparedness plan, polices and procedures to review while on site. Subsistence needs for staff and patients. [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following:	E 015		

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E 015	Continued From page 4 (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. Findings include: On January 15, 2019 the surveyor, along with the Administrator and Director of Maintenance, reviewed the facility's Emergency Plan. The plan did not include policies and procedures to provide for sewage and waste disposal. During the exit conference on January 15, 2019 the above finding was again acknowledged by the Administrator and Director of Maintenance. Failure to include policies and procedures for sewage and waste disposal in an emergency could adversely impact resident care during an emergency.	E 015	1. The facility developed a policy and procedure that addressed sewage and waste disposal during a disaster. 2. All residents have the potential to be affected by this alleged deficiency. 3. The policy and procedure will be implemented in the facility EPP. 4. The Administrator will monitor for any updates and report to the QAA Committee for three months.	3/3/19
E 023 SS=C	Policies/Procedures for Medical Documentation CFR(s): 483.73(b)(5) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:]	E 023		

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E 023	Continued From page 5 (5) A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. [(5) or (3),(4),(6)] A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. *[For RNHCIs at §403.748(b):] Policies and procedures. (5) A system of care documentation that does the following: (i) Preserves patient information. (ii) Protects confidentiality of patient information. (iii) Secures and maintains the availability of records. *[For OPOs at §486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. This REQUIREMENT is not met as evidenced by: Based on review of the facility Emergency Plan, and staff interview, it was determined the facility failed to develop and implement policy and procedures that address a system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. Findings include: The Administrator and Director of Maintenance reviewed the facility's Emergency Plan with the surveyor on January 15, 2019. The plan did not include policies and procedures to address a	E 023	1. A policy and procedure was developed on 2/28/19 that addresses Protection of Patient Information during a disaster and or emergency. 2. All residents have the potential to be affected by this alleged deficiency. 3. The policy will be included the facility EPP. 4. The Administrator shall monitor for compliance and ensure any changes or additions are included in the policy updates. The Administrator shall report to QAA for three months.	3/3/19

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E 023	Continued From page 6 system of medical documentation that preserved patient information, protected confidentiality of patient information, and secured and maintained availability of records. The Administrator and Director of Maintenance confirmed on January 15, 2019 the facility Emergency Plan did not include policies and procedures to address a system of medical documentation, and was updated annually. Failure to include policies and procedures to address a system of medical documentation that preserved patient information, protected confidentiality of patient information, and secured and maintained availability of records in an emergency could adversely impact resident care during an emergency.	E 023		
E 024 SS=C	Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.	E 024	The facility developed a policy and procedure to address the use of volunteers in an emergency or other emergency staffing strategies. 2/27/19 2. All residents have the potential to be affected by this alleged deficiency. 3. The Administrator will ensure the policy is implemented in the Emergency Preparedness Plan. 4. The Administrator will report to QAA Committee on this policy and procedure.	3/3/19

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E 024	Continued From page 7 *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. *[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to develop and implement policy and procedures for the use of volunteers in an emergency. Policies and procedures The facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following: (6) The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.	E 024		

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E 024	Continued From page 8 Findings include: On January 15, 2019 the surveyor, along with the Administrator and Director of Maintenance reviewed the facility's Emergency Plan. The plan did not include policies and procedures to address the use of volunteers in an emergency or other staffing strategies, including the use of State and Federally designated health care professional during an emergency. During the exit conference on January 15, 2019 the above findings were again acknowledged by the Administrator and Director of Maintenance Failure to address the use of volunteers in an emergency could adversely impact resident care during an emergency.	E 024		
E 025 SS=C	Arrangement with Other Facilities CFR(s): 483.73(b)(7) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] *[For Hospices at §418.113(b), PRFTs at §441.184,(b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b):] Policies and procedures. (7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive	E 025		

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E 025	Continued From page 9 patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For PACE at §460.84(b), ICF/IIDs at §483.475(b), CAHs at §486.625(b), CMHCs at §485.920(b) and ESRD Facilities at §494.62(b):] Policies and procedures. (7) [or (6), (8)] The development of arrangements with other [facilities] [or] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For RNHCIs at §403.748(b):] Policies and procedures. (7) The development of arrangements with other RNHCIs and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to RNHCI patients. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility did not develop arrangements with other long term care facilities and other providers to receive patients in the event of limitations or cessation of operations to maintain services to the facilities patients. Findings include: During an interview on January 15, 2019 the surveyor along with the Administrator and the Director of Maintenance reviewed the facility's Emergency Preparedness plan. The plan did not include any agreements or memorandum of understanding with other providers in the area.	E 025	1. The facility Administrator on 1/11/19 did locate the transfer agreements established with the following facilities: Villa Compana, Sabino Canyon Rehab, Devon Gables Rehab Center. All agreements are current and meet the required standards. 2. All residents have the potential to be affected by this alleged deficiency. 3. The Administrator will maintain all agreements in the facility Emergency Preparedness binder and update as needed. 4. The Administrator will monitor for compliance and report to the QAA Committee for three months and as needed.	3/319

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E 025	Continued From page 10 During the exit conference on January 15, 2019 the above finding was again acknowledged by the Administrator and the Director of Maintenance. Failure to develop arrangements with other long term care facilities and other providers to receive patients in the event of limitations or cessation of operations to maintain services to the facilities patients could cause harm to the patients in an emergency.	E 025		
E 026 SS=C	Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This REQUIREMENT is not met as evidenced	E 026	1. The facility developed a policy that describes the facility's role in providing care and treatment at alternate care sites under a 1135 waiver. 2. All residents could have the potential to be affected by this alleged deficiency. 3. The Administrator will include this policy in the EPP. 4. The Administrator will report to QAA Committee on this policy update for three months.	3/3/19

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(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
E 026	Continued From page 11 by: Based on observation, interview and facility record review the facility failed to develop and implement emergency preparedness policies and procedures to describe its role in providing care at alternate care sites during an emergency. Findings include: On January 15, 2019 the surveyor, along with the Administrator and Director of Maintenance reviewed the facility's Emergency Plan. The plan did not include policies and procedures describing the facility's role in providing care and treatment at alternate care sites under an 1135 waiver. During the exit conference on January 15, 2019, the above finding was again acknowledge by the Administrator and Director of Maintenance. Failure to develop emergency policy and procedures at alternative care sites may cause harm to the residents during an emergency.	E 026		
E 036 SS=F	EP Training and Testing CFR(s): 483.73(d) (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually.	E 036		

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 ______	01/15/2019

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
E 036	Continued From page 12 *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(h). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be reviewed and updated at least annually. This REQUIREMENT is not met as evidenced by: Based on observation, interview and facility record review the facility failed to develop and implement emergency preparedness policies and procedures for Emergency Planning training and testing program for new and exisitng staff. Based on observation interview and review review of the facility's Emergency Preparedness Testing Requirements, record review and staff interview, it was determined the facility failed to conduct exercises to test the emergency plan at	E 036		

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 ______	01/15/2019

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
E 036	Continued From page 13 least annually. Finding include: On January 15, 2019 the surveyor, along with the Administrator and Director of Maintenance reviewed the facility's Emergency Plan. The plan did not include policies and procedures describing the development and implementation of a training and testing program for the facility based on the Emergency Plan, facility risk assessment and the communications plan as noted below: Emergency Prep Training Program (d)(1) Training Program. The Long Term Care must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing onsite services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. On January 15, 2019 the surveyor, along with the Administrator and Director of Maintenance reviewed the facility's Emergency Preparedness Testing Requirements. The Emergency Preparedness Testing Requirements did not have documented the following: 1. Participate in a full-scale exercise that is community-based.	E 036	1. The new administrator (hired 1/11/19) and the new Maintenance Director (hired 2/7/19) will ensure the facility trains and tests the EPP plan for new and existing staff. This will include: participation in a full-scale exercise that is community based, facility based exercise, and a table-top exercise. 2. All residents have the potential to be affected by this alleged deficiency. 3. The Administrator will ensure the EPP is reviewed annually and that drills are conducted according to state and federal regulations. 4. The Administrator will report to the QAA Committee on when the drills and training occurs. The Administrator will review with the QAA this requirement for three months and as needed.	3/3/19

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 ______	01/15/2019

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
E 036	Continued From page 14 2. Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is individual, facility-based. (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically- relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. During the exit conference on January 15, 2019 the above findings were again acknowledge by the Administrator and Director of Maintenance. Failure to provide policy and procedures for the training and testing program may lead to untrained staff in an emergency situation and may result in harm to the residents during an emergency. Failure to conduct drills/exercises to test the emergency plan could lead to harm to both patients and staff.	E 036		

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

OMB Exempt

LONG-TERM CARE FACILITY APPLICATION FOR MEDICARE AND MEDICAID

Standard Survey:
From: F1 *(mm/dd/yyyy)* 1/7/19
To: F2 *(mm/dd/yyyy)* 1/10/19

Extended Survey:
From: F3 *(mm/dd/yyyy)*
To: F4 *(mm/dd/yyyy)*

Name of Facility: Sapphire of Tucson Nursing & Rehab
Provider Number: 035099
Fiscal Year Ending: F5 *(mm/dd/yyyy)* 12/31/2019

Street Address: 2900 E. Milber St.

City: Tucson
County: Pima
State: AZ
Zip Code: 85714

Telephone Number: F6 520-294-0005
State/County Code: F7
State/Region Code: F8

F9: 03
01 Skilled Nursing Facility (SNF) - Medicare Participation
02 Nursing Facility (NF) - Medicaid Participation
03 SNF/NF - Medicare/Medicaid

Is this facility hospital based? F10 .... ○ Yes ● No
If yes, indicate Hospital Provider Number: F11

Ownership: F12: 13

For-Profit	Non-Profit	Government	
01 Individual	04 Church Related	07 State	10 City/County
02 Partnership	05 Nonprofit Corporation	08 County	11 Hospital District
03 Corporation	06 Other Nonprofit	09 City	12 Federal
13 Limited Liability Corporation			

Owned or leased by Multi-Facility Organization: F13 .... ○ Yes ● No

Name of Multi-Facility Organization: F14

Dedicated Special Care Units: *(show number of beds for all that apply)*

F15 AIDS	F16 Alzheimer's Disease	F17 Dialysis
F18 Disabled Children/Young Adults	F19 Head Trauma	F20 Hospice
F21 Huntington's Disease	F22 Ventilator/Respiratory Care	F23 Other Specialized Rehabilitation: 120

Does the facility currently have an organized residents' group? F24........................ ● Yes ○ No

Does the facility currently have an organized group of family members of residents? .... ○ Yes ● No

Does the facility conduct experimental research? F26 .... ○ Yes ● No

Is the facility part of a continuing care retirement community (CCRC)? F27 .... ○ Yes ● No

If the facility currently has a staffing waiver, indicate the type(s) of waiver(s) by writing in the date(s) of last approval. Indicate the number of hours waived for each type of waiver granted. If the facility does not have a waiver, write NA in the blanks.

Waiver of seven day RN requirement:		Waiver of 24 hr licensed nursing requirement:	
Date: F28 *(mm/dd/yyyy)*	Hours waived per week: F29	Date: F30 *(mm/dd/yyyy)*	Hours waived per week: F31

Does the facility currently have an approved Nurse Aide Training and Competency Evaluation Program? F32 .... ○ Yes ● No

Name of Person Completing Form: William Amoureux
Time: 0815

Signature: [signature]
Date: 1-8-19

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

Date Printed: 1/8/2019
Unit: All
Floor: All

RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

Provider No.	Medicare F75	Medicaid F76	Other F77	Total Residents F78
	19	129	30	178

ADL	Independent	Assist of One or Two Staff	Dependent
Bathing	F79 1	F80 101	F81 76
Dressing	F82 21	F83 138	F84 19
Transferring	F85 33	F86 111	F87 34
Toilet Use	F88 23	F89 125	F90 30
Eating	F91 37	F92 127	F93 14

A. Bowel/Bladder Status

F94 26 With indwelling or external catheter

F95 Of the total number of residents with catheters, how many were present on admission 19?

F96 123 Occasionally or frequently incontinent of bladder

F97 91 Occasionally or frequently incontinent of bowel

F98 122 On urinary toileting program

F99 86 On bowel toileting program

B. Mobility

F100 15 Bedfast all or most of time

F101 121 In a chair all or most of time

F102 21 Independently ambulatory

F103 50 Ambulation with assistance or assistive device

F104 0 Physically restrained

F105 Of the total number of residents with restraints, how many were admitted or readmitted with orders for restraints 0?

F106 38 With contractures

F107 Of the total number of residents with contractures, how many had a contracture(s) on admission 28?

C. Mental Status

F108-114 - Indicate the number of residents with:

F108 5 Intellectual and/or developmental disability

F109 75 Documented signs and symptoms of depression

F110 88 Documented psychiatric diagnosis (exclude dementias and depression)

F111 67 Dementia: (e.g., Lewy-Body, vascular or Multi-infarct, mixed, frontotemporal such as Pick's disease; and dementia related to Parkinson's or Creutzfeldt-Jakob diseases), or Alzheimer's Disease

F112 94 Behavioral healthcare needs

F113 Of the total number of residents with behavioral healthcare needs, how many have an individualized care plan to support them 36?

F114 0 Receiving health rehabilitative services for MI and/or ID/DD

D. Skin Integrity

F115-118 - Indicate the number of residents with:

F115 21 Pressure ulcers (exclude Stage 1)

F116 Of the total number of residents with pressure ulcers excluding Stage 1, how many residents had pressure ulcers on admission 7?

F117 153 Receiving preventive skin care

F118 0 Rashes

Date Printed: 1/8/2019
Unit: All
Floor: All

E. Special Care

F119-132 - indicate the number of residents receiving:

Code	Number	Item
F119	7	Hospice care
F120	0	Radiation therapy
F121	0	Chemotherapy
F122	7	Dialysis
F123	7	Intravenous therapy, IV nutrition, and/or blood transfusion
F124	8	Respiratory treatment
F125	1	Tracheostomy care
F126	10	Ostomy care
F127	0	Suctioning
F128	34	Injections (exclude vitamin B12 injections)
F129	4	Tube feedings
F130	44	Mechanically altered diets including pureed and all chopped food (not only meat)
F131	32	Rehabilitative services (Physical therapy, speech-language therapy, occupational therapy, etc.) Exclude health rehabilitation for MI and/or ID/DD
F132	4	Assistive devices while eating

F. Medications

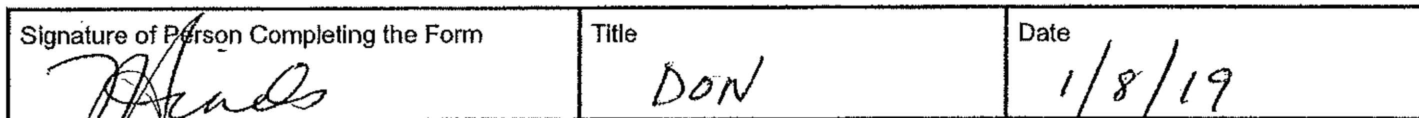
F133-139 - indicate the number of residents receiving:

Code	Number	Item
F133	109	Any psychoactive medication
F134	49	Antipsychotic medications
F135	21	Antianxiety medications
F136	88	Antidepressant medications
F137	4	Hypnotic medications
F138	30	Antibiotics
F139	84	On pain management program

G. Other

Code	Number	Item
F140	11	With unplanned significant weight loss/gain
F141	7	Who do not communicate in the dominant language of the facility (include those who use American sign language)
F142	0	Who use non-oral communication devices
F143	91	With advance directives
F144	86	Received influenza immunization
F145	62	Received pneumococcal vaccine

I certify that this information is accurate to the best of my knowledge.



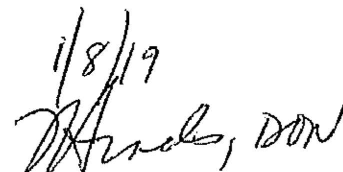
Signature of Person Completing the Form	Title	Date
[signature]	DON	1/8/19

TO BE COMPLETED BY SURVEY TEAM

F146 Was ombudsman notified prior to survey? ✓ Yes __ No

F147 Was ombudsman present during any portion of the survey? __ Yes ✓ No

F148 Medication error rate 0 %



CASPER Report 0003D
Provider History Profile

Arizona

SAPPHIRE OF TUCSON NURSING AND REHAB, LLC **CCN:** 035099
2900 EAST MILBER STREET **Phone Number:** (520)294-0005
TUCSON, AZ 85714 **Participation Date:** 02/05/1985
State's Region Code: TUC
Compliance Status: Provider meets requirements based on an acceptable plan of correction

Provider Beds
Total: 240
Certified: 240

Provider Category: SNF/NF (DUAL)
Type Action: RECERTIFICATION
Type Ownership: FOR PROFIT - CORPORATION

Program Requirements

Current Survey/Revisit Dates - 12/06/2017

Prior 3 Survey 03/2014	S/S Code	Prior 2 Survey 06/2015	S/S Code	Prior 1 Survey 09/2016	S/S Code	Current Survey 10/05/2017	S/S Code	Plan/Date of Correction		Requirement
-	-	-	-	-	-	X C	D	12/06/2017	REQ	F0154-INFORMED OF HEALTH STATUS, CARE, & TREATMENTS
-	-	-	-	-	-	- -	-	-	REQ	F0156-NOTICE OF RIGHTS, RULES, SERVICES, CHARGES
-	-	-	-	-	-	- -	-	-	REQ	F0157-NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)
-	-	-	-	-	-	- -	-	-	REQ	F0159-FACILITY MANAGEMENT OF PERSONAL FUNDS
-	-	-	-	-	-	- -	-	-	REQ	F0164-PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS
-	-	-	-	-	-	- -	-	-	REQ	F0166-RIGHT TO PROMPT EFFORTS TO RESOLVE
X	B	-	-	-	-	- -	-	-	REQ	F0167-RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE
-	-	-	-	-	-	- -	-	-	REQ	F0174-RIGHT TO TELEPHONE ACCESS WITH PRIVACY
-	-	-	-	-	-	- -	-	-	REQ	F0204-PREPARATION FOR SAFE/ORDERLY
-	-	-	-	-	-	- -	-	-	REQ	F0221-RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS
X	D	-	-	-	-	- -	-	-	REQ	F0223-FREE FROM ABUSE/INVOLUNTARY SECLUSION
X	D	X	E	-	-	- -	-	-	REQ	F0225-INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS
X	D	X	E	-	-	- -	-	-	REQ	F0226-DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES
-	-	-	-	-	-	- -	-	-	REQ	F0241-DIGNITY AND RESPECT OF INDIVIDUALITY
-	-	-	-	-	-	X C	D	12/06/2017	REQ	F0242-SELF-DETERMINATION - RIGHT TO MAKE CHOICES
-	-	-	-	-	-	- -	-	-	REQ	F0246-REASONABLE ACCOMMODATION OF
-	-	-	-	-	-	- -	-	-	REQ	F0247-RIGHT TO NOTICE BEFORE ROOM/ROOMMATE
-	-	-	-	-	-	- -	-	-	REQ	F0250-PROVISION OF MEDICALLY RELATED SOCIAL SERVICE
-	-	X	B	-	-	X C	D	12/06/2017	REQ	F0253-HOUSEKEEPING & MAINTENANCE SERVICES
-	-	-	-	-	-	- -	-	-	REQ	F0258-MAINTENANCE OF COMFORTABLE SOUND LEVELS
-	-	-	-	-	-	- -	-	-	REQ	F0272-COMPREHENSIVE ASSESSMENTS
-	-	-	-	-	-	- -	-	-	REQ	F0278-ASSESSMENT ACCURACY/COORDINATION/CERTIFIED
X	D	-	-	-	-	- -	-	-	REQ	F0279-DEVELOP COMPREHENSIVE CARE PLANS
X	D	-	-	-	-	X C	D	12/06/2017	REQ	F0280-RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP
-	-	X	D	-	-	- -	-	-	REQ	F0281-SERVICES PROVIDED MEET PROFESSIONAL
-	-	X	D	-	-	X C	E	12/06/2017	REQ	F0309-PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING

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CASPER Report 0003D
Provider History Profile

SAPPHIRE OF TUCSON NURSING AND REHAB, LLC **CCN:** 035099

Prior 3 Survey 03/2014	S/S Code	Prior 2 Survey 06/2015	S/S Code	Prior 1 Survey 09/2016	S/S Code	Current Survey 10/05/2017	S/S Code	Plan/Date of Correction		Requirement
X	D	X	D	-	-	- -	-	-	REQ	F0312-ADL CARE PROVIDED FOR DEPENDENT RESIDENTS
-	-	X	D	-	-	- -	-	-	REQ	F0313-TREATMENT/DEVICES TO MAINTAIN HEARING/VISION
-	-	X	D	-	-	- -	-	-	REQ	F0314-TREATMENT/SVCS TO PREVENT/HEAL PRESSURE
-	-	-	-	-	-	- -	-	-	REQ	F0315-NO CATHETER, PREVENT UTI, RESTORE BLADDER
-	-	X	D	-	-	X C	G	12/06/2017	REQ	F0318-INCREASE/PREVENT DECREASE IN RANGE OF MOTIC
-	-	X	E	-	-	X C	E	12/06/2017	REQ	F0323-FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES
-	-	-	-	-	-	- -	-	-	REQ	F0328-TREATMENT/CARE FOR SPECIAL NEEDS
-	-	-	-	-	-	X C	E	12/06/2017	REQ	F0329-DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS
-	-	-	-	-	-	- -	-	-	REQ	F0332-FREE OF MEDICATION ERROR RATES OF 5% OR MORE
-	-	-	-	-	-	- -	-	-	REQ	F0333-RESIDENTS FREE OF SIGNIFICANT MED ERRORS
-	-	-	-	-	-	- -	-	-	REQ	F0356-POSTED NURSE STAFFING INFORMATION
-	-	-	-	X	D	- -	-	-	REQ	F0364-NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP
-	-	X	E	X	D	- -	-	-	REQ	F0371-FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY
-	-	-	-	-	-	- -	-	-	REQ	F0425-PHARMACEUTICAL SVC - ACCURATE PROCEDURES,
X	D	X	D	X	E	- -	-	-	REQ	F0431-DRUG RECORDS, LABEL/STORE DRUGS &
X	D	X	E	-	-	- -	-	-	REQ	F0441-INFECTION CONTROL, PREVENT SPREAD, LINENS
-	-	-	-	-	-	- -	-	-	REQ	F0463-RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH
-	-	-	-	-	-	- -	-	-	REQ	F0490-EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING
-	-	-	-	-	-	- -	-	-	REQ	F0508-PROVIDE/OBTAIN RADIOLOGY/DIAGNOSTIC SVCS
-	-	-	-	-	-	- -	-	-	REQ	F0513-X-RAY/DIAGNOSTIC REPORT IN RECORD-SIGN/DATED
-	-	-	-	-	-	- -	-	-	REQ	F0514-RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE
-	-	-	-	-	-	X C	E	12/06/2017	REQ	F0520-QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLAN

LSC Deficiencies

Edition of LSC Applied

2012 HC Prior 3 Survey 03/2014	S/S Code	2012 HC Prior 2 Survey 06/2015	S/S Code	2012 HC Prior 1 Survey 09/2016	S/S Code	2012 HC Current Survey 10/05/2017	S/S Code	Plan/Date of Correction		LSC Deficiencies - Bldg # 01
-	-	-	-	-	-	- -	-	-	STD	K0161-Building Construction Type and Height
-	-	-	-	-	-	- -	-	-	STD	K0232-Aisle, Corridor, or Ramp Width

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CASPER Report 0003D
Provider History Profile

SAPPHIRE OF TUCSON NURSING AND REHAB, LLC **CCN:** 035099

Edition of LSC Applied

2012 HC Prior 3 Survey 03/2014	**S/S Code**	**2012 HC Prior 2 Survey** 06/2015	**S/S Code**	**2012 HC Prior 1 Survey** 09/2016	**S/S Code**	**2012 HC Current Survey** 10/05/2017	**S/S Code**	**Plan/Date of Correction**		**LSC Deficiencies - Bldg # 01**
-	-	-	-	-	-	- -	-	-	STD	K0281-Illumination of Means of Egress
X	E	X	D	-	-	X C	D	11/07/2017	STD	K0321-Hazardous Areas - Enclosure
-	-	-	-	-	-	X C	D	11/07/2017	STD	K0324-Cooking Facilities
-	-	-	-	-	-	- -	-	-	STD	K0331-Interior Wall and Ceiling Finish
-	-	-	-	X	E	- -	-	-	STD	K0353-Sprinkler System - Maintenance and Testing
-	-	X	D	X	E	- -	-	-	STD	K0363-Corridor - Doors
-	-	-	-	-	-	- -	-	-	STD	K0372-Subdivision of Building Spaces - Smoke Barrie
-	-	-	-	-	-	- -	-	-	STD	K0374-Subdivision of Building Spaces - Smoke Barrie
-	-	-	-	-	-	- -	-	-	STD	K0379-Smoke Barrier Door Glazing
X	D	-	-	X	F	X C	D	11/07/2017	STD	K0511-Utilities - Gas and Electric
X	F	X	D	-	-	- -	-	-	STD	K0712-Fire Drills
-	-	-	-	-	-	- -	-	-	STD	K0741-Smoking Regulations
-	-	X	D	-	-	- -	-	-	STD	K0753-Combustible Decorations
-	-	-	-	-	-	- -	-	-	STD	K0781-Portable Space Heaters
-	-	-	-	-	-	- -	-	-	STD	K0914-Electrical Systems - Maintenance and Testing
-	-	-	-	-	-	- -	-	-	STD	K0923-Gas Equipment - Cylinder and Container Storag

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CASPER Report 0003D
Provider History Profile

SAPPHIRE OF TUCSON NURSING AND REHAB, LLC **CCN:** 035099

Deficiency Summary

Type of Deficiency	Current Survey	Prior 1 Survey	Prior 2 Survey	Prior 3 Survey
Requirement	9	3	13	9
Health Total	9	3	13	9
Life Safety Code	3	3	4	3
Life Safety Code + Health	12	6	17	12

Complaint Survey Information

Survey Date	Status
02/23/2018	Substantiated
10/05/2017	Unsubstantiated
02/02/2017	Substantiated
09/29/2016	Unsubstantiated

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CASPER Report 0003D
Provider History Profile

SAPPHIRE OF TUCSON NURSING AND REHAB, LLC **CCN:** 035099

LTC Resident Census

Resident Census on 10/05/2017
Total: 152
Medicare: 7
Medicaid: 120
Other: 25

Total Certified Beds: 240

SNF	SNF/NF	NF	ICF/IID
0	240	0	0

! = Past Non-compliance C = Date of Correction N = No Date Given P = Plan of Correction R = Refused to Correct W = Waived F = FSES X = Deficient
* = Regional Office Flag (Includes COPs) ELE = Element STD = Standard COP = Condition REQ = Requirement - = No Data Entered

Sapphire of Tucson Nursing and Rehab
2900 E. Milber Street
Tucson, AZ 85714
(520) 294-0005

rizona Department of Heal
Division of Public Health
Licensing Services

MAR 26 2019

Reception Desk
150 N. 18th Ave #400
Phoenix, AZ 85007

3/25/2019

Diane Eckles
Bureau Chief
Arizona Department of Health Services
150 N. 18th Ave, Ste 440
Phoenix, AZ 85007-3247

Dear Ms. Eckles:

Enclosed please find this facility's supporting documentation as requested for the CMS 2567. I have separated according to F Tag and numbered each document with the corresponding F tag. Should you have any questions please call me at (520) 294-0005. Thank you.

Sincerely,

Sheila Wiggins

SAPPHIRE
OF TUCSON
NURSING AND REHAB

3/2/19

Diane Eckles, Bureau Chief
AZDHS
150 North 18th Ave., Ste 440
Phoenix, AZ 85007-3247

Re: Sapphire of Tucson Nursing and Rehab

Dear Ms. Eckles:

Please accept SAPPHIRE OF TUCSON NURSING AND REHAB's Plan of Correction for our Life Safety survey conducted 1/15/19. The facility is alleging substantial compliance as of 3/3/19. Please call if you have any questions concerning this Plan of Correction.

Sincerely,

Sheila Wiggins
Administrator

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