DEPARTMENT OF HEALTH AND HUMAN RVICES CENTERS R MEDICARE & MEDICAID SERVICES MEDICARE/MEDICAID CERTIFICATION AND TRANSMI. I'AL ID: V3CM PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: LTC0053 1. MEDICARE/MEDICAID PROVIDER NO. 3. NAME AND ADDRESS OF FACILITY 4. TYPE OF ACTION: 2 (L8) (L3) SAPPHIRE OF TUCSON NURSING AND REHAB, LLC (L1) 035099 1. Initial 2. Recertification 2.STATE VENDOR OR MEDICAID NO. (L4) 2900 EAST MILBER STREET 3. Termination 4. CHOW (L2) 835118 (L5) TUCSON, AZ (L6) 85714 5. Validation 6. Complaint 7. On-Site Visit 9. Other 5. EFFECTIVE DATE CHANGE OF OWNERSHIP 7. PROVIDER/SUPPLIER CATEGORY 02 (L7) 8. Full Survey After Complaint (L9) 08/17/2018 01 Hospital 05 HHA 09 ESRD 13 PTIP 22 CLIA 6. DATE OF SURVEY 01/10/2019 (L34)02 SNF/NF/Dual 06 PRTF 10 NF 14 CORF FISCAL YEAR ENDING DATE: (L35) 8. ACCREDITATION STATUS: (L10)03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC 0 Unaccredited 04 SNF 12/31 08 OPT/SP 12 RHC 16 HOSPICE 2 AOA 11. .LTC PERIOD OF CERTIFICATION 10. THE FACILITY IS CERTIFIED AS: From (a): X A. In Compliance With And/Or Approved Waivers Of The Following Requirements: To (b): Program Requirements 2. Technical Personnel Scope of Services Limit Compliance Based On: 3. 24 Hour RN \_\_ 7. Medical Director X 1. Acceptable POC 4. 7-Day RN (Rural SNF) 8. Patient Room Size 12. Total Facility Beds 240 (L18) \_ 5. Life Safety Code \_\_ 9. Beds/Room 13. Total Certified Beds 240 (L17) B. Not in Compliance with Program Requirements and/or Applied Waivers: (L12) \* Code: A1\* 14. LTC CERTIFIED BED BREAKDOWN 15. FACILITY MEETS 18 SNF 18/19 SNF 19 SNF ICF IID 1861 (e) (1) or 1861 (j) (1): (L15)240 (L37)(L38)(L39) (L42)(L43)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 Date: 18. STATE SURVEY AGENCY APPROVAL Date: 04/08/2019 04/08/2019 (L19) (L20) PART II - TO BE COMPIGETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY 19. DETERMINATION OF ELIGIBILITY 20. COMPLIANCE WITH CIVIL 1. Statement of Financial Solvency (HCFA-2572) RIGHTS ACT: Ownership/Control Interest Disclosure Stmt (HCFA-1513) \_X\_ 1. Facility is Eligible to Participate 3. Both of the Above : 2. Facility is not Eligible

= 1.11111, 10.1112.18.010	(L21)			
22. ORIGINAL DATE  OF PARTICIPATION  02/05/1985  (L24)	23. LTC AGREEMENT BEGINNING DATE (L41)	24. LTC AGREEMENT ENDING DATE (L25)	26. TERMINATION ACTION:  VOLUNTARY 00  01-Merger, Closure  02-Dissatisfaction W/ Reimbursement	(L30)  INVOLUNTARY  05-Fail to Meet Health/Safety  06-Fail to Meet Agreement
25. LTC EXTENSION DATE: (L27)	27. ALTERNATIVE SANCTIONS  A. Suspension of Admissions:  B. Rescind Suspension Date:	(L44)	03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER 07-Provider Status Change 00-Active
28. TERMINATION DATE:	20. PATERN GENA	(L45)		
20. TEXIVIIVATION DATE:	29. INTERMEDIA 01101 (L28)	RY/CARRIER NO. (L31)	30. REMARKS	
31. RO RECEIPT OF CMS-1539	32. DETERMINATI	ION OF APPROVAL DATE		
	(L32)	(L33)	DETERMINATION APPROVAL	



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

Dian Edles

DE/sf



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 HE N SERVICES PRINTED: 04/08/2019 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING \_ COMPLETED R 035099 B. WING NAME OF PROVIDER OR SUPPLIER 04/05/2019 STREET ADDRESS, CITY, STATE, ZIP CODE SAPPHIRE OF TUCSON NURSING AND REHAB, LLC 2900 EAST MILBER STREET TUCSON, AZ 85714 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) {F 000} | INITIAL COMMENTS {F 000} The follow up Federal Recertification and complaint investigation survey was conducted on 4/5/19, there were no deficiencies cited.

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

FORM CMS-2567(02-99) Previous Versions Obsolete

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

Event ID: V3CM12

Facility ID: LTC0053

TITLE

If continuation sheet Page 1 of 1

(X6) DATE

#### POST-CERTIFICATION REVISIT REPORT

	160	DATE OF RE\	
RESS, CITY, STATE, ZIP CODE BER STREET 35714	Y2	1	Y3
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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).

ITE Y4			DATE Y5	ITEN Y4	1		DATE Y5	ITEM Y4	, , , , , , , , , , , , , , , , , , , ,		DATE Y5
ID Prefix	F0552		Correction	ID Prefix	F057	78	Correction	ID Prefix	F0584		Correction
Reg.#	483.10(c)(1)(4	)(5)	Completed	Reg.#	483.1 (v)	0(c)(6)(8)(g)(12)(i)-	Completed	Reg.#	483.10(i)(1)-(7	)	Completed
LSC			04/05/2019	LSC	<u>\</u>		04/05/2019	LSC	•	N-1/-	04/05/2019 
ID Prefix	F0600		Correction	ID Prefix	Enen						· · · · · · · · · · · · · · · · · · ·
	483.12(a)(1)	·/·L	_		*****		Correction	ID Prefix			Correction
Reg. #			Completed	Reg. #	403,1	2(b)(1)-(3)	Completed	Reg.#	483.12(c)(1)(4	)	Completed
LSC	,		04/05/2019	LSC			04/05/2019	LSC	717		04/05/2019
ID Prefix	F0623		Correction	ID Prefix	F064	1	Correction	ID Prefix	F0645		Correction
Reg.#	483.15(c)(3)-(6	(8)	Completed	Reg.#	483.2	0(g)			483.20(k)(1)-(3	············	_
LSC	745		04/05/2019	LSC		1 = A	Completed 04/05/2019	Reg. #			Completed
							04/05/2019	LSC			04/05/2019
ID Prefix	F0657		Correction	ID Prefix	F068	9	Correction	ID Prefix	F0695		Correction
Reg.#	483.21(b)(2)(i)-	(iii)	Completed	Reg. #	483.2	5(d)(1)(2)	Completed	Reg.#	483.25(i)	-/na	Completed
LSC			04/05/2019	LSC			04/05/2019	LSC			04/05/2019
ID Prefix	F0698		Correction	ID Prefix	F072!	ā	Correction	ID Prefix	F0750	• • • • • • • • • • • • • • • • • • •	
Reg.#	483.25(I)	7-0	Completed	ļ		5(a)(1)(2)			483.45(c)(3)(e)	(1)-(5)	Correction
LSC	vr		04/05/2019	Reg.# LSC		//////////	O4/05/2019	reg. #			Completed
				200				LSC		//-	04/05/2019
REVIEWE STATE AG		REVIEW (INITIAL	_	DATE 4/5/1	q	SIGNATURE OF	URVEYOR		****	DATE,	5/19
REVIEWE CMS RO	D BY	REVIEW (INITIAL		DATE	-	TITLE			·	DATE	_ , ,
Form CMS	S - 2567B (09/92	2) EF (11/	(06)			Page 1 of 2			EVENT ID:	V3CM1	2

DEPARTMENT OF HEALTH AND HUMAN	<b>SERVICES</b>
CENTERS FOR MEDICARE & MEDICAID	E /ICES

		POST-	CERTIF	ICATIO	N REVISIT I	REPOI	RT		
PROVID IDENTIF	ER / SUPPLIER / ICATION NUMBE	CLIA / MULTIPLE CO						DATE OF F	REVISIT
035099		Y1 B. Wing					Y2	4/5/2019	<b>Y</b> 0
	F FACILITY IRE OF TUCSO	N NURSING AND RE	HAB, LLC		STREET ADDRESS, 2900 EAST MILBER STUCSON, AZ 85714			: <b>1</b>	<u>Y3</u>
correcte	d and the date	d by a qualified State s deficiencies previous such corrective action ne identification prefix	y reported on was accompli	the UNS-256	/, Statement of Defic	iencies and	Plan of Correc	ction, that hav	/e been
ITE	M	DATE	ITEM	<del></del>	DATE	ITEM			
Y4		Y5	Y4		Y5	Y4			<b>ATE</b> Y5
ID Prefix	F0842 483.20(f)(5), 483	Correction	ID Prefix F	-r	Correction	ID Prefix		Со	rrection
Reg. # LSC	(5)	Completed 04/05/2019	Reg.#	3.75(g)(2)(ii)	Completed 04/05/2019	Reg.# LSC	483.90(g)(2)		mpleted 05/2019
REVIEWE STATE AG	ENCY D	REVIEWED BY (INITIALS)	4/5/19	SIGNATUI	OF SURVEYOR			DATE /5//	9
REVIEWE CMS RO		REVIEWED BY (INITIALS)	DATE	TITLE	. •			DATE	. 10/1-1-1
FOLLOWI 1/10/2019		COMPLETED ON	CHECK F	FOR ANY UNCO	ORRECTED DEFICIENCIENCIES (CMS-2567)	CIES. WAS A	SUMMARY OF E FACILITY?		] NO
Form CMS	- 2567B (09/92)	EF (11/06)		Page 2 of	2	·	EVENT ID:	V3CM12	



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** 

DEPARTMENT OF HEALTH AND HEALTH AN SERVICES PRINTED: 04/08/2019 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 COMPLETED 035099 B. WING 03/08/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2900 EAST MILBER STREET SAPPHIRE OF TUCSON NURSING AND REHAB, LLC TUCSON, AZ 85714 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) {K 000} **INITIAL COMMENTS** {K 000} 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. 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 program participation.

DEPARTMENT OF HEALTH AND HUMAN S	ERVICES
CENTERS FOR MEDICARE & MEDICAID	RVICES

#### POST-CERTIFICATION REVISIT REPORT

		TA INCAIGHT INCHONT			
IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION A. Building 01 - MAIN BUILDING 01			DATE OF REV	/ISIT
035099 <sub>Y1</sub>	B. Wing		Y2	3/8/2019	Y3
NAME OF FACILITY SAPPHIRE OF TUCSON NURSING AND REHAB, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE			
SAFFHIRE OF TUCSON NURS	SING 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).

ITE Y4		DATE Y5	ITEN Y4	1		DATE Y5	ITEM Y4			DATE Y5
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg.#	NFPA 101	Completed	Reg. #	NFPA 101		Completed	Reg.#	NFPA 101		Completed
LSC	K0291	03/05/2019	LSC	K0325		03/05/2019	LSC	K0353		03/05/2019
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			0 "
Reg.#	NFPA 101	Completed		NFPA 101				NFPA 101		Correction
LSC	K0511	03/05/2019	Reg. # LSC	K0761		Completed 03/05/2019	Reg. # LSC	K0914		Ompleted 03/05/2019
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg.#	NFPA 101	Completed	Reg. #	NFPA 101		Completed	Reg.#			Completed
LSC	K0918	03/05/2019	LSC	K0920		03/05/2019	LSC			Completed
ID Prefix		Correction	ID Prefix		st.	Correction	ID Prefix			Correction
Reg.#		Completed	Reg.#			Completed	Reg. #			Completed
LSC			LSC				LSC			
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg.#		Completed	Reg.#			Completed	Reg.#			Completed
LSC			LSC				LSC			
REVIEWE STATE AC		REVIEWED BY (INITIALS)	DATE	SIG	NATURE OF S	SURVEYOR			DATE 3/A	119
REVIEWE CMS RO	ED BY	REVIEWED BY (INITIALS)	DATE	ТІТ	LE	2			DATE	
FOLLOW 1/15/2019		Y COMPLETED ON	UNC	CK FOR AN' DRRECTED	Y UNCORREC DEFICIENCIE	TED DEFICIEN S (CMS-2567)	CIES. WAS A	A SUMMARY O IE FACILITY?	F YES	NO

DEPARTMENT OF HEALTH AND HEALTH A CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING \_ COMPLETED R 035099 B. WING 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** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) {E 000} | Initial Comments {E 000} 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. LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE

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.

(X6) DATE

PRINTED: 04/08/2019

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

#### POST-CERTIFICATION REVISIT REPORT

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PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 035099	MULTIPLE CONSTRUCTION A. Building B. Wing	e a		DATE OF REVI	SIT
			Y2	3/8/2019	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
SAPPHIRE OF TUCSON NUR	SING AND REHABILIC	2900 EAST MILBER STREET			
	outo / tito / tel i/ to, eeo	7 (20 1/2 20 20 1/2 20 20 1/2 20 20 1/2 20 20 20 20 20 20 20 20 20 20 20 20 20			
		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).

ITE			DATE	ITEM			DATE	ITEM			DATE
Y4			Y5	Y4			Y5	Y4			Y5
ID Prefix	E0009	Co	orrection	ID Prefix	E001	5	Correctio	n ID Prefix	E0023		Correction
Reg.#	483.73(a)(4)	Co	mpleted	Reg. #	483.7	3(b)(1)	Complete	d Reg.#	483.73(b)(5)		Completed
LSC		03/	/05/2019	LSC			03/05/2019	(5)			03/05/2019
ID Prefix	E0024	Co	orrection	ID Prefix	E002	5	Correction	ı ID Prefix	E0026		Correction
Reg.#	483.73(b)(6)	Co	mpleted	Reg.#	483.73	3(b)(7)			483.73(b)(8)		28 CONTROL OF THE CON
LSC			05/2019	LSC			O3/05/2019				O3/05/2019
ID Prefix	E0036	Co	rrection	ID Prefix			Correction	ID Prefix			Correction
Reg.#	483.73(d)	Co	mpleted	Reg.#			Complete	d Reg.#			Completed
LSC		03/	05/2019	LSC				LSC			Completed
ID Prefix		Co	rrection	ID Prefix			Correction	ID Prefix			Correction
Reg.#		Co	mpleted	Reg. #			Complete	I Reg.#			Completed
LSC				LSC				LSC	-		•
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REVIEWE STATE AG		REVIEWED E	ЗҮ	DATE		SIGNATURE C	F SURVEYOR	1		DATE 2/0	15
REVIEWE CMS RO	D BY	REVIEWED E	ВҮ	DATE		TITLE	1/ Int.			DATE	///
1/15/2019		Y COMPLETED	ON	UNCO	K FOR	R ANY UNCORR TED DEFICIEN	ECTED DEFICI CIES (CMS-256	ENCIES. WAS 7) SENT TO T	A SUMMARY ( HE FACILITY?		в 🗆 по



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?

<u>Douglas A. Ducey | Governor Cara M. Christ MD, MS | Director</u>

150 North 18th Avenue, Suite 440, Phoenix, AZ 85007-3247 P | 602-364-2690 F | 602-324-0993

W | azhealth.gov

**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

Diane Eckler

**Bureau Chief** 

DE\sg

Attachments

### DEPARTMENT OF HEALTH AND HUN., IN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/20/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		035099	B. WING	·	¥	01/	10/2019	
9/100/- 9/100000 10/1000000 1/	PROVIDER OR SUPPLIER RE OF TUCSON NURS	SING AND REHAB, LLC		;	STREET ADDRESS, CITY, STATE, ZIP CODE 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)			IX i	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 552 SS=D	from January 7 throconjunction with the investigations: AZ00 AZ00151707, AZ00 The following deficiency from the following the resident has the participate in, his or for formed from the following from the following from the following from the from the following from the from	fication survey was conducted bugh January 10, 2019, in e following Complaint 0147662, AZ00152817, 153440 and AZ00152668, encies were cited. d/Make Treatment Decisions 1)(4)(5)  g and Implementing Care. e right to be informed of, and her treatment, including: light to be fully informed in she can understand of his or us, including but not limited to, condition.  light to be informed, in e to be furnished and the type fessional that will furnish care. light to be informed in visician or other practitioner or risks and benefits of proposed and treatment alternatives or and to choose the alternative or offers.  IT is not met as evidenced linical record review, staff lies and procedures, the ure that one resident (#135) in advance of the risks and	F	552	of Correction does not constitute ad or agreement by the Provider of the the facts alleged of the convictions in the statement of deficiencies. We implemented the Plan of Correction stated below and the facility is demonstrating compliance for the deficiencies cited.	mission truth of set forth have as		
ABURATORY	SUIRE TURS OF PROVIDE	EK/SUPPLIER REPRESENTATIVE'S SIGN	ATURE	4	Ammistra to	9/	X6) DATE	
710	11/1/1/1/1/1/1/			110	11/11/11/3/11 a TIC	9/2	7/11	

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 HUN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION		E SURVEY PLETED
		035099	B. WING			01/	10/2019
	PROVIDER OR SUPPLIER RE OF TUCSON NUR	SING AND REHAB, LLC		2	TREET ADDRESS, CITY, STATE, ZIP CODE 900 EAST MILBER STREET UCSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 552	Resident #135 was 2018, with diagnost disease, toxic ence depressive disorder. Review of the close form titled Admission 2018, which includes self-responsible.  A form titled, Consent November 7, 2018 signer of the form with medical decision might by resident #135.  A physician's order included for the result of the result of the care plan 2018 for the use of related to behavioral intervention for staff resident/family/care benefits and side enthe medication.  Further review of the evidence that the register interview was contacted to the medication.  An interview was contacted to the medication with the register interview was contacted to the medication.  An interview was contacted to the medication with the register in the	s admitted on November 7, es that included Alzheimer's aphalopathy and major r.  ed clinical record revealed a con Record dated November 7, ed the resident was  ent to Admit and Treat dated included a statement that the was the responsible party for taking. The form was signed  dated November 7, 2018 sident to receive Risperdone tic medication) two times daily  initiated on November 10, psychotropic medications al management included an if to educate the egivers about the risks, effects and toxic symptoms of the clinical record revealed no esident was informed of the side effects of Risperdone.	F	552	1. Resident had been discharged from facility on 12/26/18. Going forward a nudelegated to be the point person to obte the psychotropic consents for all reside 2. All residents who have orders for an psychotropic medications have the pote be affected by this deficient practice.  3. A complete audit was done to identife were any missing consents on 2/27/19, person will be responsible to obtain all consents. This nurse will review the neorders daily to determine if new orders require consents. * see attached policy the nurse designee to obtain the consents the staff delegated to perform this task absence.  4. The DON/Designee will review weel ensure all consents have been obtained present to QAPI for 3 months.	ain all ents. ti- ential to fy if there One for ents and in her	
		s prescribed, the use of the ined to the resident, and they					

# DEPARTMENT OF HEALTH AND HUN... SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	FOF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN			(X3) DATE SURVEY COMPLETED	
		035099	B. WING	****	01/	10/2019	
	PROVIDER OR SUPPLIER RE OF TUCSON NURS	BING AND REHAB, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2900 EAST MILBER STREET TUCSON, AZ 85714	<del></del>		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	) BE	(X5) COMPLETION DATE	
F 552	have a form which i of the medications. to obtain informed of after the risks and the	ncludes the risks and benefits The DON stated that they are consent. The DON said that benefits are explained, the	F 552	2			
	at 9:35 a.m. with a I #165). During the in there are consent to medications. Staff # unable to sign the contained from the re	onducted on January 10, 2019 RN (Registered Nurse/staff Iterview, the nurse stated that forms for antipsychotic f165 said if the resident is formsent form, consent is fesident's responsible party. ey are required to obtain for to providing an					
F 578 \$\$=E	at 10:04 a.m. with n who stated that ther for the use of Rispe A policy regarding refederal and State Is rights to all resident include the resident and participate in de Request/Refuse/Ds CFR(s): 483.10(c)(6) The rediscontinue treatme to participate in experimental participate in	ight to request, refuse, and/or nt, to participate in or refuse erimental research, and to	F 578				

# DEPARTMENT OF HEALTH AND HUN. SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		LE CONSTRUCTION		E SURVEY IPLETED
		035099	B. WING	·		01/	10/2019
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1	
SAPPHI	RE OF TUCSON NURS	SING AND REHAB, LLC			2900 EAST MILBER STREET FUCSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 578	subpart I (Advance (i) These requirements specifications and provide residents concerning medical or surgical resident's option, for (ii) This includes a versident's option, for (iii) This includes a versident's policies to it and applicable State (iii) Facilities are perentities to furnish the legally responsible frequirements of this (iv) If an adult indivitime of admission a information or articular has executed an admay give advance of individual's resident with State Law.  (v) The facility is not provide this information to the information to the appropriate time. This REQUIREMENTS, Based on clinical reand policy review, the subpart of th	facility must comply with the fied in 42 CFR part 489, Directives). In the include provisions to written information to all adult go the right to accept or refuse treatment and, at the rmulate an advance directive. Written description of the implement advance directives a law.  I mitted to contract with other is information but are still for ensuring that the is section are met. In the industry is incapacitated at the indistry is incapacitated at the indistry is incapacitated at the indistry in accordance of the information to the information to the individual once he is must be in place to provide the individual directly at the indiv	F	578			

# DEPARTMENT OF HEALTH AND HUN. SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION  NG	•		E SURVEY PLETED
		035099	B. WING		<del>_</del>	01/	10/2019
	PROVIDER OR SUPPLIER RE OF TUCSON NURS	SING AND REHAB, LLC		STREET ADDRESS, CITY, STA 2900 EAST MILBER STREE TUCSON, AZ 85714	•		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	( (EACH CORRECTIVE CROSS-REFERENCED		BE	(X5) COMPLETION DATE
F 578		_	F 5	78			
	December 18, 2018	s admitted to the facility on 3, with diagnoses that included enal disease and type 2					,
	(MDS) assessment resident scored a 9	ssion Minimum Data Set dated 12/25/18, revealed the on the Brief Interview for S), which indicated moderate nt.					
	no evidence of any resident #164. Ther	ent's clinical record revealed advance directives for re was also no documentation clined formulating advance					•
	there was no code :	e clinical record revealed status listed on the resident's available space specific for lectronic record.					
		rrent physician's orders, there code status for this resident.				7	
	(LPN/staff #153) on a.m., she stated if s resident's code stat electronic record, a code status is easily the resident's code sheet. She stated the	a Licensed Practical Nurse January 10, 2019 at 9:30 the needed to find out a us, she would look in the s there is a place where the y viewable. Further, she stated status is listed on their report ne code status should be s the resident is admitted.					
	was conducted on a	edical record staff (staff #184) lanuary 10, 2019 at 9:34 a.m. riewed resident #164's					S

### DEPARTMENT OF HEALTH AND HUM. SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		E SURVEY IPLETED
		035099	B. WING			01/	10/2019
	PROVIDER OR SUPPLIER RE OF TUCSON NURS	SING AND REHAB, LLC		2	STREET ADDRESS, CITY, STATE, ZIP CODE 2900 EAST MILBER STREET FUCSON, AZ 85714		7474014
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF	DBE	(X5) COMPLETION DATE
F 578	scanned document advance directives. stack of documents scanned, however, located. She also siphysician's binder viphysician, however, found in the binder.  In an interview with (DON/staff #125) or p.m., she stated an late December, ensadvanced directive.  Resident #121 was September 13, 2016 included chronic ost included chronic ost september 20, 2016 cognitively intact.  A physician's order indicated the reside there were no advantigned by the reside not listed on the resident listed on the resident september space speresident's electronic chronic was cognitively intact.  An interview was cognitively on January 8, stated that upon adrigned including advantation are sident's code that a resident's code	s and was unable to find any She stated it could be in a that are waiting to be no advanced directives were tated it could be in the vaiting to be signed by the no advanced directives were the Director of Nursing n January 10, 2019 at 1:31 audit had just been done in uring that all residents had forms filled out.  admitted to the facility on a, with diagnoses that teomyelitis and quadriplegia.  ssion MDS assessment dated a, revealed the resident was dated November 20, 2018 nt was a full code.  the clinical record revealed nce directives which were ent. Also, the code status was ident's face sheet or in the cific for code status in the	F	78	The following actions have been tal those residents noted to be affected alleged deficient practice:  1. The facility obtained a consent for status for resident #164 on 1/10/20 attached document.  For resident #121 the facility located signed consent for code status (dated and signed by the resident of 11/20/2018). *see attached document The consents are located in PCC (electronic medical record) under the documents section and the face she shows current code status.  2. All residents have the potential to affected this alleged deficiency.  3. An in-service for nurses was condon 2/22/19 that included the instruct obtaining mandatory consents upon admission including signed code states consents.* see attached in-service 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 determine that there is a signed concode status. This will be completed to 24 hours of admission.  4. The DON/Designee will monitor from pliance and be reviewed at mon QAPI for 3 months	by this or code 19. *see the the obe ducted ions on itus dign in to sent for within	3/3/19

# DEPARTMENT OF HEALTH AND HUN. SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING			E SURVEY PLETED
		035099	B. WING			01/	10/2019
	PROVIDER OR SUPPLIER	SING AND REHAB, LLC		STREET ADDRESS, CITY, STATE, ZIP 2900 EAST MILBER STREET TUCSON, AZ 85714	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD I E APPROPR	BE	(X5) COMPLETION DATE
	to locate any advansigned by the reside An interview was conceeded and advance directives admission or a few. An interview with the conducted on Janual stated the floor nursigned consents, inwhen the resident is said if there is a probe notified. The DO answer for what hap was not employed to that upon admission with written information and to formulate an she chooses to do a information about we executed an advance prominently in the months of the properties of advance appropriate orders of resident's medical resident's	record. Staff #150 was unable ced directives which were ent.  Inducted with Medical state of an January 8, 2019 at 1:46 re was no record of advance resident #121. She said the should be filled out upon days later.  Inducted with Medical state of advance resident #121. She said the should be filled out upon days later.  Inducted with Medical state of advance of record and plan of care.  Interpretation and state of a state of a surgical treatment advance of a surgical treatment advance directive, if he or so. The policy stated that the shether or not the resident has be directive shall be displayed the directives, so that can be documented in the ecord and plan of care. Interpretation entry the state of the cord and plan of care. Interpretation and plan of care.		578			

### DEPARTMENT OF HEALTH AND HUN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION		E SURVEY PLETED
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		BING AND REHAB, LLC	lo	2	TREET ADDRESS, CITY, STATE, ZIP CODE 800 EAST MILBER STREET UCSON, AZ 85714 PROVIDER'S PLAN OF CORRECTION	Ŋ	(X6)
PRÉFIX TAG		'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)		(X5) COMPLETION DATE
F 584	§483.10(i) Safe End The resident has a comfortable and ho but not limited to resupports for daily live. The facility must program of the facility must program of the facility must program of the facility must proposible.  (i) This includes ensured and sephysical layout of the independence and (ii) The facility shall the protection of the facility shall th	vironment. right to a safe, clean, melike environment, including ceiving treatment and ving safely.  ovide- a, clean, comfortable, and ent, allowing the resident to onal belongings to the extent suring that the resident can envices safely and that the re facility maximizes resident does not pose a safety risk, exercise reasonable care for a resident's property from loss exeeping and maintenance to maintain a sanitary, orderly,	F 5	184	1. The facility does have a policy for Q Life - Homelike Environment that addre cleanliness and institutional odors. (see attached). The Housekeeping departmegin using a urine odor neutralizer who cleaning all mattresses. The shower druthe second floor that had an odor is not regularly used. It was determined that of that, the housekeeping department with drain periodically to prevent odors. It was not a urine odor.  2. All residents could be affected by the alleged deficiency.  3. Staff was in-serviced on 2/8/19 regards answering call bells, preventing unneced odors, patient care rounds to ensure reare clean and dry. *see attached sign in with 53 staff in attendance. The Housel Supervisor will conduct environmental and report any unusual occurrences of pervasive odors and report to the unit managers and address any housekeep concerns.  4. The Housekeeping/Laundry Director report to the management team on a depart to the management team on a depart of the management team on a depart of the management of the point of	esses enent will en ain on t because vill flush is arding essary sidents a sheet keeping rounds ing r will laily om the ing its and noted rector. tor will	3/3/19

### DEPARTMENT OF HEALTH AND HUN. SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF CORRECTION	IDENTIFICATION NUMBER:	1 ' '		STRUCTION		TE SURVEY MPLETED
		035099	B, WING	····		01	/10/2019
	PROVIDER OR SUPPLIER RE OF TUCSON NUR	SING AND REHAB, LLC		2900 EA	ADDRESS, CITY, STATE, ZIP CODE AST MILBER STREET DN, AZ 85714		ILVIROSO
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 584	sound levels. This REQUIREMENT by: Based on observation staff interviews, the environment that we findings include: During a family inte 2019 at 11:07 a.m., resident stated that floor always smell if the floor always and interview was determined and in the bathroon.  During the survey from the floor always are sided in the hallways and in the hallways and floor (staff #180) January 12/staff #2: a slight sewage odd bathroom on the second interview was considered.	NT is not met as evidenced tions, and family, resident and facility failed to maintain an as free of odors.  rview conducted on January 7, the family member of a the hallways on the second like urine.  resident who resided on the onducted on January 7, 2019 esident stated that he keeps room shut, because of the conducted on January 7, with another resident who and floor, a strong pervasive ected in this resident's room and floors were frequently ways on the second floor.  Form January 7 through 10, the odors were frequently ways on the second floor.  Form was conducted on January 7, with the maintenance of and the administrator (as of 22). At this time, there was still or in the first resident's		84			

# DEPARTMENT OF HEALTH AND HUM. SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		E CONSTRUCTION		E SURVEY PLETED
		035099	B. WING	<u> </u>		0.1/	10/2019
	PROVIDER OR SUPPLIER RE OF TUCSON NURS	SING AND REHAB, LLC		2	TREET ADDRESS, CITY, STATE, ZIP CODE 900 EAST MILBER STREET UCSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 584	p.m. Staff #180 state plumber to address An interview was concluded January 10, 2019 at that she thought showhen the resident with the facility did not help prevention of odors	ted that he would call a the odor in the bathroom.  Inducted with staff #222 on the tall the tall the tall the tall the tall tall tall tall tall tall tall tal		584			
F 600 SS=E	§483.12 Freedom for Exploitation The resident has the neglect, misappropriand exploitation as includes but is not licorporal punishmer any physical or cheet treat the resident's selection with the selection of the fact of	rom Abuse, Neglect, and e right to be free from abuse, riation of resident property, defined in this subpart. This imited to freedom from at, involuntary seclusion and mical restraint not required to medical symptoms.  lity must- use verbal, mental, sexual, or poral punishment, or	F	600			

### DEPARTMENT OF HEALTH AND HUN. SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		035099	B. WING			01/	10/2019
	PROVIDER OR SUPPLIE RE OF TUCSON NUI	R RSING AND REHAB, LLC		2	TREET ADDRESS, CITY, STATE, ZIP CODE 900 EAST MILBER STREET UCSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	E VTE	(X6) COMPLETION DATE
F 600	resident (#61), and free from abuse be able to that included demonstrated mental states and readmitted on that included demonstrated mental states are plan initiated revision date of A that the resident wisk/wanderer, relability intervening as appresident's location documenting war assessment date BIMS (Brief Intervening as appresident was deluberational symptomer, wandered opsychotic disorder A nurse practition 2, 2018, revealed wandering, delirity and resident was deluberational symptomer.	d that one resident (#21) was by resident (#62).  Tas admitted on July 22, 2015 in April 16, 2018, with diagnoses nentia with behavioral tal disorder due to known dition, delusional disorder and atus.  Thical record revealed a written of a july 11, 2016, with a pril 16, 2018, which identified was an elopement lated to escapist behavior and is to leave the facility all included the resident would lity unattended. Interventions and propriate, monitoring the in every 30 minutes and indering behavior.  (Minimum Data Set) di January 25, 2018 included a view for Mental Status) score of dithe resident had moderate nent. The MDS also included the usional, had physical and verbal oms directed at others, refused laily and had dementia and	F		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 9/30/18 to be further away from Resident #62 discharged different dining ocations. Resident #117 was moved off the secured unit on 11/29/18 to unit C1, a sepa behavioral unit.  2. All residents have the potential to be affected by this alleged deficiency. The Behavioral Health Nursing Director dentified other residents to be affected throbehavioral 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 sign 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-servisheets.  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 psychologieeds.  Reviewed staffing patterns to determine the needs of the unit. *see attached staffing patterns to determine the needs of the unit. *see attached staffing	o on 61. e arate bugh ed	3/3/19

#### DEPARTMENT OF HEALTH AND HUL IN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		SURVEY PLETED
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	PROVIDER OR SUPPLIER RE OF TUCSON NURS	SING AND REHAB, LLC		2	TREET ADDRESS, CITY, STATE, ZIP CODE 1900 EAST MILBER STREET TUCSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	resident was residir safety" and received assessment also in "desperately tries to She speaks Spanis lot of English. Undeincluded the following and nuturing enviror.  A nursing note date included the resider the unit through the and also by a (locked A nursing note date following: the resident had attempted to lean the antity of the state of the unit.  A nursing note date following: the resident had struck a state back to the unit.  A nursing note date revealed the resident and had struck a state back to the unit.  A nursing note date revealed the resident the facility after she discovered in her roth had been initiated.  Continued review of #225 revealed that the facility after she Review of the facility after she breakfast and the more immediately in included the resider facility, obtain trans into Mexico, and after the same as a second of the facility, obtain trans into Mexico, and after the same as a same as a second of the same as a same	ing on the behavioral unit "for all psychiatric services. The cluded the resident of escape if given the chance." In mostly, but understands a reassessment and plan it ing: wandering-provide a safenment.  If March 17, 2018 at 6:34 a.m. in thad been exit seeking from main locked door to the unit end back door to the unit.  If March 23, 2018 included the ent had been exit seeking and ave through the front door, aff member when redirected included the resident was not form and that a "code yellow" if the closed record for resident the resident did not return to	F	600	patterns that shows the desired staffin The facility initiated a Behavioral Heal Tracking log to analyze patterns of behaviors that will enable the facility to identify reat high risk for behaviors. *see attached of a sample of these logs. This will be weekly with the Behavioral Health Teather The facility QAPI team discussed way reduce resident to resident abuse allege that includes:  a. Facility hired an experienced Behave Health Program Manager who is a LM This position will oversee and coordinates services for the residents on the Behavior. She also reviews and makes recommendations for any incidents or behaviors for other residents not resident the secured unit.  b. The facility obtained a contract with psychiatric provider group. Their presecon the unit is more frequent and they available to do increased on-site evaluation with medication recommendations.  c. Hall monitors were hired for the A1 sunit for 16 hours per day.  d. Activities were increased to 10 hourday.  e. The facility will continue ongoing stated and other potential issues that could rearesident to resident altercation.  f. The IDT is focused on more specific keep residents less agitated.  g. The LMSW does counseling and list sessions  h. Behavioral Nurse Manager and LMS an office on the unit making them access.	ch naviors. esidents ed copies reviewed m. s to gations ioral SW. ate vioral ing on a new ence ations secured sper estions secured ways to tening sW has	

### DEPARTMENT OF HEALTH AND HUN. A SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION		E SURVEY PLETED
		035099	B. WING			01/-	10/2019
	PROVIDER OR SUPPLIE	RSING AND REHAB, LLC		290	REET ADDRESS, CITY, STATE, ZIP CODE DO EAST MILBER STREET ICSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<b>,</b>	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 600	resident had beer (secured) unit, an wandering behav Continued review revealed a writter CNA (Certified Not dated April 5, 201 included that the resident dining ro 8:30 p.m. and 9:0 included that facil safety checks we An interview was Administrator (sta 10:15 a.m. The Abeen determined that resident #22: badge from a sta member thought prior to her elope obtained money if from her visitors, bus fare. The Adi security camera the examined during resident had used door and then que An interview was at 12:30 p.m. with that she had bee resident #225 on (11:00 p.m. until she arrived at 11 reported to her the	eport also included that the residing on a behavioral health of that exit seeking and iors were being monitored.  Tof the investigative report a staff statement obtained by a cursing Assistant/staff #222)  8 at 2:45 p.m. The statement resident was last seen in the om on April 4, 2018 between 00 p.m. The report further lity policies were not followed, as	F 6	00	The facility is attached. The facility's policy for observing during a C.N.A. shift and resident at risk for elopement is attached.  4. The resident to resident altercother behavioral issues will be preQAPI for 3 months.	residents s ations and	

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		035099	B. WING	AAAA TA AAAA TA AAAA AAAA AAAA AAAA AA	01/	10/2019
NAME OF PROVIDER OR SUPPLIER SAPPHIRE OF TUCSON NURSING AND REHAB, LLC			;	STREET ADDRESS, CITY, STATE, ZIP CODE 2900 EAST MILBER STREET FUCSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 600	was closed. Staff # residents in her set was unable to check she was busy carin ill. Staff #97 said the residents every than hourly, and the resident that night, her co-worker (CN, to another section residents and assure her room, because closed. She stated the resident on her approximately 2:00 enter the resident's water, and then exiassumed that the resident was malthough he entere ice water during the resident in her room was.  During an interview 2019 at 12:35 p.m. CNA stated that he #225 and did not reresident eloping from An interview was coat 1:15 p.m. with a Nurse/staff #201), worked on the sections.	the door to the resident's room 197 stated that there were other ction who were very ill and she ck on resident #225, because ag for the residents who were be facility protocol was to check of 15-30 minutes but not less at she did not check the She stated that she assumed A/staff #49) who was assigned was checking on all of the med that resident #225 was in the door to her room was that she never actually saw shift. She further stated that at a a.m., she observed staff #49 if the resident's room, and esident was in her room. The as aware that the resident had bent attempts. The CNA also prining after it was discovered dissing, staff #49 told her that did the resident's room to pass a night shift, he did not see the mand did not know where she of conducted on January 8, with a CNA (staff #49), the did not remember resident temember anything about a	F 600			

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F 600	door to the resident The nurse stated to resident had made was going to leave where she owned. The facility was un regarding frequent behavioral unit.  A policy and proce and Symptoms of definition of negled goods and service physical harm, me The policy also list neglect that include and leaving some supervision.  Review of the Repthat all suspected incidents of abuse reported to the State agency.  -Resident #61 was February 20, 2014 unspecified psycheknown physiologic disease, and schiz Review of a Nursir revealed " Reside when there is an eresident had three profanity) and two	e resident on her shift and the it's room was closed all night, hat she was aware that the frequent statements that she the facility and go to Mexico	F 60			

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F 600	A Nursing Note date "Resident had sever shift. Resident primother residents are behaviors by making. A Nursing Note date "Resident has episostartled with other levelling or doors slar A quarterly MDS as 2018, revealed the long-term memory impaired with daily also included the reassistance with one of daily living.  A Behavior care plarevealed resident #1 (agitation, poor safe aggression, repetiting disruptive/intrusive, pacing, exit seeking	Staff was there to redirect ly.  ed May 3, 2018 revealed and verbal outbursts during arily has these outbursts when having an increase in g loud noises and yelling"  ed May 21, 2018 revealed odes of yelling out when he is oud noises like other residents mming"  sessment dated August 6, resident had short-term and problems and was severely decision making. The MDS sident required extensive estaff assistance with activities and dated August 20, 2018 and has behavior problems ety awareness, verbal	Fe	300		
And Andread An	psychosis, anxiety, post traumatic brain physical aggression included the resider behaviors. Intervent medications as ordedevelop more approinteracting with other encourage the residence.	mood disorder and status injury as evidenced by towards others. The goal it will have fewer episodes of tions were to administer ered; assist the resident to opriate methods of coping and er dementia residents; lent to express feelings reasonable, discuss the				

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F 600	resident's behavior behavior is inappro intervene as neces safety of others; ap manner; divert atte and take to alternal behavior episodes underlying cause; a next to other peers prevent physical ag Review of a Nursin 2018 revealed "R altercation with and to the other resident were immediately snoted to this resident were immediately snoted to this resident Review of the annu November 1, 2018 BIMS (Brief Intervie 9, which indicated in A Nursing Note data revealed a CNA represident #61 and retheir arms with closseparated. Resident #275 hit him in the resident face.  -Resident #275 wa June 27, 2017, with unspecified dementing the same same same same same same same sam	c explain/reinforce why priate and/or unacceptable; sary to protect the rights and proach/speak in a calm nition; remove from situation te location as needed; monitor and attempt to determine and when resident is sitting, ensure appropriate space to agression towards peers.  If Note dated September 30, resident began having a verbal other resident and he went up at and struck her in the face on the other resident retaliated and on both arms. Both residents reparated. No visible injuries ent"  If IMDS assessment dated revealed resident #61 had a lew for Mental Status) score of moderate impaired cognition.  The November 16, 2018 toorted to this writer that resident #275 were swinging and fists. Both residents were not #61 stated that resident face. Reddened area noted to sadmitted to the facility on a diagnoses that included other with behavioral ophrenia, major depressive	F6				

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	US OF AN OF CORDECTION INTERPRETATION NUMBERS		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
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Recoabte Ratt Areah shairwd Areire resbwypirsnb Fr	evealed called into observed resident # another resident was lood on his face. To explain what hap Resident #275 state and was messing whe face"  A Nursing Note date esident #275 "start another room with a resident was wearing as shown that he aggressive with manto his room, let's leadent will not initiating physical activities the resident will not initiately in after dinner. The rousyness. Intervent were to anticipate a rovide activities the reactions with off social activity; and recoming evident in Review of the quark ovember 6, 2018.	ge 17 g Note dated May 17, 2018 o room by staff at 5:55 p.m., #275 laying in bed, and as sitting on floor mat with The other resident was unable opened due to cognitive deficit. ed the resident woke him up with his bed and he "hit peer in  ed July 11, 2018 revealed that ted hitting a resident from a wire waste basket in the #275 was upset that another ng his hoodie. Resident #275 is very territorial and ale residents that might wander not forget that this is a unit residents suffer from  an dated August 20, 2018 ent #275 has a history of ggression. The goal was late aggression towards other t should have a quiet area to the is sensitive to noise and tions to prevent the behaviors and prevent new incidents of nother resident; provide snack, at promote non-aggressive her residents like one to one provide activity so resident is eyness after meal times, as it is ne is not able to tolerate noise.  terly MDS assessment dated prevealed a BIMS score of 1, a resident had severe cognitive	F	600			

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		035099	B. WING		01	/10/2019
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F 600	impairment.  A Nursing Note darevealed this write resident #275 and their arms with cloquickly separated on resident #61's for the review of revealed he had two residents on Dece he was the aggress discharged from the 2018.  An interview was discharged from the 2018.  An interview was discharged from the continuit for 20-residents. The CN supposed to monite ensure that reside not occur, but that staff call in.  An interview was dwho stated that we someone monitor does not always he the best we can be do not have some that's when the resident with other resident The CNA stated the loud noises and do usually when he gresidents, because	ted November 16, 2018 r was notified by a CNA that resident #61 were swinging sed fists. Residents were by CNA. Reddened area noted				

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	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING				(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER SAPPHIRE OF TUCSON NURSING AND REHAB, LLC			2	STREET ADDRESS, CITY, STATE, ZIP CODE 1900 EAST MILBER STREET FUCSON, AZ 85714				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 600	Continued From pa	ge 19	F 6	500				
	residents. The CNA resident to resident	hh" and that irritated a lot of further stated that a lot of the altercations usually occurred not have someone to monitor						
	stated that resident hall and resident #2 stated that staffing v	onducted with a LPN who #61 runs up and down the 75 is paranold. The LPN was recently cut on this high hit and that they do the best						
ave e	9:25 a.m. Staff #20	onducted with the #20) on January 10, 2019 at stated that there should be a way at all times on that unit.						
	January 27, 2017, v	admitted to the facility on with diagnoses that included ety disorder and dementia urbance.						
	the resident require diagnoses of schizo behaviors of being attempts to provoke	on June 28, 2018, included d a secured unit due to ophrenia and dementia, non-compliant with care and peers. Interventions included lent when having behaviors.						
	17, 2018 revealed the and long-term mem moderately impaired. The assessment also required supervision.	sessment dated September the resident had short-term ory problems and was diswith daily decision making. So included the resident n with set up help only for ally living and utilized a walker.						
	Review of the clinical	al record revealed multiple						

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		035099	B. WING			01/1	10/2019
	PROVIDER OR SUPPLIER	SING AND REHAB, LLC		29	TREET ADDRESS, CITY, STATE, ZIP CODE 900 EAST MILBER STREET UCSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	lD PREF TAG	- 1	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	resident as being vand laughing loudly A nursing note date revealed that at ap #117 began having another resident #15 cheek. Resident #15 cheek. Resident #16 cheek. Resident #16 back, hitting him owere immediately noted. Both resided dining hall as each Review of the facil documentation date revealed that resident #61 was doorway to his room resident #117 in the They began yelling staff could interver #117 and then resident #17 and then resident #117 in the period of the staff could interver when resident #15 incident, she state housekeeping staff could interver when resident #16 incident, she state housekeeping staff could interver when resident #16 incident, she state housekeeping staff could interver when resident #17 incident, she state housekeeping staff could interver when resident #17 incident, she state housekeeping staff could interver when resident #17 incident, she state housekeeping staff could interver when resident #17 incident, she state housekeeping staff could interver when resident #17 incident #18	september 2018 describing the verbally aggressive toward staff of at other residents.  The describing a september 30, 2018 proximately 9:53 a.m., resident of a verbal altercation with 461), and the other resident 17 in the face on the right 117 then struck resident #61 on the arms. Both residents separated. No visible injuries onts will not be in the same a other.		300			

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F 600	heard resident #1' her. She immediat found resident #6' #117 with his fists separated immediant In an interview with at 9:32 a.m., she separated behaviors #117 is constantly intimidates a lot of In an interview with 9, 2019 at 9:41 a.m. usually hangs out instigate things. So behavior of yelling other residents off triggered by noise #117 used to be o and yelling would a staff tried to redire to stop or taking harea.  In an interview with 9, 2019 at 9:49 a.m. behaviors include and yelling at other residents sometimes other residents tel stated resident #1 that does not work she is followed by	as at the nurses' station and 17 yelling that resident #61 hit tely went to the hallway and 1 standing in front of resident up. The residents were ately.  In staff #135 on January 9, 2019 stated she had worked at the ee years and is usually on the al unit. She said that resident being verbally aggressive and				

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F 600	2018 at 10:35 a.m., break. Resident #1' laughing loudly and appeared to be direct The staff present resat back down and cigarette without furth an interview with on January 10, 201 he receives an allegaltercation, he will gwhat happened, repegin an investigating -Resident #21 was January 18, 2018, verify schizophrenia, depedisease.  A quarterly Minimum assessment dated resident had a BIM cognitive impairmed included the reside symptoms directed.  Review of the care medication related following intervention becomes agitated it escalates; guide the source of distress; conversation; and it	a conducted on January 9, during a resident smoke 17 was observed to be a sticking her tongue out, which exted at no one in particular. Edirected the resident who then continued to smoke her orther incident.  The administrator (staff #20) 9 at 1:17 p.m., he stated when gation of a resident to resident pet more information about cort to appropriate parties and ion.  admitted to the facility on with diagnoses that included ression and Parkinson's  The MDS assessment also not. The MDS assessment also not had verbal behavioral toward others.  plan regarding antipsychotic to schizophrenia included the ons: when the resident ntervene before agitation e resident away from the	F6				

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F 600	A nursing note date approximately 10:5 witnessed sitting to front of another res #21 began to yell a #62 approached the #21 to "move." Both swinging their arms were immediately sopposite directions  -Resident #62 was 2015, with diagnos dementia and depromoved a BIMS sometided a BIMS sometided a BIMS sometided a BIMS sometident had no concept the resident had the aggressive and the residents and staff staff to escort the redestination and frow keep him a safe distance witnessed standing Resident #21 was a wheelchair and resident #21 start Spanish. Resident and with a closed fresidents were swifted to get the resident were swifted witnessed fresident were swifted approximately 10:5 witnessed standing Resident #21 start Spanish. Resident and with a closed fresidents were swifted approximately were swifted approximately 10:5 witnessed standing Resident #21 start Spanish. Resident and with a closed fresidents were swifted approximately were swifted approximately 10:5 witnessed standing Resident #21 start Spanish. Resident and with a closed fresidents were swifted approximately 10:5 witnessed standing Resident were swifted approximate	ed 11/29/2018 revealed that at 60 a.m., resident #21 was wards the end of the hall in sident's (#62) room. Resident and curse in Spanish. Resident e doorway and told resident h residents were yelling and at each other. The residents eparated and redirected into. No injuries noted at this time.  admitted on November 06, es that included schizophrenia,		600			

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F 600	Review of the facilit revealed that on No a.m., resident #21 of front of the door to #62 asked resident words were exchanat each other and neport also included housekeeper (staff residents arguing ir who was telling resident #21 was uresident #62 report and I told him to sto would hit him, and I buring an interview on 1/8/19 at 2:29 president #21 was sident #21 was sident #21 was sident #21 was sident #62 yelled Resident #62 yelled Resident #21 state that he hit him back other until they were An interview was cat #148) on 1/09/19 at that she heard yelling and that the she heard yelling and the she heard	ty's investigative report ovember 29, 2018 at 10:50 was sitting in his wheelchair in resident #62's room. Resident #21 to move, and angry aged. The residents struck out to injuries were noted. The dia witness statement from the #135) that she heard the front of resident #62's door ident #21 to move. The that resident #21 hit resident that both residents were that both residents were that "He kept cussing at me op. I told him if he didn't stop I he didn't stop, so I hit him."  To conducted with resident #62 m., the resident #62 stated that itting in front of his door and to leave. Resident #62 stated lied his mother names in a hit him.	F	600			

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F 600	then assessed their that both residents off steam," but that verbal and physical Review of the facility Prevention Programmer the right to be free facility is committed from abuse by any necessarily limited. The facility's policy Residents revealed provided with a safe policy included that become abusive in his or her safety or Supervisor/Charge provide for the safe also included unmabe retained by the Review of a facility "Resident-to-Residents. The poli including those that resident-to-residents.	ded separate the residents and m for injuries. The LPN stated do occasionally yell and "blow resident #62 is often more lly threatening.  Ity's policy regarding Abuse m revealed "Our residents have from abuse, neglect" Our do protecting our residents one including, but not to "staff and other residents"  I regarding Unmanageable is that each resident will be en place of residence. The should a resident's behavior any way that would jeopardize the safety of others, the Nurse Nurse must immediately ely of all concerned. The policy anageable residents may not facility.  I policy titled, ent Altercations" included that sidents for opriate behavior towards other cy included that all altercations, t may represent t abuse, shall be investigated	F 60			
F 607 SS=E	Nursing. Develop/Implemer CFR(s): 483.12(b)	Administrator/Director of at Abuse/Neglect Policies (1)-(3) sility must develop and	F 60	7		
		policies and procedures that:				

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	PROVIDER OR SUPPLIER	SING AND REHAB, LLC		29	TREET ADDRESS, CITY, STATE, ZIP CODE 900 EAST MILBER STREET UCSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 607	§483.12(b)(1) Prohneglect, and exploimisappropriation of §483.12(b)(2) Estato investigate any significant strength shall be supported to the State of the State o	ibit and prevent abuse, tation of residents and fresident property, blish policies and procedures such allegations, and de training as required at a record review, staff interview, and policy review, the facility their Abuse policy that all of abuse and neglect, must be te Survey Agency within two gation is made, as manifested neglect for one resident  a admitted on July 22, 2015, the included dementia with ance, mental disorder due to all condition, delusional disorder status.  The definition of the resident was not oom and that a "code yellow"		507	What corrective action will be accomplinated for those residents found to have been by the alleged deficiency.  1. The facility Policy and Procedure reporting has been updated to reflect required reporting will be done within two hour time frame. *see attached principal indicates the required 2 hour reporting abuse/neglect allegations.  2. All residents could be affected by alleged deficiency.  3. The new administrator hired as of will ensure all required reporting of an eglect will be done within 2 hours by submitting the report on line to the Armonistrator of Health Services. Staff re-inserviced on this policy on 3/29/4. The Administrator will review all reincidents that should be reported at Committee on a monthly basis. This ongoing.	on affected for Abuse the the olicy that g time for this 1/11/19 buse and / izona will be 9 equired the QAA	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l''		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		035099	B. WING			   01/1	0/2019
	PROVIDER OR SUPPLIER	SING AND REHAB, LLC		29	TREET ADDRESS, CITY, STATE, ZIP CODE 900 EAST MILBER STREET UCSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 609 SS=D	report included the the facility" obtain to into Mexico, and aftransportation to a unharmed.  Continued review of revealed that althous discovered missing the facility did not runtil 3:30 p.m. on A An interview was concluding the facility did not runtil 3:30 p.m. on A An interview was concluding neglect to Administrator (staff 2:46 p.m. The Administrator also explain why the elocation of the facility Reporting Abuse to Entities/Individuals violations and all standard will be immediately agencies and other law. The policy including the policy included in the policy in the policy included in the policy included in the policy in th	nemediately implemented. The resident "was able to leave ransportation, cross the border ter entering Mexico obtained family home, arriving  If the investigative report up the resident was on April 5, 2018 at 8:30 a.m., totify the State Survey Agency worll 5.  Inducted with the facility port all allegations of abuse, the State Agency. The stated that he was unable to perment of resident #225 was State Agency.  Ity's policy and procedure titled, a State Agencies and other revealed that all suspected ubstantiated incidents of abuse reported to appropriate state rentities as may be required by uded that should a suspected incident of the per or his/her designee, will state licensing/certification liwritten notice to agencies will enty-four hours of the or hours as required).  Individual of the or or hours as required.		607			
00-0							

			COMP	LETED			
		035099	B. WING		,,	01/1	0/2019
	PROVIDER OR SUPPLIER	SING AND REHAB, LLC		29	REET ADDRESS, CITY, STATE, ZIP CODE 1000 EAST MILBER STREET UCSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 609	§483.12(c) In responeglect, exploitation must:  §483.12(c)(1) Ensuinvolving abuse, not mistreatment, inclusiource and misappare reported imme hours after the allest that cause the allest serious bodily injurthe events that cause and do not a the administrator of officials (including adult protective sefor jurisdiction in loaccordance with Sprocedures.  §483.12(c)(4) Repinvestigations to the designated representations accordance with Sprocedures.  §483.12(c)(4) Repinvestigations to the designated representations and if the appropriate correct This REQUIREMED by:  Based on clinical facility documents the facility failed to neglect for one reserved.	onse to allegations of abuse, in, or mistreatment, the facility are that all alleged violations eglect, exploitation or ading injuries of unknown propriation of resident property, diately, but not later than 2 gation is made, if the events gation involve abuse or result in y, or not later than 24 hours if use the allegation do not involve result in serious bodily injury, to f the facility and to other to the State Survey Agency and revices where state law provides ing-term care facilities) in tate law through established out the results of all the administrator or his or her entative and to other officials in tate law, including to the State thin 5 working days of the alleged violation is verified tive action must be taken. INT is not met as evidenced arecord review, staff interview, and policies and procedures, on ensure that an allegation of sident (#225) was reported to ugency within two hours after	1000 property Communication Co	609	1. The facility hired a new administrate 1/11/19. The Administrator will process required reports with in the two hour tiframe by submitting the report through AZDHS portal. Policy will updated on to reflect the correct reporting time 2. All residents have the potential to affected by this alleged deficiency.  3. New Administrator hired effective 01/11/2019. The administrator will repail allegations of abuse or neglect in accordance with state and federal reg to required agencies. The online portathe Arizona Department of Health Serwill be utilized for the day one report. *see attached policy*  4. All incidents that are required to be reported to state and local agencies were viewed at the monthly QAPI meeting three months.	s me nother state of the state	3/3/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED			
		035099	B. WING		to a Carolia Mahaminin mundak ya mana kata kata kata kata kata kata kata k	01/	10/2019
	PROVIDER OR SUPPLIE RE OF TUCSON NU	R RSING AND REHAB, LLC		290	EET ADDRESS, CITY, STATE, ZIP CODE 0 EAST MILBER STREET CSON, AZ 85714		7
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X6) COMPLETION DATE
F 609	with diagnoses the behavioral disturk known physiologicand altered ments. A nursing note derevealed the residence of the fact	as admitted on July 22, 2015, nat included dementia with bance, mental disorder due to ical condition, delusional disorder ral status.  ated April 5, 2018 at 10:05 a.m. dent was discovered missing at ite included the resident was not room and that a "code yellow" d.  cility's investigative report dated ealed that on the morning of April etermined that the resident had breakfast, so missing person immediately implemented. The ne resident "was able to leave in transportation, cross the border after entering Mexico obtained a family home, arriving report also included that the in residing on a behavioral health and that exit seeking and viors were being monitored.  In otify the State Survey Agency		609			
	including neglect	t to the State Agency. The so stated that he was unable to	,				

AND PLAN O	FCORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		035099	B. WING		A AND THE RESIDENCE OF THE PARTY OF THE PART	01/1	0/2019
****	ROVIDER OR SUPPLIER	SING AND REHAB, LLC		29	TREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST MILBER STREET UCSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 623 SS=D	reported late to the A facility's policy at Signs and Sympto a definition of negl goods and service physical harm, me The policy also list neglect that includ and leaving some supervision.  Review of the facil Reporting Abuse to Entities/Individuals violations and all s will be immediately agencies and other law. The policy incoviolation or substamistreatment, neg facility Administrate promptly notify the agency. The verbabe made within twoccurrence (not two Notice Requireme CFR(s): 483.15(c)  §483.15(c)(3) Noting Before a facility transident, the facility in the reasons for the language and man	pement of resident #225 was a State Agency.  Ind procedure titled Recognizing ms of Abuse/Neglect included ect as the failure to provide as a necessary to avoid intal anguish, or mental illness, ed signs of actual physical ed inadequate provision of care one unattended who needs  ity's policy and procedure titled, to State Agencies and other a revealed that all suspected substantiated incidents of abuse or entities as may be required by eluded that should a suspected intiated incident of lect or abuse be reported, the or or his/her designee, will a State licensing/certification al/written notice to agencies will enty-four hours of the ro hours as required). Ints Before Transfer/Discharge (3)-(6)(8)		623			
ORM CMS-2	667(02-99) Previous Version	ns Obsolete Event ID: V3CM	11	Fa	cility ID: LTC0053 If continua	tion sheet	Page 31 of 68

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COMF	PLETED
		035099	B. WING			01/1	0/2019
	PROVIDER OR SUPPLIER RE OF TUCSON NUR	SING AND REHAB, LLC		2	TREET ADDRESS, CITY, STATE, ZIP CODE 900 EAST MILBER STREET UCSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 623	Long-Term Care O (ii) Record the reas discharge in the reas discharge in the reas accordance with pa and (iii) Include in the n paragraph (c)(5) of §483.15(c)(4) Timin (i) Except as specific)(8) of this section discharge required made by the facility resident is transfer (ii) Notice must be before transfer or c (A) The safety of in be endangered und this section; (B) The health of in be endangered, und this section; (C) The resident's allow a more immed under paragraph (c) (D) An immediate of required by the res under paragraph (c) (E) A resident has days. §483.15(c)(5) Cont notice specified in must include the fo (i) The reason for (ii) The effective day	ne Office of the State mbudsman. cons for the transfer or sident's medical record in aragraph (c)(2) of this section; otice the items described in this section.  In this section.  In the notice of transfer or under this section must be at least 30 days before the red or discharged. made as soon as practicable discharge when- dividuals in the facility would der paragraph (c)(1)(i)(C) of adividuals in the facility would der paragraph (c)(1)(i)(D) of the alth improves sufficiently to ediate transfer or discharge, b)(1)(i)(B) of this section; transfer or discharge is ident's urgent medical needs, b)(1)(i)(A) of this section; or not resided in the facility for 30  tents of the notice. The written paragraph (c)(3) of this section	F	323	What corrective action will be accorfor those residents found to be affect the deficient practice.  1 On 1/10/19, an updated discharge was sent to the local Ombudsman month of December. *See attached December discharge list that was so the Ombudsman.  2. All residents discharged from the have the potential to be affected by alleged deficiency.  3. The Business Office Manager wis send a Monthly Admissions/Discharreport to the local Ombudsman by the 5th business day of the month via expectation email that the discharges for January and February sent to the Ombudsman.  4. The Business Office Manager with the QAA Committee monthly for the months. The Administrator will mon compliance	ed list for the ent to e facility this sill rge email. t eruary	3/3/19

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		CONSTRUCTION		COMPLETED	
		035099	B. WING		the state of the s	01/1	10/2019	
	PROVIDER OR SUPPLIER	SING AND REHAB, LLC		290	REET ADDRESS, CITY, STATE, ZIP CODE 00 EAST MILBER STREET ICSON, AZ 85714			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 623	including the name and telephone number to obtain an appeal completing the form hearing request; (v) The name, add telephone number Long-Term Care O (vi) For nursing fact and developmental disabilities, the matelephone number the protection and developmental disabilities, the matelephone number and Bill of Rights Acodified at 42 U.S. (vii) For nursing fadisorder or related email address and agency responsible advocacy of individes tablished under for Mentally III Individuals (a) 15(c)(6) Chall the information is effecting the transmust update the reas practicable one becomes available §483.15(c)(8) Notion the case of facilities.	narged; the resident's appeal rights, a, address (mailing and email), aber of the entity which lests; and information on how I form and assistance in and submitting the appeal ress (mailing and email) and of the Office of the State mbudsman; sility residents with intellectual I disabilities or related iling and email address and of the agency responsible for advocacy of individuals with abilities established under Part lental Disabilities Assistance act of 2000 (Pub. L. 106-402, C. 15001 et seq.); and cility residents with a mental disabilities, the mailing and telephone number of the e for the protection and duals with a mental disorder the Protection and Advocacy viduals Act.  Inges to the notice. In the notice changes prior to fer or discharge, the facility ecipients of the notice as soon e the updated information		523				

•		AND HUN. SERVICES		11	FORM/	APPROVED
STATEMENT	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	0938-0391 SURVEY PLETED
		035099	B. WING		01/1	0/2019
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
SAPPHIR	E OF TUCSON NUR	SING AND REHAB, LLC		1900 EAST MILBER STREET FUCSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 623	written notification to the State Survey State Long-Term C the facility, and the well as the plan for relocation of the red 483.70(I). This REQUIREMED by:  Based on clinical rand review of policifailed to notify the SOmbudsman when transferred/dischar separate occasions (#175) was dischar separate occasions (#175) was dischar Findings include:  -Resident #50 was October 26, 2018, acute respiratory fato thrive and a president was sent to difficulty breathing. 2018 revealed the facility.  Review of a quarter	Agency, the Office of the Agency, the Office of the are Ombudsman, residents of resident representatives, as the transfer and adequate sidents, as required at §  NT is not met as evidenced ecord reviews, staff interviews es and procedures, the facility State Long Term Care one resident (#50) was ged to the hospital on two s, and when one resident	F 623			

intact.

Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IPLE CONSTRUCTION  NG	(X3) DAT COM	E SURVEY MPLETED
		035099	B. WING _		01/	10/2019
	PROVIDER OR SUPPLIER	RSING AND REHAB, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2900 EAST MILBER STREET TUCSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHI (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 623	Continued From p	age 34	F 62	23		
		er 26, 2018 revealed that the mitted to the facility.				
	State Long Term (	as no documentation that the Care Ombudsman was sent a of discharges for each				
	practical nurse (LF 2019 at 1:08 p.m., a patient ready to notify the Ombuds	conducted with a licensed PN/staff #150) on January 8, who stated that when she gets be transferred, she does not sman and said the case ompletes the paperwork when discharged.				
	at 1:19 p.m. with o stated that she co resident is being o	conducted on January 8, 2019 case manager (staff #190), who mpletes the paperwork when a discharged and staff #193 dsman about the discharge.				
	2:42 p.m. He state last fall to talk about the Ombudsman is called the Ombud notify her by emai discharged. He sat doesn't want to be need the informat inundated with no	erviewed on January 8, 2019 at ed that the facility had a meeting out a better way to make sure is notified. He said that he is man and asked if he could it, when a resident is aid that she told him that she is notified, because they don't is and they are being tifications. He said that Social dling the notifications at that				
	at 3:06 p.m. with t (staff #204), who	conducted on January 8, 2019 he Director of Social Services stated that there was a meeting				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		035099	B. WING			01/1	10/2019	
	PROVIDER OR SUPPLIER RE OF TUCSON NUF	SING AND REHAB, LLC		2	TREET ADDRESS, CITY, STATE, ZIP CODE 900 EAST MILBER STREET 'UCSON, AZ 85714			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 623	notifying the Ombodischarged. She so be notified when acknowledged that notifying the Ombodischarged and stoke Ombudsman in from this point forward the October 1, 2018, where the october 4, 2018 redischarge to her poliving facility, after completed.  A physician's order indicated the reside October 13, 2018, whealth.  A review of the Minassessment discharged to the october 13, was discharged to the october 13, was discharged to the october 13, was discharged to the october 13, and of the clim of the october 13, and of the october 13, was discharged to the october 13, was discharged to the october 13, and october 13, was discharged to the october 14, which was disch	red to verify the process for addsman when a resident is aid the Ombudsman didn't want in a resident is discharged. She it the facility has not been addsman when a resident is ated that she will be notifying in writing on a monthly basis ward.  The sadmitted to the facility on with a diagnosis of shortness of the sharge care plan initiated on evealed resident #175 was to revious residence an assisted skilled nursing services were are dated October 9, 2018 then the may be discharged on with physical therapy home with physical therapy home in mum Data Set (MDS) the arge/return not anticipated and 2018, revealed the resident of the community.  The side of the resident of the community of the notice conducted with the Director of conducte	F	623				
	at 9:21 AM. She s	staff #204) on January 9, 2019 stated the facility has not been udsman when a resident is						

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		035099	B. WING		About and the second se	01/1	0/2019
	PROVIDER OR SUPPLIER	SING AND REHAB, LLC		29	REET ADDRESS, CITY, STATE, ZIP CODE 00 EAST MILBER STREET JCSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X6) COMPLETION DATE
F 623	discharged. She st facility is responsible ombudsman did no discharges.  An interview with the (DON/staff #125) v	ated that she is aware that the le for notifications, but the of want to be notified of the Director of Nursing was conducted on January 10,	F€	523			
	been told the ombi- notified of discharg notify her anyway. sending a list of dis the end of every m						
	Discharge Notice representative will transfer or dischard it is practicable but discharge, when the resident's welfare cannot be met in the immediate transfer resident's urgent not stated that a copy	policy regarding Transfer or evealed the resident an/or be notified of an impending ge from the facility as soon as before the transfer or he transfer is necessary for the and the resident's needs he facility or when an or or discharge is required by the nedical needs. The policy also of the discharge notice will be of the State Long-Term Care	A CANADA A	1.2.2.0.0.0.0.0.0.0.0.0.0.0.0.0.0.0.0.0.			
F 641 SS=D	Accuracy of Asses CFR(s): 483.20(g) §483.20(g) Accura The assessment n resident's status. This REQUIREME by: Based on clinical and the Resident A		F	641		**	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ELE CONSTRUCTION (	(X3) DATE SURVEY COMPLETED
		035099	B. WING		01/10/2019
	PROVIDER OR SUPPLIE RE OF TUCSON NU	RSING AND REHAB, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2900 EAST MILBER STREET TUCSON, AZ 85714	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	EE (X5) COMPLETION DATE DATE
F 641	Data Set (MDS) a regarding antibiot one resident (#62) Findings include: Resident #62 was 2015, with diagnor hypertension, der Review of the phyfollowing: -Bactrim 400-80 to day by mouth for dated October 16-Ipratropium Brommicrograms (mog for COPD (chroni disease) dated At-Metoprolol 25 minus hypertension date-Levothyroxine 78 hypothyroidism disease) dated At-Levothyroxine 78 hypothyroidism disease of the Minus the resident refused October 16-31. Tresident refused October 27- 31 mon October 27, 25 Levothyroxine on	assessment was accurate ic use and refusal of care for ).  admitted on November 06, uses that included schizophrenia, mentia, and depression.  Assician's orders revealed the milligrams (mg) by mouth once a prophylaxis for chronic UTI is, 2018 and HFA aerosol solution 17 is) one puff orally every 6 hours in constructive pulmonary ugust 24, 2018 ground by mouth once a day for ed August 25, 2018 and august 25, 2018.  AR for October 2018 revealed was administered Bactrim from the MAR also revealed the pratropium Bromide from multiple times, refused Metoproloi is, and 29, and refused October 27 and 30.	F 64		this  MDS 3/3/19  ion by  ated for  the  ll audit s on a
	assessment date the resident did n displayed no refu look-back period.	of the quarterly MDS d November 1, 2018, revealed ot receive an antibiotic and sal of care during the 7 day The MDS assessment also nterview for Mental Status score			

#### PRINTED: 02/20/2019 DEPARTMENT OF HEALTH AND HUN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X3) DATE SURVEY COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A, BUILDING 035099 B. WING 01/10/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2900 EAST MILBER STREET SAPPHIRE OF TUCSON NURSING AND REHAB, LLC **TUCSON, AZ 85714** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 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

FORM CMS-2567(02-99) Previous Versions Obsolete

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

development of an individualized care plan. The RAI manual instructs to review the clinical record for documentation regarding any antibiotics that

MDS assessment is the basis for the

Event ID: V3CM11

Facility ID: LTC0053

If continuation sheet Page 39 of 68

PRINTED: 02/20/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	٠,,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		035099	B. WING			01/10/2019	
	PROVIDER OR SUPPLIER RE OF TUCSON NURS	SING AND REHAB, LLC		29	REET ADDRESS, CITY, STATE, ZIP CODE 00 EAST MILBER STREET JCSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 641	look-back period as was received. The review the clinical r any refusal of care	ne resident during the 7 day nd record the number of days it RAI manual also instructs to ecord and interview staff for (e.g. taking medications) ok-back period and code the	F	641			
F 645 SS≃E		······································	F	645			
	individuals with a m with intellectual dis	nental disorder and individuals					
	or after January 1, (i) Mental disorder (i) of this section, u authority has deter independent physic performed by a per State mental health (A) That, because condition of the ind	rsing facility must not admit, on 1989, any new residents with: as defined in paragraph (k)(3) nless the State mental health mined, based on an cal and mental evaluation reon or entity other than the authority, prior to admission, of the physical and mental ividual, the individual requires a provided by a nursing facility;		The state of the s			
	(B) If the individual services, whether the specialized service (ii) Intellectual disaction (k)(3)(ii) of this section intellectual disability authority has deterned (A) That, because condition of the incomplete.	requires such level of he individual requires s; or bility, as defined in paragraph tion, unless the State y or developmental disability mined prior to admission- of the physical and mental lividual, the individual requires s provided by a nursing facility;	Table State	ALTERNATION OF THE PROPERTY AND THE PROP			TAXABOR DING T
·	and	requires such level of					

Facility ID: LTC0053

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		035099	B. WING	l		01/	10/2019
	PROVIDER OR SUPPLIE	RSING AND REHAB, LLC		2	TREET ADDRESS, CITY, STATE, ZIP CODE 1900 EAST MILBER STREET "UCSON, AZ 85714	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 645	services, whether specialized services, whether specialized services.  §483.20(k)(2) Exception— (i) The preadmissing paragraph(k)(1) of the condition of the condition of the condition of the condition for which the conditi	the individual requires ses for intellectual disability.  Deptions. For purposes of this on screening program under fithis section need not provide in the case of the readmission y of an individual who, after the nursing facility, was re in a hospital.  To choose not to apply the pening program under of this section to the admission y of an individualed to the facility directly from a priving acute inpatient care at the nursing facility services for the hospital that the individual less than 30 days of nursing finition. For purposes of this a considered to have a mental ividual has a serious mental		345			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		035099	B. WING		01/1	0/2019
	PROVIDER OR SUPPLIE RE OF TUCSON NUI	RSING AND REHAB, LLC	25	TREET ADDRESS, CITY, STATE, ZIP CODE 900 EAST MILBER STREET UCSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 645	and review of faci facility failed to en referred to the ap authority for Level screening and resident matrices.  Findings include: Resident #61 was February 20, 2014 unspecified psych known physiologic disease, and schill Review of the residence of the residen	lity policies and procedures, the sure one resident (#61) was propriate state-designated. II PASARR (pre-admission sident review) evaluation and admitted to the facility on a with diagnoses that included posis not due to a substance or cal condition, Parkinson's zoaffective disorder. Ident's clinical record revealed a plated June 4, 2015 which lent had a primary diagnosis of all letermination for mental the clinical record revealed no facility referred the resident to ate-designated authority for a		1. For Resident #61 a Level II screwas obtained on 1/10/19, see attactopy of the PASARR  2. All residents who need a Level II screening could be affected by this deficiency.  3. The facility conducted an in-serve 2/4/19 regarding the process for Leter PASAAR for all Social Services states in-service will repeat on 2/28/1 include the nurse managers, Admist Department, Medical Records and MDS Director. The Social Services will review all new admissions to desif a Level II screening is needed. The Behavioral Health Program Directive the PASAAR during the admister process to ensure the appropriate Level II referral.  4. A tracking log was developed to that if a Level II is needed it has becombitted. *See attached log for Level II tracking.  This will monitored by the Behavior Program Director and the Administration Results submitted monthly to the QAA Committee.	ched  I alleged lice on vel II ff. 9 and ssion the Director etermine ector will hission ensure en  al Health	3/3/19

		WILDIO/IID OLIVIOLO	/V0\ 1411	Julion in	CONSTRUCTION	(X3) DATE	SURVEY	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		CONSTRUCTION	COMPLETED		
		035099	B, WING			01/1	0/2019	
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
SAPPHIR	RE OF TUCSON NUR	SING AND REHAB, LLC			00 EAST MILBER STREET JCSON, AZ 85714			
		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	N	(X5) COMPLETION	
(X4) ID PREFIX TAG	(FACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	COMPLETION DATE	
F 645 F 657 SS=E	referral for a Level that the referral was Review of the facility revealed "Nursing individuals with medisabilities will be of the Medicaid Pre-AR Resident Review pextent possible"  Care Plan Timing a	II PASARR. Staff #204 stated s not completed yet.  ty's policy Admission Criteria g and medical needs of ental disorders or intellectual determined by coordination with Admission Screening and erogram (PASARR) to the end Revision	Annual Control of the	645				
	§483.21(b)(2) A collection (i) Developed within the comprehensive (ii) Prepared by an includes but is not (A) The attending (B) A registered nuresident. (C) A nurse aide with the resident. (D) A member of five (E) To the extent part the resident and the resident and their resident not practicable for resident's care play (F) Other approprise disciplines as deteor as requested by (iii) Reviewed and	interdisciplinary team, that limited to physician. urse with responsibility for the with responsibility for the with responsibility for the sood and nutrition services staff. The participation of the resident's representative(s). The participation of the resident representative is determined the development of the team. The participation of the resident representative is determined the development of the team. The participation of the test of t						

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	JETIPLE CONSTRUCTION  DING		(X3) DATE SURVEY COMPLETED	
		035099	B. WING	}		01/	10/2019
	PROVIDER OR SUPPLIER RE OF TUCSON NUF	SING AND REHAB, LLC		2	TREET ADDRESS, CITY, STATE, ZIP CODE 900 EAST MILBER STREET 'UCSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 657	by: Based on clinical and policy and proper ensure a care plant (#74).  Findings include: Resident #74 was December 7, 2017 multiple sclerosis: A physician's order the order to apply bedtime and take contractures was a contracture was extensive/total ass (ADLS).  Review of the care November 24, 201 limited physical mocomorbidities includerms at night and Further review of the care was a contracture of the care november 24, 201 limited physical mocomorbidities includerms at night and further review of the care was a contracture of the care november 24, 201 limited physical mocomorbidities includerms at night and	end quarterly review ENT is not met as evidenced record review, staff interview, scedure, the facility failed to a was revised for one resident admitted to the facility on with diagnoses that included and quadriplegia.  In dated July 23, 2018, revealed splints to both arms at night at off in the morning to prevent	F.	657	1.		
		conducted with the Assistant g (ADON/staff #21) on January					

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STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		035099	B. WING			01/1	0/2019
SAPPHIR		SING AND REHAB, LLC	D	29	REET ADDRESS, CITY, STATE, ZIP CODE 900 EAST MILBER STREET UCSON, AZ 85714 PROVIDER'S PLAN OF CORRECTION	v [	(X5) COMPLETION
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	COMPLÉTION DATE
F 657	resident's splints he stated that she did had not been upda departments are recare plan, including management meet residents' care plan. An interview was c	I. Staff #21 stated the ad been discontinued. She not know why the care plan ted. The ADON stated all esponsible for updating the g nursing. She said the nursing ts every morning to discuss as, change of condition, etc.	F	357	1. The Care Plan for Resident #74 has updated to reflect the discontinuant splints on 2/24/19. The resident car scheduled for review on 2/28/19. *I see attached update care plan.  2. Residents with adaptive equipme the potential to be affected by this p 3. The IDT team will review new ord the previous 24 hours and on Mondathe weekends and update care plan change of condition occur. Education	ce of the e plan is Please of the ease of	3/3/19
	9:29 AM. The DON plan related to nurs they have an intercevery morning. She adding to the care discontinuing thing should have been Review of the facili Comprehensive residents are ongo	f #125) on January 10, 2019 at I stated anything in the care sing is updated daily. She said disciplinary team (IDT) meeting e stated they are good at plan but need to get better at its. The DON said the splints resolved in the care plan.  Ity's policy titled "Care Plans revealed assessments of bing and care plans are revised.			provided to the IDT on 2/25/2019 to understanding and compliance. 4. The DON/Designee will monitor for compliance and report to the QAA C for three months.	or	
F 689 SS=D	resident's condition Free of Accident H CFR(s): 483.25(d) §483.25(d) Accide The facility must e §483.25(d)(1) The	lazards/Supervision/Devices (1)(2) ents. nsure that - resident environment remains	L.	689			
	s free of accident §483.25(d)(2)Each supervision and as accidents. This REQUIREME by:	t hazards as is possible; and n resident receives adequate ssistance devices to prevent ENT is not met as evidenced ations, staff interviews, and	The state of the s				

Event ID: V3CM11

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ł .	LE CONSTRUCTION		SURVEY PLETED
		035099	B. WING		01/1	10/2019
,	PROVIDER OR SUPPLIER RE OF TUCSON NUR	SING AND REHAB, LLC	1	STREET ADDRESS, CITY, STATE, ZIP CODE 2900 EAST MILBER STREET FUCSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	failed to ensure that to residents was free Findings include:  During an observat 2019 at 10:30 a.m., observed near the When the door to released, the door a potential accident use the restroom. It is area to go to the of the facility.  An interview was constant the same at the public restriction of the public restriction in there anyway residents probably night when no one Staff #191 further stated to be looked and 10, 2019 review to the public restriction and fron traffic area with restriction and fron traffic area with restriction out of the facility.	nd procedures, the facility to a public restroom accessible the from accident hazards.  ion conducted on January 7, two unlocked restrooms were front entrance of the facility. The estroom #1 was opened and rapidly slammed shut causing the hazard to residents who may fultiple residents passed by the front lobby and to go outside the public residents not to come but that some of them Staff #191 stated that the cuse the public restrooms at its at the receptionist desk. Itated the public bathroom cked.  Ions conducted on January 8, realed the area near the public to be a high idents going to the front lobby indents going to the front lobby.	F 689	1. On January 10, 2019 the door closs Restroom #1 was repaired to prevent door from slamming shut. The locks restrooms were changed to require a from the receptionist in order to enter restroom.  This was effective 1/10/2019.  2. All residents who enter the lobby a request a restroom could be affected.  3. The Maintenance Director will ensithe doors to the restroom are in worki condition. The receptionist will report concerns to the Maintenance Director 4. The Maintenance Director will includoor operations as part of his prevent maintenance program. The Administrishall monitor for compliance and report QAPI for three months.	the to both key the area and ure ang, safe any : ude ive ator	
	#194 further stated	use the public restrooms, Staff the doors used to be locked.				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		ı ·	X3) DATE COMP	PLETED
		035099	B. WING			01/1	0/2019
	PROVIDER OR SUPPLIER RE OF TUCSON NUR	SING AND REHAB, LLC		29	REET ADDRESS, CITY, STATE, ZIP CODE 900 EAST MILBER STREET UCSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 689	2019 at 12:35 p.m. facility will be repail does not slam shut. Review of the facility Supervision of Responder strives to make the accident hazards a included resident substance to preven priorities. Respiratory/Trache CFR(s): 483.25(i)  § 483.25(i) Respiratory care and tracheostomy care the facility must ended respiratory care and tracheal scare, consistent will practice, the compicate plan, the resident and 483.65 of this This REQUIREME by:  Based on clinical rand policy and progensure one resider	sty (staff #220) on January 10, Staff #220 stated that the ring the door today so that it it ty's policy Safety and idents revealed "Our facility environment as free from a possible". The policy afety and supervision and ent accidents are facility-wide costomy Care and Suctioning and tracheal suctioning. Insure that a resident who care, including tracheostomy suctioning, is provided such th professional standards of rehensive person-centered lents' goals and preferences,		395	1. The Policy and Procedure for Oxygen Administration was updated on 2/26/19 to include weekly tube change and date. *S attached updated policy and procedure.  2. Residents who receive oxygen could 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 oxyger 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. Attact the audit of the oxygen tubing for February and as of March 21st.  4. The DON/Designee will monitor for	be  ched is	3/3/19
	October 26, 2018,	readmitted to the facility on with diagnoses that included ailure with hypoxia, adult failure elegia.			compliance and report to QAA for three months.		
		<b>-</b>					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		035099	B. WING	)	14.5	01/1	0/2019	
	PROVIDER OR SUPPLIE	R RSING AND REHAB, LLC		29	REET ADDRESS, CITY, STATE, ZIP CODE 00 EAST MILBER STREET JCSON, AZ 85714			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	OBE	(X5) COMPLETION DATE	
F 695	Continued From	page 47	F	695				
	orders revealed a at 2 liters per mir October 26, 2018	rrent summary of physician's an order for oxygen continuously oute via nasal cannula dated B and an order to change the ery Wednesday on the night shift D, 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.		Notice to the state of the stat			Water to the state of the state		
			187					
	on January 7, 20 concentrator was however, the res cannula, as it was	ew conducted with the resident by 19 at 3:23 p.m., the oxygen is observed to be set at 2.5 liters, sident did not have on the nasal as lying on the resident's tray. The tubing revealed no date when een changed.						
	was observed sl oxygen tubing or 2,5 liters. The tu	019 at 12:28 p.m., the resident eeping in his wheelchair with the n and the concentrator was set at bing was not observed to have a hen the tubing had been last	And the state of t				The state of the s	
	An interview was	s conducted with a certified						

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	COMPLETED		
		035099	B. WING			01/	10/2019	
,	PROVIDER OR SUPPLIER RE OF TUCSON NUR	SING AND REHAB, LLC	STREET ADDRESS, CITY, STATE, ZIP CO 2900 EAST MILBER STREET TUCSON, AZ 85714					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE	
F 695	nursing assistant (2019 at 9:14 a.m., the overnight shift oxygen concentral date on the tubing changed. She stat the tubing or if the overdue, she char the oxygen tubing, no date on the rest the oxygen machinevel of oxygen was at 9:22 a.m. with a (LPN/staff #159), the night shift charevery Sunday and changed in the constated that if she of she would changed it is the nurse's rest amount of oxygen reviewing the order oxygen at 2 liters.  Review of the resi including in the tas no documentation. November and Definition of the properties of the night shift every the facility's policy.	CNA/staff #58) on January 10, who stated that the CNA's on change the tubing on the tors every Sunday, and tape the to show when the tubing was ed that if there is no date on date indicates that it is ages the tubing. After observing she confirmed that there was ident's tubing or anywhere on the set at 2.5 liters per minute.  Conducted on January 10, 2019 a licensed practical nurse who stated that the CNA's on the set at 2.5 liters per minute.  Conducted on January 10, 2019 a licensed practical nurse who stated that the CNA's on the set and date the oxygen tubing document the tubing was imputer in the task section. She lid not see a date on the tubing, the tubing. She also stated that sponsibility to monitor the received per a minute. After the sers, she stated the order is for dent's electronic record sk section, revealed there was that the tubing was changed in exember 2018.  We conducted with the Director of ff #125) on January 10, 2019 at a lated the expectation is that the cobe changed by the CNA's on		395				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING		(X3) DATE SURVEY COMPLETED		
		035099	B, WING			01/1	0/2019
	ROVIDER OR SUPPLIER LE OF TUCSON NUR	SING AND REHAB, LLC		29	REET ADDRESS, CITY, STATE, ZIP CODE 100 EAST MILBER STREET JCSON, AZ 85714		
(X4) ID PREFIX TAG	/FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 695	Continued From pa	·	F	695			
	guidelines for safe -Verify that there is procedure.	is procedure is to provide oxygen administration. a physician's order for this cian's order or facility protocol stration.		Little Control of the			
F 698 SS=E	monitoring when o changed. Dialysis	address a process for xygen equipment is to be	F	698	1. Physician order for dialysis was c	shtained	
	require dialysis red with professional s comprehensive pe the residents' goal This REQUIREME by: Based on clinical and policy review,	Dialysis. must ensure that residents who lysis receive such services, consistent sional standards of practice, the nsive person-centered care plan, and nts' goals and preferences. JIREMENT is not met as evidenced clinical record review, staff interviews, review, the facility failed to ensure orders were in place for one resident			on 1/10/19. See attached copy of thi order.  2. All residents who receive dialysis be affected by this alleged deficiency. An audit was conducted on 2/27/19 residents receiving dialysis to ensure are in place.100% audited had the corders.  3. The admission audit process will residents needing dialysis to ensure are current physician orders. *See a	s could y. for all e orders correct identify there attached	3/3/19
	November 16, 20	ns admitted to the facility on 18 with diagnoses that included isease, sepsis, and bacteremia.			<ul> <li>audits for February and as of March dialysis orders.</li> <li>4. The DON/Designee will monitor compliance and report to the QAA of for three months.</li> </ul>	for	
	the resident had s memory problems	nimum Data Set (MDS) d November 23, 2018 included short-term and long-term s and had severe impairment n making. The MDS assessmen					- Triple

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUI A. BUILE		(X3) DATE SURVEY COMPLETED			
		035099	B, WING			01/	10/2019
	PROVIDER OR SUPPLIER RE OF TUCSON NUF	RSING AND REHAB, LLC		290	REET ADDRESS, CITY, STATE, ZIP CODE 00 EAST MILBER STREET CSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 698	A nursing note dal revealed the resident needs the resident needs renal disease. Interest and document.  However, review of evidence that there dialysis treatment to check and chardily.  In an interview with (LPN/staff #165) of a.m., he stated the dialysis, there shot treatment to include order to monitor the resident has a monitored every or reviewed resident was unable to local dialysis treatment.  During an interview of the resident has a monitored every or reviewed resident was unable to local dialysis treatment.	resident was receiving dialysis.  ted November 23, 2018 ent had a right sided vascular  ical record revealed the resident sappointments on several ember and December 2018 and  December 21, 2018 included a dialysis related to end stage erventions included checking dressing daily at access site  of the clinical record revealed note was a physician's order for s, to monitor the dialysis site, or age the access site dressing  tha licensed practical nurse on January 10, 2019 at 10:31 at for a resident receiving and be an order for the dialysis de the days for dialysis and an an endialysis site. He stated that if a port site then it should be lay for bleeding. The nurse #151's electronic record and ate an order for the resident's we conducted with the LPN (staff		398			
	#153) caring for the at 10:38 a.m., she	nis resident on January 10, 2019 e stated the resident was alvais center. She stated she					

		AND HUL SERVICES			FORM	02/20/2019 APPROVED	
STATEMENT	RS FOR MEDICARE OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, .	PLE CONSTRUCTION G	(X3) DAT	(X3) DATE SURVEY COMPLETED	
		035099	B. WING			10/2019	
	ROVIDER OR SUPPLIER	SING AND REHAB, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2900 EAST MILBER STREET TUCSON, AZ 85714			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 698	based on an appoint every day and her redialysis days and till when the resident reassessment is done site. She stated the documented every an order to monitor. In an interview with (DON/staff #125) of a.m., she stated the order in place for distributed includes the location stated there should	sident is scheduled for dialysis at the sident log that is reviewed report sheet that has the me. The LPN also stated that returns from dialysis an e which includes checking the site should be assessed and shift, and that there should be	F 69				
F 725 SS=E	Access Care" did n regarding a resider Per the DON, there to dialysis. Sufficient Nursing CFR(s): 483.35(a)( §483.35(a) Sufficier The facility must have appropriate corprovide nursing an	1)(2)	F 72	25			

practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care

diagnoses of the facility's resident population in accordance with the facility assessment required

and considering the number, acuity and

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		035099	B. WING_		01/	10/2019
·		RSING AND REHAB, LLC		STREET ADDRESS, CITY, STATE, 2 2900 EAST MILBER STREET TUCSON, AZ 85714	ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X6) COMPLETION DATE
F 725	at §483.70(e).  §483.35(a)(1) The by sufficient number of personner nursing care to al resident care plar (i) Except when withis section, licential (ii) Other nursing limited to nurse a section of the	e facility must provide services pers of each of the following el on a 24-hour basis to provide I residents in accordance with his:  vaived under paragraph (e) of sed nurses; and personnel, including but not ides.  cept when waived under this section, the facility must sed nurse to serve as a charge ar of duty.  ENT is not met as evidenced and staff interviews, facility hid policies and procedures, the lave sufficient nursing staff to and related services to assure and attain or maintain the highest cal, mental and psychosocial	F 72	1. The facility updated the reflect a more structured who call in resulting in stapolicy was presented to sattached policy regarding. There has been an increased c.N.A.'s and nurses to fill. This will reduce the numb agency usage resulting in consistent patient care. patterns were reviewed to increased staffing on the consistent patient could be alleged deficiency.  3. The Resident Council reviewed by the Administ monitored to ensure a resplan will be addressed for An additional Guest Servithas been hired as of 3/1/resident concerns and as grievances.  4. The Administrator will compliance and report to QAA Committee for three	procedure for those off shortages. This staff on 2/22/19.*See call-in's. Use in the hiring of open positions. User of outside in better and open the staffing of reflect a need for Behavioral Unit. Eaffected by this summer and action all concerns. Uses Coordinator of the staff any monitor for the	3/3/19

#### PRINTED: 02/20/2019 DEPARTMENT OF HEALTH AND HUM. SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 035099 B. WING 01/10/2019 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2900 EAST MILBER STREET SAPPHIRE OF TUCSON NURSING AND REHAB, LLC **TUCSON, AZ 85714** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 725 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.

require two staff to provide care.

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

An interview was conducted with another CNA,

CEITIEI	TO LOIT MEDIO/ 11/E	O MILDIONO DELLA VIOLE						
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING				(X3) DATE SURVEY COMPLETED	
		035099	B. WING	;		01/1	0/2019	
	PROVIDER OR SUPPLIER RE OF TUCSON NUR	SING AND REHAB, LLC		2	TREET ADDRESS, CITY, STATE, ZIP CODE 900 EAST MILBER STREET UCSON, AZ 85714			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 725	who stated that she could use more stated that sometiment on 2nd shift for this most of the resider staff to provide car facility is trying to sare now using age  An interview was controlled in the resider staff. The LP short, I do not focus paperwork and hele and interview was controlled in the staff. The LP short, I do not focus paperwork and hele and interview was controlled in the staff. The short is the staff in the staff in the staff in the staff. The same more CNAs so surveyors are here. Review of the Res February 2018 through the following concernation of the staff and residents answered prompting yellow in the staff and residents and yellow in the yellow in the yellow in the yellow in the yellow	e thought the afternoon shift aff especially on the weekends. at they used to have a hall anymore.  onducted with a CNA, who mes they only have two CNA's a hallway and it's hard because into on this hallway require two e. The CNA stated that the staff adequately because they included with a LPN (licensed the LPN stated they could use into one in the could use i		725				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		035099	B. WING	)	AND THE RESIDENCE OF THE PARTY	01/	10/2019
	PROVIDER OR SUPPLIER	SING AND REHAB, LLC		2	STREET ADDRESS, CITY, STATE, ZIP CODE 2900 EAST MILBER STREET FUCSON, AZ 85714	# <u></u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 725	a.m 3:00 p.m. B2 -September 13: "R staff." -October 12: "Call and residents and 15 minutes on B2.' -November 8: "Ove stated by one residents to 30 being met. Residents the dining room haweek. Residents in passing food."  According to the redocumentation, and 2019 at 2:10 p.m., documentation, for that there was not to wait extended prassistance.  On the last page of for the above mone "Interventions to be month this section  An interview was of director (staff #2) of Staff #2 stated that director since April minutes for the residents' concern resident council kr	2 (long term care unit)." esidents feel like they lack lights are not answered quick family are waiting more than erworked and understaffed was lent. B2 (all shifts). CNA's do a most are exhausted." resident stated there have patients and needs are not nts stated staffing issues for we happened three times this eed help with feeding and esident council meeting meeting was held on January 9, with six residents. Per the ur of the six residents stated enough staff and that they had eriods of time for staff  f the Resident Council Minutes ths was a section titled, e implemented" however, each		725			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		035099	B, WING			01/1	0/2019
	PROVIDER OR SUPPLIER RE OF TUCSON NUR	SING AND REHAB, LLC		29	REET ADDRESS, CITY, STATE, ZIP CODE 00 EAST MILBER STREET JCSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 725	regarding staffing.  An interview was of administrator (staf 9:25 a.m. Staff #20 monitor in the half Staff #20 stated the residents concerns.  An interview was of partner of the facility of			725			
F 758 SS=D	Review of the faci revealed, "Our fac of staff with the sk to provide care an accordance with r facility assessmen to our facility's sta Administrator or h Free from Unnec CFR(s): 483.45(c) §483.45(e) Psych §483.45(c)(3) A p affects brain activ processes and be	lity's policy regarding Staffing cility provides sufficient numbers cill and competency necessary and services for all residents in esident care plans and the ntInquiries or concerns relative ffing should be directed to the lis/her designee."  Psychotropic Meds/PRN Use (13)(e)(1)-(5)	F	758			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 758	(i) Anti-psychotic; (ii) Anti-depressant (iii) Anti-anxiety; an (iv) Hypnotic  Based on a compreresident, the facility \$483.45(e)(1) Resipsychotropic drugs unless the medicat specific condition a in the clinical record \$483.45(e)(2) Residugs receive gradibehavioral interven contraindicated, in drugs;  \$483.45(e)(3) Resipsychotropic drugs unless that medicat diagnosed specific in the clinical record \$483.45(e)(4) PRN are limited to 14 da \$483.45(e)(5), if the prescribing practitic appropriate for the beyond 14 days, he rationale in the resindicate the duratio \$483.45(e)(5) PRN drugs are limited to \$483.45(e)(6) PRN drugs are limited to	chensive assessment of a must ensure that—dents who have not used are not given these drugs fon is necessary to treat a sidiagnosed and documented d; dents who use psychotropic all dose reductions, and tions, unless clinically an effort to discontinue these dents do not receive pursuant to a PRN order tion is necessary to treat a condition that is documented	F 758	The following actions have been taken those residents noted to be affected be alleged deficient practice.  1. Resident #135 was discharged on 12/26/18.  2. All residents could be affected by the alleged deficiency. The Behavioral Henurse manager conducted an audit be 1/28/19-2/1/19 to determine correct diagnosis for use of psychotropic drug.  3. The Behavioral Health nurse manage conduct ongoing random audits on or psychotropic medications for the correct diagnosis. *see attached audit correct diagnosis for psychotropic medications the orders will reviewed by nurse managers to check appropriate diagnosis. All other orders in-house residents will be reviewed a clinical meeting.  4. The DON/Designee will monitor for compliance and report any issues to the Committee for three months.	his ealth etween gs. ger will rders for dications. I be k for s for et daily	3/3/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		035099	B. WING			01/	10/2019
	PROVIDER OR SUPPLIER	BING AND REHAB, LLC		29	REET ADDRESS, CITY, STATE, ZIP CODE 00 EAST MILBER STREET JCSON, AZ 85714		
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F 758	prescribing practition the appropriateness. This REQUIREMENT by: Based on closed conterviews, and polifacility failed to ensions who was prescribe upon admission, has been supon to a significant of the supon to a significant him and traumatic brain with normal mood at the supon transfersident was received included the Rission other antipsychotic continued review of a discharge summation traumation of the supon transfersion of the supon transfersion but did psychosis.	oner evaluates the resident for sof that medication.  NT is not met as evidenced linical record review, staff cies and procedures, the ure that one resident (#135) dan antipsychotic medication ad indications for its use.  Admitted on November 7, as that included Alzheimer's ephalopathy, and major r. The resident was discharged 8.  Records prior to the resident's da H&P (History and Physical) nber 5, 2018 that the resident story of Alzheimer's dementiant injury and was cooperative and cognition. The hospital of medications that the ring in the hospital. The list did peridone (antipsychotic) or any		758			

# DEPARTMENT OF HEALTH AND HUM. SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		035099	B. WING		01/	10/2019
•••	PROVIDER OR SUPPLIER RE OF TUCSON NUF	RSING AND REHAB, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2900 EAST MILBER STREET FUCSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTIES OF T	D BE	(X5) COMPLETION DATE
F 758	Continued From page 59		F 758			
		dated November 7, 2018 for ng tablet two times daily for				
	The Medication Administration Record for November 2018 revealed the resident was administered Risperidone as ordered.					
	assessment dated BIMS (Brief Interv 11 which indicated impaired cognition resident felt tired, sleeping, and vert The assessment a received antipsycl	(Minimum Data Set) d December 26, 2018 included a lew for Mental Status) score of the resident had moderately n. The assessment included the depressed, had difficulty pal behaviors directed at others, also included the resident notic medications. However, the ot include the resident had a disorder.				
	any additional doc diagnosis of deme	the closed record did not reveal cumented evidence that the entia for the use of the lication Risperidone had been				
	at 9:17 a.m. with to a compare the compare	conducted on January 10, 2019 the Director of Nursing The Director stated that a ed to support the use of specific that if the physician prescribes a ich the resident does not have a rse is to question the doctor sis. The DON stated that when a ed from the hospital, the are prescribed must verify with the nurse. The DON stated that thug cannot be prescribed for there is a diagnosis to support				

# DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		035099	B. WING	- All believes		01/10/2019	
	NAME OF PROVIDER OR SUPPLIER  SAPPHIRE OF TUCSON NURSING AND REHAB, LLC			STREET ADDRESS, CITY, STATE, ZIP O 2900 EAST MILBER STREET TUCSON, AZ 85714	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPRODEFICIENCY)		(X5) COMPLETION DATE	
F 758	further stated that the drug for resident #1 with the physician.  During an interview 2019 at 9:35 a.m. with the physician.  During an interview 2019 at 9:35 a.m. with the physician.  During an interview 2019 at 9:35 a.m. with the physician with the physician with the number of the facility's policy and the physician's attention.  The facility's policy Antipsychotic Medicatement that antip considered for residenter medical, physician medical, physician with the phy	sychotic drug. The DON he use of the antipsychotic 35 should have been clarified  conducted on January 10, ith a RN (Registered he nurse stated that if a opriate for an ordered se would bring it to the h.  and procedure titled cation Use included a policy osychotic medications may be lents with dementia but only cal, functional, psychological, ic, social and environmental al symptoms have been ossed. The policy included beceive antipsychotic hecessary to treat specific hat they are indicated and  Identifiable Information h, 483.70(i)(1)-(5)  ent-identifiable information. release information that is to the public. release information that is to an agent only in contract under which the agent of the facility itself is permitted	F 7	758			
	S. 100.1 O(I) MEGICAL	Coolag.					

# DEPARTMENT OF HEALTH AND HUM. SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			COMPLETED		
		035099	B, WING			01/1	0/2019
SAPPHIRE OF TUCSON NURSING AND REHAB, LLC  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREF	2 T	TREET ADDRESS, CITY, STATE, ZIP CODE 900 EAST MILBER STREET "UCSON, AZ 85714  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION	
PREFIX TAG	Continued From pa §483.70(i)(1) In ac professional stand- must maintain med that are- (i) Complete; (ii) Accurately docu (iii) Readily access (iv) Systematically §483.70(i)(2) The tall information con- regardless of the formation	age 61 cordance with accepted ards and practices, the facility lical records on each resident imented; lible; and organized facility must keep confidential tained in the resident's records, orm or storage method of the	TAG		CEACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)  The facility does have a policy that access to all electronic medical records to this facility to August 2018. During the certification conducted 1/7-1/10 the facility made multiple attempts to obtain the elect medical records for Resident #225 previous owners. The previous own (Avalon) would not send electronical PCC (Point Click Care) but did send through email therefore allowing Sapphire of Tucson to print the medical record for the survey team.	t allows ords. ok over n survey e ronic from the ners ally to	3/3/19
	records, except where (ii) To the individual representative where (iii) Required by La (iii) For treatment, operations, as perwith 45 CFR 164.5 (iv) For public heal neglect, or domest activities, judicial at law enforcement purposes, research medical examiners a serious threat to by and in compliant	nen release is- I, or their resident I, or health care I, or health oversight I, or coroners I, or to coroners I, or to coroners I, or to coroners I, or to avert I, or health or safety as permitted I, or with 45 CFR 164.512.			2. The residents who are affected by alleged deficiency would be dischar residents that were under the contribution of the previous owners.  3. If there are future request for me records under the control of the precords under the control of the precords obtain the records for all entities agencies that request them.  4. The Administrator will monitor at the point person for this issue	ged of the edical vious reffort	
	record information unauthorized use.  §483.70(i)(4) Medifor- (i) The period of till (ii) Five years from there is no require	facility must safeguard medical against loss, destruction, or cal records must be retained me required by State law; or the date of discharge when ment in State law; or years after a resident reaches	The state of the s				

# DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		035099	B. WING	,		01/	10/2019
	PROVIDER OR SUPPLIER	SING AND REHAB, LLC		29	REET ADDRESS, CITY, STATE, ZIP CODE 200 EAST MILBER STREET UCSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 842	legal age under State \$483.70(i)(5) The rile (ii) Sufficient inform (ii) A record of the rile (iii) The compreher provided; (iv) The results of a and resident review determinations con (v) Physician's, nur professional's prog (vi) Laboratory, rad services reports as This REQUIREMED by:  Based on record repolicies and procedensure that electro for one resident (#2 the State Survey Testindings include:  Resident #225 was with diagnoses that behavioral disturbation known physiological disorder, and altered #225 was discharged.  During random revirecords conducted revealed the electrod #225 were not acceptioned.  An interview was continued.	nedical record must containation to identify the resident; resident's assessments; resident's assessments; resident's assessments; resident's assessments; resident's assessments; resident's assessments; resident solutions and ducted by the State; se's, and other licensed ress notes; and iology and other diagnostic required under §483.50, NT is not met as evidenced review, staff interviews and dures, the facility failed to record and paper health records (225) were readily accessible to ream.  I admitted on July 22, 2015 and included dementia with record and condition, delusional red mental status. Resident red on April 5, 2018.  I iews of the facility electronic on January 7, 2019 it was onic health records for resident resible in the data base illity.	F	342			
		onducted with the #20) on January 7, 2019 at					

# DEPARTMENT OF HEALTH AND HUM. SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND DIAM OF CORDECTION ENGINEERS AND ARRESTS.				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		035099	B. WING		And the same of th	01/	10/2019
	PROVIDER OR SUPPLIER RE OF TUCSON NURS	SING AND REHAB, LLC		29	REET ADDRESS, CITY, STATE, ZIP CODE 100 EAST MILBER STREET UCSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 842	10:15 a.m. The adr facility did not have for resident #225, a records had been nof the facility when the current owner in Administrator states previous owner that needed, and that the they were supposed electronic health reached for the maintained for stated that staff were previous owners of the health records for the process of uploating and that printed after the upshe did not know we resident #225 were previous owner price.	ninistrator stated that the access to electronic records and that access to those emoved by the previous owner the facility was purchased by August 2018. The did that he would notify the access to the records was a facility staff were aware that did to have access to all cords for resident #225.  Inducted with a corporate staff of the access to medical records was ar 7 years. Staff #220 also are in communication with the the facility to obtain access to for resident #225.  Inducted on January 8, 2019 and the paper records and cords for resident #225 were ause the records (staff #184). The previous owner was a the facility. She stated that adding the documents would be load. Staff #184 stated that hether or not the records for being pre-screened by the or to being uploaded.	F	342			

# DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 867 SS=E	obtain access to elethe previous owner  In a follow-up intervon January 8, 2019 provided a stack of resident #225 and access to electronic #225.  Review of the facilitielectronic Medical that authorized Fedas outlined in curre access to electronic QAPI/QAA Improve CFR(s): 483.75(g)( §483.75(g) Quality §483.75(g)(2) The assurance committed (ii) Develop and impaction to correct identified This REQUIREMED by: Based on concern staff interview and assessment and as failed to identify quappropriate plans of deficiencies.  Findings include:	ectronic health records from of the facility.  Piew with staff #184 conducted at 2:08 p.m., the staff #184 printed paper records for stated that there would be not health records for resident by's policy and procedure titled Records included a statement teral and State survey agents and regulations may be granted by medical records.  Piement Activities (2)(ii)  Passessment and assurance.  Quality assessment and dee must:  Polement appropriate plans of entified quality deficiencies;  Part is not met as evidenced by identified during the survey, policy review, the quality seurance (QAA) committee delity concerns and implement fraction to correct the quality	F 867		quality ent
		annual recertification survey, vere identified in the following			

# DEPARTMENT OF HEALTH AND HUM. SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		035099	B. WING	<b>V</b>		01/1	10/2019
	PROVIDER OR SUPPLIER RE OF TUCSON NURS	SING AND REHAB, LLC		STREET ADDRESS, CITY, STATE, 2900 EAST MILBER STREET TUCSON, AZ 85714	ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD	BE	(X8) COMPLETION DATE
F 867	-Resident to reside -One resident elope -Implement facility   allegation of negled -Report an allegatio -A physician's order -Failed to maintain -Failed to provide a timely.  An interview was coadministrator (staff 2:26 p.m. Staff #20 a quality concern th QAA committee. St	roughout the facility, and abuse involving 5 residents, and from the facility, colley regarding reporting an at.  In of neglect within two hours, was not obtained for dialysis, adequate staffing, coess to electronic records	F	367			
F 919 SS=D	QAA committee monodinistrator further action plans regard identified during the process had not identified during the process had not identified during the process had not identified to the QAPI Committee of the QAPI Com	initors the progress. The ar acknowledged there were no ing the quality concerns a survey and that the QAA entified the above issues.  By's policy regarding Quality formance Improvement revealed "The primary goals attee are toHelp identify a negative outcomes relative to esolve them appropriately"	F §	019			

		AND HUM / SERVICES  & MEDICAID SERVICES			, j		APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
		035099	B. WING	}		01/	10/2019
NAME OF F	PROVIDER OR SUPPLIER	***************************************	In a company of the c	s	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
SAPPHIF	RE OF TUCSON NURS	BING AND REHAB, LLC		l	1900 EAST MILBER STREET FUCSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 919	Continued From pa work area.	ge 66	F	919			
	This REQUIREMEN by: Based on observat facility failed to ensi	and bathing facilities.  IT is not met as evidenced ions and staff interviews, the ure that two public restrooms, id, were equipped to allow staff assistance.	777				
	Findings include:						
	2019 at 10:30 a.m., observed near the f Neither restroom we communication syst resident require ass Once inside of each was observed on the was unable to be ur the door in the even were posted on bott stated "Lobby restroonly. Residents, ple Thank you for your Sapphire Managem	tem to alert staff should a sistance while in the restroom. It restroom a deadbolt lock to					
And the second s	(staff #191) on Janu #191 stated that the the public restrooms residents go in there that the residents prestrooms at night v	inducted with a receptionist lary 8, 2019 at 9:25 a.m. Staff by ask the residents not to use to but that some of the anyway. Staff #191 stated robably use the public when no one is at the taff #191 further stated that		Transport Adapte			

the public bathroom doors used to be locked.

DEPARTMENT OF HEALTH AND HUM SERVICES

PRINTED: 02/20/2019

# DEPARTMENT OF HEALTH AND HUN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		035099	B. WING	B. WING		01/	10/2019
SAPPHII	T	SING AND REHAB, LLC		2	TREET ADDRESS, CITY, STATE, ZIP CODE 900 EAST MILBER STREET 'UCSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 919	Observations cond 2019 revealed the and front lobby con with residents going the facility.  An interview was conceptionist (staff #11:00 a.m. Staff #11:00 a	ucted on January 8, 9, and 10, area near the public restrooms tinued to be a high traffic area of to the front lobby or out of conducted with another 194) on January 10, 2019 at 194 stated that the residents use the public restrooms. Staff of facility put the signs on the restrooms due to the fact that in there and fall and they they were in there because a Staff #194 further stated the cked.  Inducted with the managing of (staff #220) on January 10, Staff #220 stated that the doors were his fault. Staff then he first came to the facility dignity issue to be in the people knocking on the door here. Staff #220 stated that he cupied/unoccupied deadbolts esolve the dignity issue.	F	919	The following action have been taken those residents noted to be affected alleged deficient practice.  1. The locks to both public restrooms changed to require a key from the receptionist in order to enter the restroom. The residents will not be to use the public restroom as there is call system in place. This was effective 1/10/19.  2. All residents who enter the lobby a and request a restroom could be affect this alleged deficiency.  3. The manging partner for the facility confirmed that the restrooms will remain locked with accessibility only through controlled method of obtaining a key from the receptionist.  4. The Administrator will monitor for compliance and report any issues to QAA Committee for 3 months.	by this were e allowed not a e trea cted by / has ain the	3/3/19

# DEPARTMENT OF HEALTH AND HUM. ... SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/20/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		COMPLETED		
		025000		B. WING		04/40/0040	
NAME OF F	DOVIDED OF SUPPLIES	035099	D. VYING		STREET ADDRESS, CITY, STATE, ZIP CODE	1 01/	10/2019
	PROVIDER OR SUPPLIER	v v v v v v v v v v v v v v v v v v v		70.50	900 EAST MILBER STREET		
SAPPHIR	RE OF TUCSON NURS	SING AND REHAB, LLC			TUCSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	from January 7 throconjunction with the investigations: AZ0 AZ00151707, AZ00 The following deficing Right to be Informed CFR(s): 483.10(c)(s) 483.10(c) Plannin The resident has the participate in, his of Section 1988.10(c)(1) The language that he other total health stating or her medical of section 1988.10(c)(4) The advance, of the care of care giver or professional, of the care, of treatment options a option he or she professional, of the care, of treatment options a option he or she professional polifically failed to enshad been informed.	fication survey was conducted bugh January 10, 2019, in electrological following Complaint 0147662, AZ00152817, 0153440 and AZ00152668, iencies were cited. ed/Make Treatment Decisions 1)(4)(5)  gland Implementing Care. he right to be informed of, and right to be fully informed in right to be fully informed in right to be fully informed in right to be informed, in condition.  right to be informed, in reto be furnished and the type of essional that will furnish care. In the care of exists and benefits of proposed and treatment alternatives or and to choose the alternative or	F	552	of Correction does not constitute ac or agreement by the Provider of the the facts alleged of the convictions in the statement of deficiencies. W implemented the Plan of Correction stated below and the facility is dem compliance for the deficiencies cite	dmission truth of set forth e have as constrating d.  of Healt Health 1999	
LABORATOR	Y DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		7 TITLE	41	(X6) DATE

deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that orner 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
	Marinesa Jan June	M	6A-68
	Hea Smith	gr	18-06
	Druce.	CPN	6A-6P
	Dryghilleoner	LPN	WP-GA
	Angela D'Edwards	LPN	6A-6P
	Stophaniel Hotter	RN	6p-6A
	Charles Wylie	LPN	6u-6p
	Babara Bogard	HN	lea-lep
	comie morris	LPN	Le A · Le P
	CLAUDIA Cotional	<u> Lan</u>	GA-GP
	Jena Panebianco.		UA-UPM.
	Manuela Bran	UPN	60-6Pm
	Mandee Kruse	LPW.	6A-6PM
	Calulla C		UN JOHN
	for	cpn	6am-6/n
4		<i>y</i>	
		·	
L			

F518



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 .

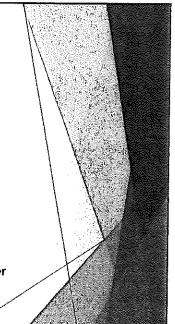
"THEY may forget your name, BUT they will never forget how you made them feel." Maya Angelou

### 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

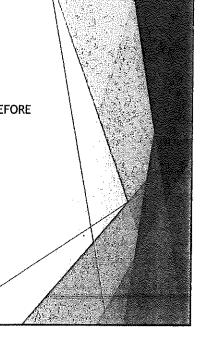


## Admit / Readmit Screener

- ▶ 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! ◎

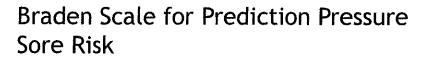
## Consent to Treat

- ▶ 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!!!



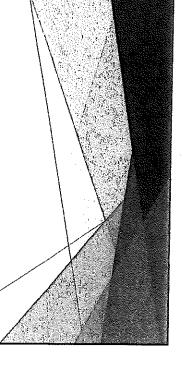
## **Admission Note**

- 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.



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



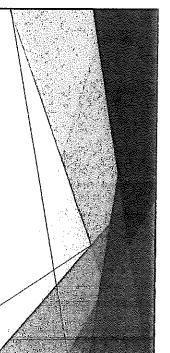


# Dehydration Risk Screener

▶ 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.
- Nou 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

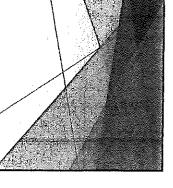
- ▶ Advanced directives must be input for EACH RESIDENT!!!
- ► If the resident has a 'DNR' code status, an orange DNR sheet MUST be filled out and signed by the resident/appointed guardian/POA.
  - ▶ Without the orange form filled out correctly, the resident is considered a full code. Please take caution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

## Diet

- ▶ A diet order <u>must</u> 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.

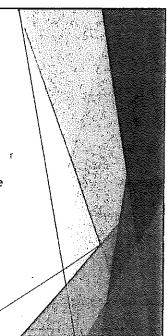


# Appointments and Transport

- ➤ Appointments are a PRIORITY, not an ➤ The appointment/transportation 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
- Donna's box/hanging file box is located next to the pharmacy fax machine on the second floor nurses station.
- 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.

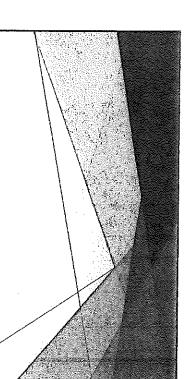


# Medication Orders and Faxing to PharMerica

- ▶ Once orders are <u>verified</u> 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

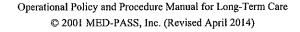
#### **Policy Statement**

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.
- 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.

continues on next page



# ATTENDANCE FORM

In-service Title: Annual Su	rver Besuets, Bush	to of Life Poles Rome.				
In-service Title: Annual Survey Results, Bushity of Life Policy Henew Topics Discussed (May Attach Outline):						
Employee Sland	Book Attendance,	Palia				
Yunsing / Alm	LARCH TILLIAMI.	Alla Salad C. C.				
Instructor's Name & Title: All &	Wigsins, Administrate +	Customer Servis				
	HAFF Geon Psely-DOI	answern Call Be				
Date: 2/8/19		Oders, Care found				
Name - Please Print	Title	Hours Earned				
Tagried Pervaiz	LPN	·				
jillian la Crojo	Operations					
17mber Stogner	CNA					
Marih Waldenado	UPW					
Heid Snith	you.					
IRINE PAKAYO	pr					
Anet Onchimbo	LPN					
LONNA BROOM	SLP					
TRENE ARRIERO	CNA					
MARY EllEN WOZDIAN	MDS RN					
Dana Greenlee	Cota/L					
Marghan Nomark	z CNA					
Jennifer Roaders	UPN					
Ouddore Johnson	HOUSEKEEPS OF	·				
mary Clay	HOUSEKEEPING					
AngelA EdiNAROS	UPN					
Kosela Medina	Lowdon					
Charles Lylie	LPN J					
McDupello	CWA					
leons is Uriante	Cha					
don Tries	Lra					
TH (5AD) (45-9)	CNA					
Micheela Calla 1	CNA	7				
by Alex Mare	SEND	H				
Killy Teurs,	CNA.					
TYldóna Verchese	INPN					

# ATTENDANCE FORM

the compared to the control of the c



In-service Title:	Survey Bessets Dags	ily of Life Policy Review
Topics Discussed (May Attach O	utline):	
Employee Soul Book,	Dualish of Life solone	answer and the
Care Rounds, Life.	CAL La	
Instructor's Name & Title:	La Wiggins, Administrate	r, Jean Cseley-Duretor Aussins
Required Depart/nents:		Aussins
Date: 2/8/19		
Name - Please Print	Title	Hours Earned
Manuela Brano	Mhuis	·
Corinne Pineda	LPN	
Cornil morris	ALPN	
dumlid scoched	Hoorteel	
Phungferenian	IPN.	
JEFF ARKS TRONG	Diet Aid	
Samantha Mallin	UPN CM	
(July Bothme)	Hn.	
Ciridia Citienes	Casi	
Britain Marble	RN Unit Manage	P
Jebby Buitan	RD	
KINDAN KESTEVSMUN	OWA	
Jamie Hadley	CNA	
AMY Watsabaugh	CNA	
Lita G. Monero Libbon Martinez	CNA	
LAVOCTUR Wing	CNA	
Libba Martinez	Diet tech	
	·	

# ATTENDANCE FORM

the configuration of the control of

In-service Title: Honual.	Survey Oxtcomes, Que	lig of Life, Policy Kon
Copics Discussed (May Attach O	utline):	
	<del>,</del>	
nstructor's Name & Title: <u>Slej</u>	La Miggins, Administrator	, Jaon Csoley - Due other &
equired Departments:		Parsing
Pate:2/8//9 _	and the same of th	
Name - Please Print	,Title,	Hours Earned
Verlene Antone	Howkenn x	
esirae whitehead	Housekeeping	
Ma Downs	nuersina	
yra Wiggure	GF-	
I AMA / (WEN		
Ana Fosas	ACT	
FRMA Beck	med Kec	
Makylon Aguirre	HIM	
Lariah Arenivas	-CNA	
Thanky Homings	CYVIT .	
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#### F600

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

- 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.

#### **NURSING**

IN-SERVICE ATTENDANCE FORM

IN-SERVICE TITLE: De-escalating Technique

Presented by Patry Soto/Maricela Nunaryon Beh Misserest

Required department: All a

Required department: All of Instructor: Date: 2115119

Mandatory In-service:

Name- Please print	Title	Shift
Eileen Acosta	ACTIVITIES CNA	9 am - 7 pm
angie Quintero	act /CWA	9-7
jillian La Crojs	Operations	24 Hes
JERR Martinez	CNN	7-3 pm
Ida Trier	LNa	11-73pm
Alx Salar	LAVA	7-3 Am
Kasemany Koybal	LPN	6A-6P
Gealin M. Coury	LPA	CA GP
lose Cedillo	(fn	lone Gpm
Monica Varquez	CNA	7-3pm
	CNA/GR	12-80m
Herron Green	Activities	9-2pm

Lorena Pesquirua = Alos needs Centificate

De Escalation
Training
3/2/19
2pm

Abriette autre

CNA

Drene Hopers Angie Ovinteres

CNA

Marina Duarte

Activities

Corinne Pineda

CI-Nuse

12/21/18

De-escalating techniques with Harve morrus PHD

12/12/118 Mulidia Bones Montea Vazavez Rosemany Royally T Ana laBlue in Luna Gutierrez CPN. MARY Erdmann-Belz Valeria Escobar. petra Reyes Harriette Antone V. Form LAVOCTURE Winn

4:30-4:45pm

## **IN-SERVICE ATTENDANCE FORM**

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

Topics Discussed (May Attach Outline):

Instructor's Name & Title:, Amelia Gabus: MSW, SSD
Required Departments: CNA's + NWSING

Date: 4 ~ 9 - 15	<i>J</i>	
Name – Please Print	Title	Hours Earned
Mclissa Boneo	CMSA	
Retra Rayes Repra Turado	CNA	
Kula Carares	CNA	
Maria Craumo	_ CNA	
Sharon Walter	Dor	
Ana Rusas	ACT/CNA ONA JEACT	
Myce Grintero	ONA JEACT	
Makeyille	CNA	
addenia Escobar	CNA	
partler padilla	CIUA	
Bolon Bonifacio	LNH	
Then are	CNA	
Onguni Liadu	CIVII	
Lindsey maninn	CWA	
friene Hall	(+) V	
KHI / ( I C)	CDA	
110/ ///	1014	
Chapter Carron	1/07	
CHARLES TOWN	CNA	
Jan () 100	CNA	
Harriste Antino	QNA	
1011A TO 12	Rivit	
Holda III Ma assed	CNA	
Dear He a service	CNA	
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# 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.
- communication techniques, to diffuse, re-direct, or de-Approach is to use calm language, along with other 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 55% OF COMMUNICATION IS NON-VERBAL



What is her body language saying?

# BODY LANGUAGE CAN ESCALATE TENSION

## Match the body language to its message.

- Shoulder shrugging
- Jaw set with clenched teeth
- Finger pointing
  - A fake smile
- Excessive gesturing, pacing, fidgeting, or weight shifting
- culturally appropriate Touching, even when Ó

- B. Accusing or threatening A. Mocking or uncaring
- C. Anxiety
- Hostility or threatening
- E. Not open-minded or listening Uncaring or unknowing
- Aggressive postures Also avoid: Turning your back

## 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.
- promotes greater balance and mobility and exposes less of the body Stance- at an angle, feet hips width apart, one foot in front. This as a target.
- Stay far enough away so that the individual cannot hit, kick or grab

### 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=xD7rVRInrJI

# 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
- 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
- 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

### 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=-4EDhdAHr0g

### 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

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

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F600

Position	Shift	Hours	A1	В1	<b>C1</b>	A2	B2	C2
Activities	9:00AM-7:00PM	10	1	1	1			
Hall Monitor	7:00AM-3:00PM	8	1	_		-	-	-
Hall Monitor	3:00PM-11:00PM	8	1	_	-	-	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

12

Staffing Patherns

6:00AM-6:00PM

6:00PM-6:00AM

LPN/RN

LPN/RN

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)					

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.

### **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
  - 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.



- 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

Sapphire of Tucson Nursing and Rehab

F 607

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

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  - h. Interview the resident's roommate, family members, and visitors;
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  - b. The local/State Ombudsman;
  - c. The Resident's Representative (Sponsor) of Record;
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  - e. Law enforcement officials;
  - f. The resident's Attending Physician; and
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  - 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

### **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.

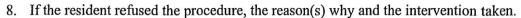
### Steps in the Procedure

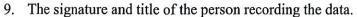
- 1. Wash and dry your hands thoroughly.
- 2. Place an "Oxygen in Use" sign on the outside of the room entrance door. Close the door.
- 3. Place an "Oxygen in Use" sign in a designated place on or over the resident's bed.
- 4. Remove all potentially flammable items (e.g., lotions, oils, alcohol, smoking 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.
- 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.





### 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)

F125

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

1 <sup>st</sup> unscheduled absence	Verbal Warning
2 <sup>nd</sup> unscheduled absence	Written Warning
3 <sup>rd</sup> unscheduled absence	Suspension of up to 3 shifts
4 <sup>th</sup> 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,



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.

Douglas A. Ducey | Governor Cara M. Christ MD, MS | Director

Sapphire of Tucson Nursing and Rehab, L.L.C. February 20, 2019 Page Two

### 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.

Sapphire of Tucson Nursing and Rehab, L.L.C. February 20, 2019
Page Three

### **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

Sapphire of Tucson Nursing and Rehab, L.L.C. February 20, 2019 Page Four

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 <a href="https://dab.efile.hhs.gov">https://dab.efile.hhs.gov</a> 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: <a href="https://dab.efile.hhs.gov/user\_sessions/new">https://dab.efile.hhs.gov/user\_sessions/new</a> 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: <a href="https://dab.efile.hhs.gov/appeals/to\_crd\_instructions">https://dab.efile.hhs.gov/appeals/to\_crd\_instructions</a>. 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

Sapphire of Tucson Nursing and Rehab, L.L.C. February 20, 2019
Page Five

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, Calles

Diane Eckles Bureau Chief

DE:sf

### DEPARTMENT OF HEALTH AND HUM, ... SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/20/2019 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED		
	035099		B. WING			01/10/2019		
NAME OF PROVIDER OR SUPPLIER SAPPHIRE OF TUCSON NURSING AND REHAB, LLC				29	TREET ADDRESS, CITY, STATE, ZIP CODE 900 EAST MILBER STREET UCSON, AZ 85714			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL, REGULATORY OR LSC IDENTIFYING INFORMATION)				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 552 SS=D	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		F 000  Preparation and/or execution of Correction does not constitute or agreement by the Provider the facts alleged of the conviction the statement of deficiencies the provisions of the Federal at F 552  F 552  F 000  Preparation and/or execution of Correction does not constitute or agreement by the Provider the facts alleged of the conviction the statement of deficiencies the provisions of the Federal at F 552		Preparation and/or execution of this of Correction does not constitute ad or agreement by the Provider of the the facts alleged of the convictions in the statement of deficiencies require the provisions of the Federal and Statement of the Federal a	truth of set forth uired by		
LABORATOR	Findings include:	MDER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		1 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.

Facility ID: LTC0053 If continuation sheet Page 1 of 68

### DEPARTMENT OF HEALTH AND HUM, SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/20/2019 FORM APPROVED OMB NO. 0938-0391

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		035099	B, WING	S	4	01/1	10/2019
NAME OF PROVIDER OR SUPPLIER  SAPPHIRE OF TUCSON NURSING AND REHAB, LLC  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREF TAG	29 T	TREET ADDRESS, CITY, STATE, ZIP CODE 900 EAST MILBER STREET UCSON, AZ 85714  PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	(X5) GOMPLETION DATE
F 552	2018, with diagnos disease, toxic ence depressive disorder Review of the close form titled Admissis 2018, which includ self-responsible.  A form titled, Cons November 7, 2018 signer of the form medical decision in by resident #135.  A physician's order included for the resoluted for the resoluted for the resoluted for the use or related to behavior intervention for staresident/family/car benefits and side of the medication.  Further review of the risks, benefits and An interview was at 9:17 a.m., with (DON/staff #125), antipsychotic drug	es admitted on November 7, es that included Alzheimer's ephalopathy and major er.  ed clinical record revealed a on Record dated November 7, ed the resident was  ent to Admit and Treat dated included a statement that the was the responsible party for naking. The form was signed of dated November 7, 2018 sident to receive Risperdone of the medication) two times daily initiated on November 10, f psychotropic medications ral management included an	F	5552	1. Resident had been discharged from facility on 12/26/18. Going forward a not delegated to be the point person to obthe psychotropic consents for all residents.  2. All residents who have orders for an psychotropic medications have the pobe affected by this deficient practice.  3. A complete audit was done to ident were any missing consents on 2/27/18 person will be responsible to obtain a consents. This nurse will review the morders daily to determine if new orders require consents.  4. The DON/Designee will review were ensure all consents have been obtain present to QAPI for 3 months.	urse was tain all ents.  hti- tential to tify if there concential aew s ekly to	

# DEPARTMENT OF HEALTH AND HUM. SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		E CONSTRUCTION	(X3) DATE	SURVEY PLETED
		035099	B. WING			01/1	10/2019
	PROVIDER OR SUPPLIER	SING AND REHAB, LLC		2	TREET ADDRESS, CITY, STATE, ZIP CODE 1900 EAST MILBER STREET TUCSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX.	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X6) COMPLETION DATE
F 552	of the medications to obtain informed after the risks and resident signs the An interview was cat 9:35 a.m. with a #165). During the ithere are consent if medications. Staff unable to sign the obtained from the its Staff #165 stated to informed consent,	includes the risks and benefits. The DON stated that they are consent. The DON said that benefits are explained, the	F	552			
F 578 SS=E	at 10:04 a.m. with who stated that the for the use of Risp.  A policy regarding Federal and State rights to all resider include the resider and participate in CRequest/Refuse/DCFR(s): 483.10(c)(6) The discontinue treatm to participate in exformulate an advantage of the state of	right to request, refuse, and/or ent, to participate in or refuse perimental research, and to	T.	578			

### DEPARTMENT OF HEALTH AND HUM, SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		035099	B. WING	·	MARKET AND	01/1	0/2019
	PROVIDER OR SUPPLIER RE OF TUCSON NURS	SING AND REHAB, LLC		2	TREET ADDRESS, CITY, STATE, ZIP CODE 900 EAST MILBER STREET UCSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 578	inappropriate.  §483.10(g)(12) The requirements speci subpart I (Advance (i) These requirements of inform and provide residents concerning medical or surgical resident's option, for (ii) This includes a facility's policies to and applicable Stat (iii) Facilities are perentities to furnish the legally responsible requirements of thi (iv) If an adult indivitime of admission a information or article has executed an amay give advance individual's resident with State Law.  (v) The facility is not provide this information or she is able to refollow-up proceduthe information to tappropriate time. This REQUIREME by:  Based on clinical rand policy review, and policy review,	e facility must comply with the fied in 42 CFR part 489, Directives). The include provisions to written information to all adulting the right to accept or refuse treatment and, at the formulate an advance directive, written description of the implement advance directives to law. The implement advance directives to law are met. The implement advance directive and is unable to receive ulate whether or not he or she divance directive, the facility directive information to the attractive in accordance to the representative in accordance to the individual once he ceive such information. The individual directly at the law and the individual directly at the law and the individual directly at the law and the individual directly at the second reviews, staff interviews the facility failed to ensure that 4 and the individual directly were afforded the law and the individual directly at the second reviews, staff interviews the facility failed to ensure that 4 and the individual directly were afforded the individual directly at the individual directly	F	578			

# DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		035099	B. WING			01/1	0/2019
	PROVIDER OR SUPPLIER	SING AND REHAB, LLC		2	TREET ADDRESS, CITY, STATE, ZIP CODE 900 EAST MILBER STREET UCSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X6) COMPLETION DATE
F 578	Continued From pa	age 4	F	578			
	December 18, 201	s admitted to the facility on 8, with diagnoses that included renal disease and type 2					
	(MDS) assessmen resident scored a 9	ssion Minimum Data Set t dated 12/25/18, revealed the on the Brief Interview for IS), which indicated moderate ent.	2-10-11				
	no evidence of any resident #164. The	dent's clinical record revealed advance directives for a documentation eclined formulating advance	The state of the s				·
	there was no code	he clinical record revealed status listed on the resident's e available space specific for electronic record.					
	According to the co	urrent physician's orders, there code status for this resident.					
	(LPN/staff #153) o a.m., she stated if resident's code state electronic record, code status is eas the resident's code sheet. She stated updated, as soon	n a Licensed Practical Nurse n January 10, 2019 at 9:30 she needed to find out a atus, she would look in the as there is a place where the ily viewable. Further, she stated a status is listed on their report the code status should be as the resident is admitted.					
	was conducted on	medical record staff (staff #184) January 10, 2019 at 9:34 a.m. eviewed resident #164's					

# DEPARTMENT OF HEALTH AND HUM. SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	! ' '	E CONSTRUCTION	(X3) DATE S COMPL	
		035099	B. WING		01/10	/2019
*	PROVIDER OR SUPPLIE	R RSING AND REHAB, LLC	2:	TREET ADDRESS, CITY, STATE, ZIP CODE 900 EAST MILBER STREET UCSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE '	(X5) COMPLETION DATE
F 578	scanned docume advance directive stack of docume scanned, however located. She also physician's binder physician, however found in the bind. In an interview we (DON/staff #125) p.m., she stated late December, advanced directifully represented included chronical Review of the acceptember 13, 2 included chronical Review of the acceptember 20, 2 cognitively intact. A physician's ordinated the resident's electron and interview was signed by the remot listed on the available space resident's electron and interview was #150) on Januar stated that upon signed including that a resident's	ents and was unable to find any es. She stated it could be in a ents that are waiting to be er, no advanced directives were of stated it could be in the er waiting to be signed by the ver, no advanced directives were er.  Which the Director of Nursing on January 10, 2019 at 1:31 an audit had just been done in ensuring that all residents had ver forms filled out.  Was admitted to the facility on entering that diagnoses that osteomyelitis and quadriplegia.  Ilmission MDS assessment dated 2018, revealed the resident was a full code.  For dated November 20, 2018 sident was a full code.  For of the clinical record revealed divance directives which were sident. Also, the code status was resident's face sheet or in the specific for code status in the	F 578	The following actions have been take those residents noted to be affected alleged deficient practice:  1. The facility obtained a consent for status for resident #164 on 1/10/201 For resident #121 the facility located signed consent for code status (dated and signed by the resident or 11/20/2018). The consents are located in PCC (electronic medi record) under the documents section the face sheet shows current code soon 2. All residents have the potential to affected this alleged deficiency.  3. An inservice for nurses was condon 2/22/19 that included the instruct obtaining mandatory consents upon admission including signed code state consents. The DON has instituted a whereby all nurse managers will be assigned to review new admissions determine that there is a signed concode status. This will be completed 24 hours of admission.  4. The DON/Designee will monitor compliance and be reviewed at mor QAPI for 3 months	by this r code 19. I the cal n and status. b be lucted tions on attus a system s to asent for within	3/3/19

### DEPARTMENT OF HEALTH AND HUM. SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		(3) DATE SURVEY COMPLETED	
2		035099	B. WING			01/1	0/2019	
	PROVIDER OR SUPPLIER	SING AND REHAB, LLC		29	TREET ADDRESS, CITY, STATE, ZIP CODE 900 EAST MILBER STREET UCSON, AZ 85714			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE	
F 578 F 584 SS=E	to locate any advarsigned by the resident signed by the resident Records (staff #18 PM. She stated the directives on file for advance directives admission or a few. An interview with the conducted on Janusigned consents, it when the resident said if there is a probe notified. The Doanswer for what he was not employed. The facility policy for Implementation for that upon admission with written inform refuse or accept mand to formulate a she chooses to do information about executed an advarprominently in the Nursing or designed physician of advarappropriate orders resident's medical Safe/Clean/Comformation and the safe/Clean/Comformation resident safe/Cl	record. Staff #150 was unable need directives which were lent.  onducted with Medical 3) on January 8, 2019 at 1:46 are was no record of advance or resident #121. She said the should be filled out upon a days later.  The DON (staff #125) was lary 10, 2019 at 11:40 AM. She rese is responsible for obtaining including advance directives is admitted to the facility. She soblem social services should DN stated she could not appened in September, as she by the facility at that time.  For Interpretation and a Advance Directives indicated on, the resident will be provided atton concerning the right to nedical or surgical treatment in advance directive, if he or is so. The policy stated that the whether or not the resident has nee directive shall be displayed medical record. The Director of the will notify the attending need in the record and plan of care. Ortable/Homelike Environment		578				

## DEPARTMENT OF HEALTH AND HUM, SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/20/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF D AND PLAN OF CO	EFICIENCIES RRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	PLETED
		035099	B. WING			01/1	0/2019
		SING AND REHAB, LLC		29	REET ADDRESS, CITY, STATE, ZIP GODE 100 EAST MILBER STREET JCSON, AZ 85714 PROVIDER'S PLAN OF CORRECTION	Ni T	(35)
(X4) ID PREFIX TAG	/FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	(X5) COMPLETION DATE
\$48 The correction of the superior of the supe	mfortable and he inot limited to reports for daily lie facility must proports for daily lie facility must proports for daily lie facility must proports for daily lie facility must professible.  This includes error and sysical layout of the facility shade protection of the facility shade protectio	right to a safe, clean, omelike environment, including ecciving treatment and iving safely.  rovide- re, clean, comfortable, and nent, allowing the resident to sonal belongings to the extent ensuring that the resident can services safely and that the che facility maximizes resident I does not pose a safety risk. If exercise reasonable care for ne resident's property from loss sekeeping and maintenance by to maintain a sanitary, orderly, nterior;  In bed and bath linens that are sectional each specified in §483.90 (e)(2)(iv); quate and comfortable lighting		584	1. The facility does have a policy for C Life - Homelike Environment that addre cleanliness and institutional odors. (see attached). The Housekeeping departmegin using a urine odor neutralizer who cleaning all mattresses. The shower does the second floor that had an odor is not regularly used. It was determined that of that, the housekeeping department the drain periodically to prevent odors. It was not a urine odor.  2. All residents could be affected by the alleged deficiency.  3. Staff was in-serviced on 2/8/19 regularly used. It was not a urine odor.  2. All residents could be affected by the alleged deficiency.  3. Staff was in-serviced on 2/8/19 regularly answering call bells, preventing unnected odors, patient care rounds to ensure reare clean and dry. The Housekeeping Supervisor will conduct environmental and log any unusual occurrences of products and report to the unit managers address any housekeeping concerns.  4. The Housekeeping/Laundry Director report to the management team on a basis if there are problems detected from the management team on a basis if there are problems detected from the weekend and report to the C The DON/Designee and the Administr for compliance and report findings the Committee for 3 months.	esses e nent will nen rain on of because will flush nis arding essary esidents rounds ervasive and or will daily from the ping nds and or noted birector. rator will	3/3/19

Facility ID: LTC0053

#### DEPARTMENT OF HEALTH AND HUM, SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	COTOR MEDICANE	i	//o\ L411	וחנדי	E CONSTRUCTION	/X3) DATE	SURVEY
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		PLETED
•			,	,			
		035099	B, WING			01/1	0/2019
NAME OF F	PROVIDER OR SUPPLIER	1			TREET ADDRESS, CITY, STATE, ZIP CODE		
SAPPHIR	RE OF TUCSON NURS	SING AND REHAB, LLC			900 EAST MILBER STREET		
			T	1	UCSON, AZ 85714	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 584	by: Based on observa staff interviews, the environment that we findings include: During a family into 2019 at 11:07 a.m. resident stated that floor always smell lead on the second floor was cat 11:49 a.m. The resident of the bath sewage odor.  During an interview 2019 at 1:28 p.m. Are resided on the second in the bath root puring the survey for 2019, pervasive ur smelled in the hallow. An environmental for 10, 2019 at 12:30 is director (staff #180 January 12/staff #20 January 12/staff #2	NT is not met as evidenced tions, and family, resident and a facility failed to maintain an eas free of odors.  Priview conducted on January 7, the family member of a the hallways on the second like urine.  President who resided on the onducted on January 7, 2019 resident stated that he keeps aroom shut, because of the producted on January 7, with another resident who ond floor, a strong pervasive ected in this resident's room m.  From January 7 through 10, ine odors were frequently ways on the second floor.  From January 7 through 10, ine odors were frequently ways on the second floor.  From January 7 through 10, ine odors were frequently ways on the second floor.  From January 7 through 10, ine odors were frequently ways on the second floor.  From January 7 through 10, ine odors were frequently ways on the second floor.		584			
		onducted with the maintenance o) on January 10, 2019 at 12:40					

#### DEPARTMENT OF HEALTH AND HUM. SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/20/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA . IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		035099	B, WING	i	1-77	01/1	0/2019
***************************************	PROVIDER OR SUPPLIER	SING AND REHAB, LLC		29	TREET ADDRESS, CITY, STATE, ZIP CODE 900 EAST MILBER STREET UCSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 584	p.m. Staff #180 sta plumber to address An interview was or January 10, 2019 a that she thought sh	ige 9 ted that he would call a the odor in the bathroom. onducted with staff #222 on it 12:45 p.m. Staff #222 stated e smelled urine yesterday, was being changed.	F	584		A CONTRACTOR OF THE CONTRACTOR	
F 600 SS=E	prevention of odors Free from Abuse a		F	600			
	Exploitation The resident has the neglect, misappropriand exploitation as includes but is not corporal punishme any physical or che	from Abuse, Neglect, and ne right to be free from abuse, priation of resident property, defined in this subpart. This limited to freedom from nt, involuntary seclusion and emical restraint not required to medical symptoms.	A STATE OF THE STA	And the state of t			
	§483.12(a) The fac	ility must-					
	physical abuse, co involuntary seclusic This REQUIREME by: Based on observa staff and resident i and policies and prensure that one reand behaviors was ensure that one reabuse by resident	use verbal, mental, sexual, or rporal punishment, or on; NT is not met as evidenced tion, clinical record reviews, nterviews, facility documents rocedures, the facility failed to sident (#225) with dementia free from neglect, failed to sident (#61) was free from (#275), failed to ensure that ) was free from abuse by					

Event ID: V3CM11

## DEPARTMENT OF HEALTH AND HUN. ... SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION (C		PLETED
		035099	B. WING	·		01/1	0/2019
• • • • • • • • • • • • • • • • • • • •	PROVIDER OR SUPPLIE RE OF TUCSON NUI	RSING AND REHAB, LLC		29	TREET ADDRESS, CITY, STATE, ZIP CODE 2000 EAST MILBER STREET UCSON, AZ 85714	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE ATE	(X6) COMPLETION DATE
F 600	resident (#61), and free from abuse to Findings include:  -Resident #225 wand readmitted on that included dem disturbance, men physiological consultered mental state Review of the clir care plan initiated revision date of A that the resident visk/wanderer, rel history of attempt unattended. A go not leave the faci included identifyir intervening as ap resident's location documenting war A quarterly MDS assessment date BIMS (Brief Inter 9, which indicated cognitive impairm resident was delubehavioral sympt care, wandered opsychotic disorder A nurse practition 2, 2018, revealed wandering, delirity wandering wan	ras admitted on July 22, 2015 In April 16, 2018, with diagnoses In Ital disorder due to known Ital disorder due to known Ital disorder due to known Ital disorder and disorder and Ital disorder due to known Ital record revealed a written Ital on July 11, 2016, with a Ital pril 16, 2018, which identified Ital was an elopement Ital death of escapist behavior and Ital included the resident would Ital included the resident modering and Ital propriate, monitoring the In every 30 minutes and Ital danuary 25, 2018 included a Ital January 25, 2018 included a I		600	The following actions have been taken for those noted to be affected by this allege 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 rogen y/30/18 to be further away from Resident Residents were assigned different dining locations. Resident #117 was moved off secured unit on 11/29/18 to unit C1, a sebehavioral 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 to behavioral tracking. An audit was conducted to the Elopement Risk assessment to determine if there were other residents a risk for elopement and care plans update accordingly.  3. The facility conducted de-escalating techniques training to recognize the first of possible altercations on 4/10/18. Activities have been increased on the un The facility hired a LCSW for Behavioral training and to address residents psychoneeds. Reviewed staffing patterns to determine needs of the unit.  4. The facility initiated a Behavioral Health Tracking log to analyze patterns of behat that will enable the facility to identify residenting risk for behaviors. This will be revieweekly with the Behavioral Health Team	om on t #61. If the eparate signs hits. Cological the lith eviors. Idents viewed	3/3/19

### DEPARTMENT OF HEALTH AND HUN. SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		SURVEY PLETED
		035099	B, WING	;		01/1	10/2019
•••	PROVIDER OR SUPPLIER	SING AND REHAB, LLC		29	REET ADDRESS, CITY, STATE, ZIP CODE 000 EAST MILBER STREET UCSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	resident was residing safety" and receive assessment also in "desperately tries to She speaks Spanis lot of English. Under included the following and nuturing environ.  A nursing note date included the reside the unit through the and also by a (lock of the unit through the and also by a (lock of the unit).  A nursing note date following: the resident had attempted to learn the discovered in her resident to the unit.  A nursing note date following: the resident the resident the same that the resident the facility after shear the facility after shear the facility after shear the facility, after shear the facility, obtain transint of Mexico, and as into Mexico,	ang on the behavioral unit "for ad psychiatric services. The acluded the resident of escape if given the chance." In mostly, but understands a ser assessment and plan it lang: wandering-provide a safe onment.  The March 17, 2018 at 6:34 a.m. and had been exit seeking from the main locked door to the unit led) back door to the unit.  The March 23, 2018 included the lent had been exit seeking and leave through the front door, taff member when redirected led April 5, 2018 at 10:05 a.m. and was discovered missing at a included the resident was not loom and that a "code yellow" of the closed record for resident the resident did not return to		600	and presented at the monthly QAPI mongoing.	eetings	

# DEPARTMENT OF HEALTH AND HUM. ... SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE	SURVEY PLETED
		035099				01/1	0/2019
	PROVIDER OR SUPPLIER		<u> </u>	29	TREET ADDRESS, CITY, STATE, ZIP CODE 900 EAST MILBER STREET UCSON, AZ 85714		
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 600	unharmed. The reresident had been (secured) unit, and wandering behavior continued review revealed a written CNA (Certified Nu dated April 5, 2018 included that the resident dining rocks: 30 p.m. and 9:00 included that facilisafety checks were An interview was Administrator (statio:15 a.m. The Adbeen determined that resident #225 badge from a staff member thought in prior to her eloper obtained money in from her visitors, bus fare. The Adn security camera fexamined during resident had used door and then quit An interview was at 12:30 p.m. with that she had beer resident #225 on (11:00 p.m. until 7 she arrived at 11: reported to her the	port also included that the residing on a behavioral health it that exit seeking and ors were being monitored.  of the investigative report staff statement obtained by a rsing Assistant/staff #222) at 2:45 p.m. The statement esident was last seen in the orn on April 4, 2018 between 0 p.m. The report further ty policies were not followed, as		600			

## DEPARTMENT OF HEALTH AND HUN... SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED		
		035099	B. WING			/10/2019		
	PROVIDER OR SUPPLIEF	RSING AND REHAB, LLC		STREET ADDRESS, CITY, STATE, 2900 EAST MILBER STREET TUCSON, AZ 85714				
(X4) ID PREFIX TAG	(FACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
F 600	that she observed was closed. Staff residents in her si was unable to che she was busy car ill. Staff #97 said the residents eve than hourly, and tresident that nigh her co-worker (Cl to another section residents and assher room, becaus closed. She state the resident on he approximately 2:0 enter the resident water, and then e assumed that the CNA stated she a history of elope stated later that in the resident was although he ente ice water during resident in her rowas.  During an interview as at 1:15 p.m. with Nurse/staff #201 worked on the se	I the door to the resident's room #97 stated that there were other ection who were very ill and she eck on resident #225, because ing for the residents who were the facility protocol was to check ry 15-30 minutes but not less hat she did not check the t. She stated that she assumed NA/staff #49) who was assigned in was checking on all of the sumed that resident #225 was in see the door to her room was set the door to her room was set shift. She further stated that all 00 a.m., she observed staff #49 the resident was in her room. The was aware that the resident had ment attempts. The CNA also morning after it was discovered missing, staff #49 told her that red the resident's room to pass the night shift, he did not see the own and did not know where she ew conducted on January 8, m. with a CNA (staff #49), the he did not remember resident is remember anything about a		600				

### DEPARTMENT OF HEALTH AND HUN. SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION		E SURVEY PLETED
		035099	B, WING		***************************************	01/	10/2019
	PROVIDER OR SUPPLIE RE OF TUCSON NUI	RSING AND REHAB, LLC	•	290	REET ADDRESS, CITY, STATE, ZIP CODE 00 EAST MILBER STREET ICSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X6) COMPLETION DATE
F 600	she did not see the door to the resider. The nurse stated resident had mad was going to leave where she owned. The facility was usuregarding frequent behavioral unit.  A policy and proceand Symptoms of definition of neglegods and service physical harm, mandle that include and leaving some supervision.  Review of the Rethat all suspected incidents of abuse.	ne resident on her shift and the nt's room was closed all night. that she was aware that the e frequent statements that she e the facility and go to Mexico	The state of the s	500	DEFIGIENCY)		
	February 20, 201 unspecified psych known physiologi disease, and schi Review of a Nurs revealed "Resid when there is an Resident had thre profanity) and two	is admitted to the facility on 4, with diagnoses that included nosis not due to a substance or cal condition, Parkinson's izoaffective disorder.  Ing Note dated February 4, 2018 that has had a few outbursts excessive amount of noise. The episodes of yelling out (using the resident who was yelling out the resident who was yelling to go	Transfer of the state of the st	nees			

#### DEPARTMENT OF HEALTH AND HUN. SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMF	SURVEY
		035099	B. WING	}	Market and the second s	01/1	0/2019
	PROVIDER OR SUPPLIER	SING AND REHAB, LLC		2	STREET ADDRESS, CITY, STATE, ZIP CODE 2900 EAST MILBER STREET FUCSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPIDE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	resident immediate A Nursing Note dat "Resident had seves shift. Resident primother residents are behaviors by makin A Nursing Note dat "Resident has epis- startled with other I yelling or doors sla A quarterly MDS as 2018, revealed the long-term memory impaired with dally also included the re assistance with one of daily living.  A Behavior care pla revealed resident # (agitation, poor saf aggression, repetit disruptive/intrusive pacing, exit seekin thinking and physic psychosis, anxiety, post traumatic brai physical aggressio included the reside behaviors. Interver	Staff was there to redirect ly.  ed May 3, 2018 revealed bral verbal outbursts during harily has these outbursts when having an increase in hig loud noises and yelling"  ed May 21, 2018 revealed odes of yelling out when he is oud noises like other residents mming"  seessment dated August 6, resident had short-term and problems and was severely decision making. The MDS esident required extensive estaff assistance with activities and dated August 20, 2018 fe1 has behavior problems ety awareness, verbal live statements, wandering, mood issues, g, refusal of care, disorganized cal aggression), related to mood disorder and status in injury as evidenced by in towards others. The goal ent will have fewer episodes of intions were to administer		800			
	develop more appr interacting with oth encourage the resi	lered; assist the resident to ropriate methods of coping and er dementia residents; dent to express feelings freasonable, discuss the					

#### DEPARTMENT OF HEALTH AND HUN. SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/20/2019 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DATE COMP		SURVEY		
		035099	B. WING	) <u></u>		01/1	0/2019
	PROVIDER OR SUPPLIER	SING AND REHAB, LLC		2	TREET ADDRESS, CITY, STATE, ZIP CODE 900 EAST MILBER STREET UCSON, AZ 85714		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 600	resident's behavior behavior is inappro intervene as neces safety of others; and manner; divert atte and take to alternate behavior episodes underlying cause; next to other peers prevent physical and Review of a Nursing 2018 revealed "Faltercation with an to the other resident were immediately noted to this resident were immediately noted to this resident #61 and their arms with class parated. Resident #275 hit him in the resident #275 w June 27, 2017, wi unspecified deme	r; explain/reinforce why opriate and/or unacceptable; sary to protect the rights and oproach/speak in a calm ention; remove from situation ate location as needed; monitor and attempt to determine and when resident is sitting a, ensure appropriate space to ggression towards peers.  In Note dated September 30, Resident began having a verbal other resident and he went up not and struck her in the face on the other resident retaliated and it on both arms. Both residents separated. No visible injuries ent"  In IMDS assessment dated a revealed resident #61 had a liew for Mental Status) score of moderate impaired cognition.  In Impaired to this writer that resident #275 were swinging osed fists. Both residents were ent #61 stated that resident ent at the face. Reddened area noted to the as admitted to the facility on the diagnoses that included entia with behavioral cophrenia, major depressive	F	600			

Facility ID: LTC0053

#### PRINTED: 02/20/2019 SERVICES FORM APPROVED DEPARTMENT OF HEALTH AND HUM OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING \_\_\_ B. WING 01/10/2019 035099 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2900 EAST MILBER STREET SAPPHIRE OF TUCSON NURSING AND REHAB, LLC **TUCSON, AZ 85714** (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 600 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

# DEPARTMENT OF HEALTH AND HUM. IN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI		(X3) DATE SURVEY COMPLETED		
		035099	B. WING			01/1	0/2019
•	PROVIDER OR SUPPLIER	SING AND REHAB, LLC		29	TREET ADDRESS, CITY, STATE, ZIP CODE 900 EAST MILBER STREET UCSON, AZ 85714		
(X4) ID PREFIX TAG	/FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 600	impairment.  A Nursing Note darevealed this writer resident #275 and their arms with cloquickly separated on resident #61's for the revealed he had two residents on Dece he was the aggres discharged from the 2018.  An interview was as a stated that the faction this unit for 20-residents. The CN supposed to monity ensure that reside not occur, but that staff call in.  An interview was a who stated that we someone monitor does not always he he best we can be do not have some that's when the restated that residents with other residents and dusually when he considerts, because the considerts, because the considerts, because the residents, because the considerts when he considerts, because the considerts, because the considerts, because the considerts when he considered the consid	ted November 16, 2018 r was notified by a CNA that resident #61 were swinging sed fists. Residents were by CNA. Reddened area noted		600			

### DEPARTMENT OF HEALTH AND HUN. A SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

<u> </u>	TO TO IT WED TO THE						
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		SURVEY PLETED
		035099	B, WING			01/1	10/2019
.,,	PROVIDER OR SUPPLIER	SING AND REHAB, LLC		2	TREET ADDRESS, CITY, STATE, ZIP CODE 900 EAST MILBER STREET UCSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE.	(X5) COMPLETION DATE
F 600	residents. The CN/ resident to resident	age 19 Inh" and that irritated a lot of A further stated that a lot of the t altercations usually occurred Inot have someone to monitor	F	300			
	stated that resident hall and resident #: stated that staffing	onducted with a LPN who t #61 runs up and down the 275 is paranoid. The LPN was recently cut on this high nit and that they do the best					
	9:25 a.m. Staff #20	onducted with the #20) on January 10, 2019 at stated that there should be a way at all times on that unit.					
	January 27, 2017,	s admitted to the facility on with diagnoses that included liety disorder and dementia turbance.	Paraman 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4				
	the resident require diagnoses of schiz behaviors of being attempts to provok	d on June 28, 2018, included ed a secured unit due to ophrenia and dementla, non-compliant with care and te peers. Interventions included dent when having behaviors.	To Allegan				
	17, 2018 revealed and long-term mer moderately impaire The assessment a required supervision	ssessment dated September the resident had short-term mory problems and was ed with daily decision making. elso included the resident on with set up help only for laily living and utilized a walker.	a delegation of the second				
	Review of the clini	cal record revealed multiple					

#### DEPARTMENT OF HEALTH AND HUN. SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	:	(X1) PROVIDER/SUPPLIER/CLIA	(X3) MIII	TIPI	E CONSTRUCTION	(X3) DATE	(X3) DATE SURVEY	
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:			PLETED			
						_		
		035099	B. WING			01/1	0/2019	
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
		nuo ampirentia		2	900 EAST MILBER STREET			
SAPPHIR	RE OF TUCSON NUR	SING AND REHAB, LLC		Т	UCSON, AZ 85714			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	tD		PROVIDER'S PLAN OF CORRECTIO	N N	(X5) COMPLETION	
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	RIATE	DATE	
TAG	(NEODENION ON E				DEFICIENCY)			
			1					
F 600	Continued From pa	ige 20	F	600		[		
	nursing notes for S	eptember 2018 describing the						
	resident as being v	erbally aggressive toward staff						
	and laughing loudly	at other residents.						
		d 0 - at- ash on 20, 2048	1					
	A nursing note date	ed September 30, 2018 proximately 9:53 a.m., resident						
	#117 hegan having	a verbal altercation with						
	another resident (#	61), and the other resident	1					
	struck resident #11	7 in the face on the right						
	cheek. Resident #1	117 then struck resident #61						
		n the arms. Both residents						
	were immediately s	separated. No visible injuries						
	1 **	nts will not be in the same						
	dining hall as each	other.						
	Review of the facili	ty's investigative						
	documentation dat	ed September 30, 2018,						
	revealed that resid	ent #117 was in the hallway by						
	her room, which w	as across the hall from resident	any and a second					
		ent #117 began cursing in the						
	hallway, as she ha	s a history of this behavior.						
		sitting in his wheelchair in the						
	doorway to his roo	m and got up and confronted				l		
	resident #117 in th	e hallway outside their rooms.	1					
	They began yelling	back and forth and before						
	staff could interver	ne, resident #61 hit resident dent #117 hit resident #61. The						
		parated and resident #117 was						
		room. No injuries were noted.						
		7 was asked about the						
		d "He hit mel" Per the report, a						
	housekeeping staf	f (#135) witnessed the incident.				,		
	She reported that	resident #117 was cursing at						
	her and resident#	61 told resident #117 to be						
	quiet. Resident #1	17 kept cursing, and then						
	resident #61 got u	p, went to resident #117 and						
	they both made co	intact with each other. A						
		icensed practical nurse						
	THE PROPERTY TERMS IN	remarkan da ber seller da de la dela de					i	

# DEPARTMENT OF HEALTH AND HUN. SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

CENTE	42 FOR MEDICARE	& MEDICAID SERVICES				WAY DATE	: CISDVEV
STATEMENT AND PLAN (	OF DEFICIENCIES OF CORRECTION	CIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
		035099	B. WING			01/	10/2019
	PROVIDER OR SUPPLIER	SING AND REHAB, LLC		29	REET ADDRESS, CITY, STATE, ZIP CODE 100 EAST MILBER STREET UCSON, AZ 85714		
(X4) ID PREFIX TAG	/FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X6) COMPLETION DATE
F 600	the incident but was heard resident #11 her. She immediat found resident #61 #117 with his fists separated immediated imm	as at the nurses' station and 7 yelling that resident #61 hit rely went to the hallway and 1 standing in front of resident up. The residents were ately.  In staff #135 on January 9, 2019 stated she had worked at the ree years and is usually on the lal unit. She said that resident being verbally aggressive and		600			

## DEPARTMENT OF HEALTH AND HUM. SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		035099	B. WING			01/1	0/2019
	PROVIDER OR SUPPLIER RE OF TUCSON NURS	SING AND REHAB, LLC		29	TREET ADDRESS, CITY, STATE, ZIP CODE 900 EAST MILBER STREET UCSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPED DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	An observation was 2018 at 10:35 a.m. break. Resident #1 laughing loudly and appeared to be directly appeared to be directly and appeared to be directly appeared to be directly and cigarette without further an interview with on January 10, 2016 he receives an allealtercation, he will what happened, rebegin an investigate.	s conducted on January 9, , during a resident smoke 17 was observed to be I sticking her tongue out, which ected at no one in particular. edirected the resident who then continued to smoke her rther incident.  I the administrator (staff #20) 9 at 1:17 p.m., he stated when gation of a resident to resident get more information about port to appropriate parties and		600			
	January 18, 2018, schizophrenia, dep disease.  A quarterly Minimu assessment dated resident had a BIM cognitive impairme included the reside symptoms directed.  Review of the care medication related following interventi becomes agitated escalates; guide the source of distress; conversation; and	with diagnoses that included pression and Parkinson's m Data Set (MDS) 10/08/2018 included the IS score of 15, indicating no ent. The MDS assessment also ent had verbal behavioral it toward others.  I plan regarding antipsychotic to schizophrenia included the ons: when the resident intervene before agitation are resident away from the	- Andrews - Andr				

#### DEPARTMENT OF HEALTH AND HUM. ✓ SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1''		E CONSTRUCTION	COMPLETED			
		035099	B, WING			01/10/2019		
	PROVIDER OR SUPPLIE	R RSING AND REHAB, LLC		2	TREET ADDRESS, CITY, STATE, ZIP CODE 900 EAST MILBER STREET TUCSON, AZ 85714			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE	
F 600	approximately 10 witnessed sitting front of another re #21 began to yell #62 approached #21 to "move." Be swinging their arr were immediately opposite direction—Resident #62 wa 2015, with diagnodementia and de A quarterly MDS included a BIMS resident had no cassessment also behavioral sympt. Review of the curthe resident had aggressive and the residents and statistion and fikeep him a safe. A nurse's note da approximately 10 witnessed standi. Resident #21 wa a wheelchair and Resident #21 statistion spanish. Resident were standing with a closed residents were statistion were standing with a closed residents were standing from the standing resident were standing with a closed residents were standing from the standing resident were standing from the standing fr	ated 11/29/2018 revealed that at 1:50 a.m., resident #21 was towards the end of the hall in esident's (#62) room. Resident and curse in Spanish. Resident the doorway and told resident oth residents were yelling and ans at each other. The residents a separated and redirected into as. No injuries noted at this time.		600				

## DEPARTMENT OF HEALTH AND HUN. SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	COMPLETED		
		035099	B. WING	3		01/1	0/2019
	PROVIDER OR SUPPLIE RE OF TUCSON NUI	RSING AND REHAB, LLC		2	TREET ADDRESS, CITY, STATE, ZIP CODE 900 EAST MILBER STREET 'UCSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 600	into opposite direct Review of the factor revealed that on fa.m., resident #21 front of the door to #62 asked reside words were exchanted at each other and report also include housekeeper (states residents arguing who was telling residents arguing who was telling resident #21 was resident #62 in the face and hitting each other resident #62 report and I told him to would hit him, and During an interview on 1/8/19 at 2:29 resident #21 was that he asked him that the resident Spanish and that During an interview on 1/8/2019 at 2: resident #62 yellow Resident #62 yellow Resident #61 yellow Resident #62 yellow Resident #62 yellow Resident #61 yellow Resident #62 yellow Resident #62 yellow Resident #61 yellow Resident #62 yellow Resident #61 yellow Resident #62 yellow Resident #62 yellow Resident #62 yellow Resident #61 yellow Resident #62 yellow Resident #62 yellow Resident #62 yellow Resident #61 yellow Resident #62 y	ctions. No injuries were noted.  Ility's investigative report November 29, 2018 at 10:50 I was sitting in his wheelchair in to resident #62's room. Resident and #21 to move, and angry anged. The residents struck out no injuries were noted. The ed a witness statement from the eff #135) that she heard the in front of resident #62's door esident #21 to move. The ed that resident #21 hit resident and that both residents were The report revealed that unable to recall the incident and exted that "He kept cussing at me stop. I told him if he didn't stop I d he didn't stop, so I hit him."  Ew conducted with resident #62 p.m., the resident stated that sitting in front of his door and in to leave. Resident #62 stated called his mother names in he hit him.  Ew conducted with resident #21 43 p.m., the resident stated that ed at him and he yelled back. ted that resident #62 hit him and ack and that they punched each	The state of the s	600			
	that she heard ye	at 10:01 a.m. The LPN stated billing and saw the housekeeper ent #21 and resident #62. She					

# DEPARTMENT OF HEALTH AND HUN. SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				OMPLETED	
		035099	B. WING			01/1	0/2019
	ROVIDER OR SUPPLIER	SING AND REHAB, LLC		29	REET ADDRESS, CITY, STATE, ZIP CODE 2000 EAST MILBER STREET UCSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	then assessed their that both residents off steam," but that verbal and physical Review of the facility Prevention Programmer the right to be free facility is committed from abuse by any necessarily limited. The facility's policy Residents revealed provided with a safe policy included that become abusive in his or her safety or Supervisor/Charge provide for the safe	bed separate the residents and m for injuries. The LPN stated do occasionally yell and "blow resident #62 is often more lly threatening.  ty's policy regarding Abuse m revealed "Our residents have from abuse, neglect" Our do to protecting our residents one including, but not to "staff and other residents"  regarding Unmanageable is that each resident will be see place of residence. The tank and the safety of others, the Nurse way that would jeopardize the safety of others, the Nurse Nurse must immediately each of residents may not	F	300			
F 607 SS=E	staff will monitor reaggressive/inapproresidents. The polincluding those the resident-to-resider and reported to the Nursing.  Develop/Implemer CFR(s): 483.12(b)  §483.12(b) The face	lent Altercations" included that esidents for operiate behavior towards other cy included that all altercations, at may represent abuse, shall be investigated a Administrator/Director of at Abuse/Neglect Policies		607			

# DEPARTMENT OF HEALTH AND HUN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

OL-IVII-II	O I OIT WEDIONITE	. O WILDIO/ IID OLIVITORS				OVOL DATE	CHDARA
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	PLETED
		035099	B. WING			01/1	0/2019
,,,,,,,	ROVIDER OR SUPPLIER LE OF TUCSON NUR	SING AND REHAB, LLC		29	FREET ADDRESS, CITY, STATE, ZIP CODE 900 EAST MILBER STREET UCSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 607	neglect, and exploi misappropriation of \$483.12(b)(2) Estato investigate any significant states and significant states are significant states and significant states and significant states are significant states and significant states and significant states are significant states and significant states and significant states are significant states and significant st	nibit and prevent abuse, itation of residents and f resident property, ablish policies and procedures such allegations, and ade training as required at 5, into the metas evidenced record review, staff interview, and policy review, the facility their Abuse policy that all of abuse and neglect, must be ate Survey Agency within two regation is made, as manifested in neglect for one resident as admitted on July 22, 2015, at included dementia with ance, mental disorder due to all condition, delusional disorder all status.  The death of the metas at 10:05 a.m. the ent was discovered missing at the included the resident was not room and that a "code yellow"		607	What corrective action will be accomptor those residents found to have bee by the alleged deficiency.  1. The facility Policy and Procedure for reporting has been updated to reflect required reporting will be done within two hour time frame.  2. All residents could be affected by a alleged deficiency.  3. The new administrator hired as of will ensure all required reporting of all neglect will be done within 2 hours by submitting the report on line to the Ar Department of Health Services.  4. The Administrator will review all reincidents that should be reported at the Committee on a monthly basis. This ongoing.	or Abuse the this 1/11/19 buse and izona equired he QAA	

## DEPARTMENT OF HEALTH AND HUN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

<u> </u>	CENTEROT ON WEDIONAL & MEDIONIO SERVICES				WAL DATE	CHDVEV
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	(X3) DATE SURVEY COMPLETED			
		035099	B. WING		01/1	0/2019
NAME OF PROVIDER OR SUPPLIER SAPPHIRE OF TUCSON NURSING AND REHAB, LLC			2	TREET ADDRESS, CITY, STATE, ZIP CODE 900 EAST MILBER STREET UCSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 607	procedures were in report included the the facility" obtain to into Mexico, and all transportation to a unharmed.  Continued review of revealed that althor discovered missing the facility did not reported in the facility in the faci	resident "was able to leave ransportation, cross the border fer entering Mexico obtained family home, arriving  of the investigative report ugh the resident was gon April 5, 2018 at 8:30 a.m., notify the State Survey Agency April 5.  conducted with the f#20) on January 8, 2019 at hinistrator stated that the facility eport all allegations of abuse, to the State Agency. The stated that he was unable to openent of resident #225 was a State Agency.  Ity's policy and procedure titled, to State Agencies and other arevealed that all suspected substantiated incidents of abuse or reported to appropriate state are entities as may be required by sluded that should a suspected intiated incident of lect or abuse be reported, the or or his/her designee, will estate licensing/certification al/written notice to agencies will enty-four hours of the yo hours as required).				

# DEPARTMENT OF HEALTH AND HUM, ... SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED	
	035099			·		01/10/2019	
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	PROVIDER OR SUPPLIER	SING AND REHAB, LLC		29	FREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST MILBER STREET UCSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD IT TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE
F 609	§483.12(c) In resp neglect, exploitation must:  §483.12(c)(1) Ensinvolving abuse, no mistreatment, inclusiource and misap are reported immediate that cause the allest serious bodily injuiting the events that care abuse and do not the administrator of officials (including adult protective set for jurisdiction in leaccordance with Sprocedures.  §483.12(c)(4) Reginvestigations to the designated repression accordance with Survey Agency, wincident, and if the appropriate correct This REQUIREMIBLE.  Based on clinical facility documents the facility failed to neglect for one residue.	onse to allegations of abuse, on, or mistreatment, the facility ure that all alleged violations eglect, exploitation or uding injuries of unknown propriation of resident property, ediately, but not later than 2 egation is made, if the events egation involve abuse or result in ry, or not later than 24 hours if use the allegation do not involve result in serious bodily injury, to of the facility and to other to the State Survey Agency and ervices where state law provides ong-term care facilities) in State law through established for the results of all the administrator or his or her sentative and to other officials in State law, including to the State entative action must be taken. ENT is not met as evidenced to record review, staff interview, and policies and procedures, or ensure that an allegation of sident (#225) was reported to Agency within two hours after		609	1. The facility hired a new administrator 1/11/19. The Administrator will process required reports with in the two hour tiframe by submitting the report through AZDHS portal. Policy will updated on 3 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 regall allegations of abuse or neglect in accordance with state and federal regit to required agencies. The online portation the Arizona Department of Health Serwill be utilized for the day one report.  4. All incidents that are required to be reported to state and local agencies we reviewed at the monthly QAPI meeting three months.	s me on the 3/4/19 pe poort ulations al with vices	3/3/19

#### PRINTED: 02/20/2019 DEPARTMENT OF HEALTH AND HUM. SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING \_\_\_\_ B. WING 01/10/2019 035099 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2900 EAST MILBER STREET SAPPHIRE OF TUCSON NURSING AND REHAB, LLC **TUCSON, AZ 85714** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 609 F 609 Continued From page 29 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.,

until 3:30 p.m. on April 5.

An interview was conducted with the

the facility did not notify the State Survey Agency

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

# DEPARTMENT OF HEALTH AND HUM, ... SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				CONSTRUCTION	COMPLETED		
		035099	B, WING			01/1	0/2019
	PROVIDER OR SUPPLIER	SING AND REHAB, LLC		290	REET ADDRESS, CITY, STATE, ZIP CODE 10 EAST MILBER STREET CSON, AZ 85714		
(X4) ID PREFIX TAG	/EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPROFICIENCY)	DBE [	(X5) COMPLETION DATE
F 623 SS=D	reported late to the A facility's policy at Signs and Sympto a definition of negl goods and service physical harm, me The policy also list neglect that includ and leaving some supervision.  Review of the facility Reporting Abuse to Entitles/Individuals violations and all swill be immediated agencies and other law. The policy individuals violation or substantiated agency and the law. The policy individuals violation or substantiated promptly notify the agency. The verbe made within two ccurrence (not to Notice Requirement (FR(s): 483.15(c) S483.15(c) Notice Requirement (i) Notify the resident, the facility the reasons for the language and materials.	ppement of resident #225 was a State Agency.  Ind procedure titled Recognizing ms of Abuse/Neglect included ect as the failure to provide is as necessary to avoid antal anguish, or mental illness. It is ded signs of actual physical ed inadequate provision of care one unattended who needs in the failure to appropriate state in the failure to appropriate the failure to abuse be reported, the failure to appropriate will be state licensing/certification in the failure to agencies will be state licensing/certification in the failure to agencies will be state licensing/certification in the failure to agencies will be state licensing/certification in the failure to agencies will be state licensing/certification in the failure to agencies will be state licensing/certification in the failure to agencies will be state licensing/certification in the failure to agencies will be state licensing/certification in the failure transfer for t	<u></u>	623			

#### DEPARTMENT OF HEALTH AND HUM, SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/20/2019 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		035099	B. WING	·		01/1	0/2019
NAME OF PROVIDER OR SUPPLIER  SAPPHIRE OF TUCSON NURSING AND REHAB, LLC  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES			ID.	25	TREET ADDRESS, CITY, STATE, ZIP CODE 900 EAST MILBER STREET UCSON, AZ 85714 PROVIDER'S PLAN OF CORRECTION	n I	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 623	Long-Term Care O (ii) Record the reas discharge in the reas discharge in the reas accordance with pa and (iii) Include in the n paragraph (c)(5) of §483.15(c)(4) Timin (i) Except as specin (c)(8) of this section discharge required made by the facility resident is transfer (ii) Notice must be before transfer or c (A) The safety of in be endangered une this section; (B) The health of in be endangered, une this section; (C) The resident's allow a more immed under paragraph (c) (D) An immediate required by the res under paragraph (c) (E) A resident has days.  §483.15(c)(5) Con notice specified in must include the fo (i) The reason for (ii) The effective day	me Office of the State mbudsman. sons for the transfer or sident's medical record in aragraph (c)(2) of this section; notice the items described in f this section.  In gof the notice. If the notice of transfer or under this section must be y at least 30 days before the red or discharged. made as soon as practicable discharge when- individuals in the facility would der paragraph (c)(1)(i)(C) of individuals in the facility would ider paragraph (c)(1)(i)(D) of health improves sufficiently to ediate transfer or discharge, c)(1)(i)(B) of this section; transfer or discharge is sident's urgent medical needs, c)(1)(i)(A) of this section; or not resided in the facility for 30  tents of the notice. The written paragraph (c)(3) of this section	F	623	What corrective action will be according for those residents found to be affect the deficient practice.  1 On 1/10/19, an updated discharge was sent to the local Ombudsman month of December.  2. All residents discharged from the have the potential to be affected by alleged deficiency.  3. The Business Office Manager was send a Monthly Admissions/Discharge of the the local Ombudsman by the Sthemaster of the local Ombudsman by the Usaness of the month via each of the Manager with the QAA Committee monthly for the months. The Administrator will month compliance	ed list for the e facility this ill rge the email. li report	3/3/19

Facility ID: LTC0053

# DEPARTMENT OF HEALTH AND HUM, SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  035099		' '		LE CONSTRUCTION	01/10/2019		
			B. WING		444			
NAME OF PROVIDER OR SUPPLIER SAPPHIRE OF TUCSON NURSING AND REHAB, LLC				2	STREET ADDRESS, CITY, STATE, ZIP CODE 1900 EAST MILBER STREET FUCSON, AZ 85714			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 623	including the name and telephone num receives such requito obtain an appear completing the form hearing request; (v) The name, add telephone number Long-Term Care C (vi) For nursing fact and developmental disabilities, the matelephone number the protection and developmental dis C of the Developmental dis C of the Developmental disorder or related email address and agency responsible advocacy of individestablished under for Mentally III Indial §483.15(c)(6) Chall the information is effecting the transmust update the reas practicable one becomes available §483.15(c)(8) Not In the case of facility in t	the resident's appeal rights, and dress (mailing and email), aber of the entity which lests; and information on how it form and assistance in and submitting the appeal ress (mailing and email) and of the Office of the State embudsman; cility residents with intellectual it disabilities or related illing and email address and of the agency responsible for advocacy of individuals with abilities established under Part lental Disabilities Assistance act of 2000 (Pub. L. 106-402, C. 15001 et seq.); and cility residents with a mental disabilities, the mailing and it telephone number of the efor the protection and duals with a mental disorder the Protection and Advocacy viduals Act.  Inges to the notice. In the notice changes prior to fer or discharge, the facility ecipients of the notice as soon the the updated information		623				

#### DEPARTMENT OF HEALTH AND HUM, SERVICES FORM APPROVED OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 035099 B. WING 01/10/2019 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2900 EAST MILBER STREET SAPPHIRE OF TUCSON NURSING AND REHAB, LLC **TUCSON, AZ 85714** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES Œ (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC (DENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 623 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 bv: 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.

intact.

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

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

PRINTED: 02/20/2019

## DEPARTMENT OF HEALTH AND HUM, ... SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUI A. BUILI		(X3) DATE SURVEY COMPLETED			
		035099	B, WING	<u> </u>		01/	10/2019
NAME OF PROVIDER OR SUPPLIER SAPPHIRE OF TUCSON NURSING AND REHAB, LLC				29	REET ADDRESS, CITY, STATE, ZIP CODE 2000 EAST MILBER STREET UCSON, AZ 85714		
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F 623	However, there we state Long Term copy of the notice hospitalization.  An interview was practical nurse (L. 2019 at 1:08 p.m. a patient ready to notify the Ombud manager (#190) a patient is being a patient is being a patient is being notifies the Ombud Staff #193 was in 2:42 p.m. He state last fall to talk about the Ombudsman called the Ombudsman called the Ombudsman called the Ombudsman called the information in the companion of the information in the companion of the information of the information of the information of the information.	er 26, 2018 revealed that the imitted to the facility.  as no documentation that the Care Ombudsman was sent a of discharges for each conducted with a licensed PN/staff #150) on January 8, who stated that when she gets be transferred, she does not sman and said the case completes the paperwork when discharged.  conducted on January 8, 2019 case manager (staff #190), who ompletes the paperwork when a discharged and staff #193 idsman about the discharge.  terviewed on January 8, 2019 at ed that the facility had a meeting out a better way to make sure is notified. He said that he disman and asked if he could il, when a resident is aid that she told him that she e notified, because they don't tion and they are being offications. He said that Social indling the notifications at that		623			
	at 3:06 p.m. with (staff #204), who	conducted on January 8, 2019 the Director of Social Services stated that there was a meeting man on August 6, 2018.					

#### PRINTED: 02/20/2019 DEPARTMENT OF HEALTH AND HUM. SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING\_ 035099 B. WING 01/10/2019 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2900 EAST MILBER STREET SAPPHIRE OF TUCSON NURSING AND REHAB, LLC **TUCSON, AZ 85714** (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) F 623 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.

of discharge.

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

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

# DEPARTMENT OF HEALTH AND HUM, SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI		(X3) DATE SURVEY COMPLETED		
AND PLAN O	PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILT	ING _			
		035099	B. WING			01/1	0/2019
NAME OF PROVIDER OR SUPPLIER SAPPHIRE OF TUCSON NURSING AND REHAB, LLC				29	REET ADDRESS, CITY, STATE, ZIP CODE 00 EAST MILBER STREET JCSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	OBE	(X5) COMPLETION DATE
F 623	discharged. She st facility is responsible ombudsman did not discharges.  An interview with the (DON/staff #125) verify at 11:04 AM. been told the ombountified of dischargenotify her anyway.	ated that she is aware that the le for notifications, but the of want to be notified of the Director of Nursing was conducted on January 10, The DON stated that she had audsman did not want to be uses, but that the facility must She stated the facility will be	F	623			
F 641 SS=D	Review of a facility Discharge Notice is representative will transfer or dischar it is practicable bus discharge, when the resident's welfare cannot be met in the immediate transfer resident's urgent resident's urgent resident's urgent resident to the Office Ombudsman.  Accuracy of Assess CFR(s): 483.20(g)  §483.20(g) Accurate the Assessment resident's status. This REQUIREMED by:  Based on clinical and the Resident	r policy regarding Transfer or revealed the resident an/or be notified of an impending ge from the facility as soon as t before the transfer or ne transfer is necessary for the and the resident's needs he facility or when an or discharge is required by the nedical needs. The policy also of the discharge notice will be of the State Long-Term Care		641			

## DEPARTMENT OF HEALTH AND HUM. SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  035099  NAME OF PROVIDER OR SUPPLIER  SAPPHIRE OF TUCSON NURSING AND REHAB, LLC  PROVIDER OR SUPPLIER  SAPPHIRE OF TUCSON NURSING AND REHAB, LLC  STREET ADDRESS, CITY, STATE, ZIP CODE 2900 BAST MILIBER STREET TUCSON, AZ BST44  STREET TUCSON, AZ BST44  FOR UPPLIED CONSTRUCTION  REGULATORY OR LSC IDENTIFYING INFORMATION)  FREID  FREID  FROM CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY  FRINDING  FREID  FROM CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY  FRINDING  FREID  FROM CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY  FRINDING  FREID  FROM CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY  FREID  FROM CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY  FREID  FROM CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY  FREID  FROM CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY  FROM CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY  FROM CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY  FREID  FROM CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY  FREID  FROM CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY  FREID  FROM CROSS-REFERENCED TO THE APPROPRIATE TO SERVENCE  FROM FROM CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY  FREID  FROM CROSS-REFERE	<u> </u>	TO COLUMEDIA COL	01.17.01.07.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.07.11.0					
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### SAPPHIRE OF TUCSON NURSING AND REHAB, LLC    2900 EAST MILBER STREET TUCSON, AZ 85714			035099	B. WING		A SECTION OF THE SECT	01/1	0/2019
FREETX TAG  F1 Continued From page 37 Data Set (MIDS) 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 -Invaroptum Bromide HFA aerosol solution 17 micrograms (mcg) one puff orally every 6 hours for COPD (chronic obstructive pulmonary disease) dated August 25, 2018.  A review of the MAR for October 2018 revealed the resident refused ipratroptum Bromide from October 17-3. The MAR also revealed the resident refused ipratroptum Bromide from October 27-2, 82, 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 for one resident did not receive an antibiotic and displayed no refusal of care for one resident did not receive an antibiotic and displayed no refusal of care for one resident refused i pratropium Bromide HFA aerosol solution 17 micrograms (mcg) one puff orally every 6 hours for COPD (chronic obstructive pulmonary disease) dated August 25, 2018.  A review of the MAR for October 2018 revealed the resident refused ipratropium Bromide from October 17-3. The MAR also revealed the resident dated November 1, 2018, revealed the resident for November 2, 2018 and 2018 are recommended to th					29	900 EAST MILBER STREET		
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 (mg) 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 hyportension dated August 25, 2018 -Levothyroxine 76 mg 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 plartropium Bromide from October 27, 31 multiple times, refused Metoprolol on October 27-31 multiple times, refused Metoprolol 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 for one resident of care for one resident did not receive an antibiotic and displayed no refusal of care for one resident refused curing the 7 day	PREFIX	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	
look-back period. The MDS assessment also	F 641	Data Set (MDS) as regarding antibiotic one resident (#62).  Findings include:  Resident #62 was a 2015, with diagnos hypertension, deminated of the physical following:  -Bactrim 400-80 m day by mouth for p dated October 16, -Ipratropium Bromi micrograms (mcg) for COPD (chronic disease) dated Aug-Metoprolol 25 mg hypertension dated -Levothyroxine 75 hypothyroidism data the resident wootober 16-31. The resident refused Ip October 27- 31 muon October 27, 28, Levothyroxine on Chowever, review of the wootober dated the resident did no displayed no refus look-back period.	sessment was accurate use and refusal of care for admitted on November 06, es that included schizophrenia, entia, and depression.  ician's orders revealed the illigrams (mg) by mouth once a rophylaxis for chronic UTI 2018 de HFA aerosol solution 17 one puff orally every 6 hours obstructive pulmonary just 24, 2018 by mouth once a day for I August 25, 2018 mcg by mouth once a day for red August 25, 2018.  IR for October 2018 revealed as administered Bactrim from e MAR also revealed the ratropium Bromide from and 29, and refused Dctober 27 and 30.  If the quarterly MDS November 1, 2018, revealed t receive an antibiotic and all of care during the 7 day The MDS assessment also		341	those residents found to be affected be deficient practice:  1. Resident #62 medical records and were reassessed. A modification was submitted to CMS with correct informal 2/24/19.  2. An audit of 25% of all residents on antibiotics will have their MDS reevall accuracy and coding.  3. The MDS Director in-serviced the Coordinator on accurately completing MDS on 2/25/19. The MDS Director was random sample of MDS for antibiotic monthly basis for three months.  The MDS Director will monitor for corrections and the model of the months.	MDS sation by uated for g the vill audit	

### PRINTED: 02/20/2019 DEPARTMENT OF HEALTH AND HUM SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A, BUILDING \_ B. WING 035099 01/10/2019 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2900 EAST MILBER STREET SAPPHIRE OF TUCSON NURSING AND REHAB, LLC **TUCSON, AZ 85714** (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) 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

development of an individualized care plan. The RAI manual instructs to review the clinical record for documentation regarding any antibiotics that

MDS assessment is the basis for the

PRINTED: 02/20/2019 FORM APPROVED OMB NO. 0938-0391

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F 641 F 645 SS=E	look-back period as was received. The review the clinical rany refusal of care during the 7 day loo behavior if it occurs PASARR Screenin CFR(s): 483.20(k)( \$483.20(k)) Preadn	ne resident during the 7 day and record the number of days it RAI manual also instructs to record and interview staff for (e.g. taking medications) ok-back period and code the red.  Ig for MD & ID  Injection Screening for mental disorder and individuals		641			
	or after January 1, (i) Mental disorder (i) of this section, tauthority has deter independent physi performed by a pe State mental healt (A) That, because condition of the ind the level of service and (B) If the individua services, whether specialized service (ii) Intellectual disa (k)(3)(ii) of this sec intellectual disabili authority has dete (A) That, because condition of the intellectual of service and	arsing facility must not admit, on 1989, any new residents with: as defined in paragraph (k)(3) unless the State mental health mined, based on an cal and mental evaluation rson or entity other than the hauthority, prior to admission, of the physical and mental dividual, the individual requires as provided by a nursing facility; I requires such level of the individual requires es; or ability, as defined in paragraph ction, unless the State ty or developmental disability rmined prior to admission of the physical and mental dividual, the individual requires es provided by a nursing facility; at requires such level of					

Facility ID: LTC0053

FORM CMS-2567(02-99) Previous Versions Obsolete

### PRINTED: 02/20/2019 DEPARTMENT OF HEALTH AND HUM. SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING \_ B. WING 01/10/2019 035099 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2900 EAST MILBER STREET SAPPHIRE OF TUCSON NURSING AND REHAB, LLC **TUCSON, AZ 85714** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) F 645 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 (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 (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

This REQUIREMENT is not met as evidenced

Based on clinical record review, staff interviews,

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.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	COMP	LETED
		035099	B. WING			01/1	0/2019
		RSING AND REHAB, LLC		29	REET ADDRESS, CITY, STATE, ZIP CODE 00 EAST MILBER STREET JCSON, AZ 85714	A	, , , , , , , , , , , , , , , , , , ,
(X4) ID PREFIX TAG	(FACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPED DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 645	and review of facility failed to er referred to the ap authority for Leve screening and red determination.  Findings include: Resident #61 was February 20, 201 unspecified psycl known physiologidisease, and sch Review of the residence that the astronus mental referral for a Level II PASARR revealed the residence that the appropriate scriber in the appropriate scriber in PASARR.  An interview was (staff #203) on James and staff #203 on James and scriber in PASARR should she was unsure PASARR was contained in the staff #204	lity policies and procedures, the issure one resident (#61) was propriate state-designated I II PASARR (pre-admission sident review) evaluation and admitted to the facility on 4 with diagnoses that included nosis not due to a substance or cal condition, Parkinson's izoaffective disorder.  Sident's clinical record revealed a dated June 4, 2015 which dent had a primary diagnosis of illness (SMI) and required a fel II determination for mental atte-designated authority for a		645	1. For Resident #61 a Level II screwas obtained on 1/10/19 2. All residents who need a Level screening could be affected by this deficiency. 3. The facility conducted an in-ser 2/4/19 regarding the process for Lepasana For all Social Services states This in-service will repeat on 2/28/include the nurse managers, Adm Department, Medical Records and MDS Director. The Social Service will review all new admissions to dif a Level II screening is needed. The Behavioral Health Program Dreview the PASAAR during the adprocess to ensure the appropriate Level II referral. 4. A tracking log was developed to that if a Level II is needed and it h submitted correctly and timely. This will monitored by the Behavior Program Director and the Adminis Results submitted monthly to the QAA Committee.	vice on evel II aff. 19 and ission the s Director etermine irector will mission	3/3/19

PRINTED: 02/20/2019 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		035099	B, WING			01/1	0/2019	
	PROVIDER OR SUPPLIER	SING AND REHAB, LLC	STREET ADDRESS, CITY, STATE, ZIP C 2900 EAST MILBER STREET TUCSON, AZ 85714					
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETION DATE	
	Review of the facili revealed "Nursinindividuals with medisabilities will be of the Medicaid Pre-A Resident Review pextent possible" Care Plan Timing a CFR(s): 483.21(b) §483.21(b) Compr §483.21(b)(2) A cobe- (i) Developed within the comprehensive (ii) Prepared by an includes but is not (A) The attending (B) A registered nuresident. (C) A nurse aide wresident. (D) A member of f(E) To the extent put the resident and their resident and their resident not practicable for resident's care pla (F) Other appropridisciplines as deteor as requested by (iii) Reviewed and	II PASARR. Staff #204 stated is not completed yet.  Ity's policy Admission Criteria g and medical needs of ental disorders or intellectual determined by coordination with Admission Screening and erogram (PASARR) to the end Revision (2)(I)-(iii)  The enesive Care Plans emprehensive care plan must interdisciplinary team, that limited to-physician.  The with responsibility for the exit of and nutrition services staff. For a cresident's representative(s), and the participation of the resident representative is determined the development of the enesident's needs in ermined by the resident's needs		645				

Facility ID: LTC0053

#### PRINTED: 02/20/2019 DEPARTMENT OF HEALTH AND HUM ... SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING \_ B. WING 01/10/2019 035099 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2900 EAST MILBER STREET SAPPHIRE OF TUCSON NURSING AND REHAB, LLC **TUCSON, AZ 85714** (X5) COMPLETION PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) 1. F 657 F 657 Continued From page 43 comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced

Findings include:

(#74).

Resident #74 was admitted to the facility on December 7, 2017 with diagnoses that included multiple sclerosis and quadriplegia.

Based on clinical record review, staff interview, and policy and procedure, the facility failed to ensure a care plan was revised for one resident

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

PRINTED: 02/20/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
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		035099	B, WING_			01/1	0/2019	
• • • • • • • • • • • • • • • • • • • •	ROVIDER OR SUPPLIER	SING AND REHAB, LLC		290	REET ADDRESS, CITY, STATE, ZIP CODE DO EAST MILBER STREET ICSON, AZ 85714			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 657	9, 2019 at 3:46 PM resident's splints has stated that she did had not been update departments are recare plan, including management meet residents' care plan. An interview was conversing (DON/staff 9:29 AM. The DON plan related to nursithey have an interested to the care discontinuing thing should have been a Review of the facilic Comprehensive" resident's splints.	Staff #21 stated the ad been discontinued. She not know why the care plan ted. The ADON stated all esponsible for updating the nursing. She said the nursing is every morning to discuss as, change of condition, etc. conducted with the Director of #125) on January 10, 2019 at I stated anything in the care sing is updated daily. She said lisciplinary team (IDT) meeting a stated they are good at plan but need to get better at s. The DON said the splints resolved in the care plan.	F6	57	1. The Care Plan for Resident #74 has updated to reflect the discontinuant splints on 2/24/19. The resident car scheduled for review on 2/28/19.  2. Residents with adaptive equipme the potential to be affected by this p 3. The IDT team will review new ord the previous 24 hours and on Mondathe weekends and update care plan change of condition occur. Education provided to the IDT on 2/25/2019 to understanding and compliance.  4. The DON/Designee will monitor for compliance and report to the QAA Conforthree months.	ce of the re plan is ont have ractice. Hers from ay from s when on will be ensure	3/3/19	
F 689 SS=D	as information aboresident's condition Free of Accident H CFR(s): 483.25(d). §483.25(d) Accide The facility must eligable §483.25(d)(1) The as free of accident \$483.25(d)(2)Each supervision and as accidents. This REQUIREME by:	azards/Supervision/Devices (1)(2) nts.	F 6	889				

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: LTC0053

PRINTED: 02/20/2019 FORM APPROVED OMB NO. 0938-0391

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STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	PLETED
		035099	B. WING			01/1	0/2019
	PROVIDER OR SUPPLIER	SING AND REHAB, LLC		29	TREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST MILBER STREET UCSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	review of policies a failed to ensure that to residents was for Findings include:  During an observation 2019 at 10:30 a.m. observed near the When the door to released, the door a potential accident use the restroom. This area to go to the facility.  An interview was constant for the facility.  An interview was constant for the facility of the faci	and procedures, the facility at a public restroom accessible ee from accident hazards.  tion conducted on January 7, ., two unlocked restrooms were front entrance of the facility. restroom #1 was opened and rapidly slammed shut causing at hazard to residents who may Multiple residents passed by the front lobby and to go outside conducted with a receptionist muary 8, 2019 at 9:25 a.m. Staff they asked the residents not to be crooms but that some of them at use the public restrooms at the is at the receptionist desk. Stated the public bathroom ocked.  Ations conducted on January 8, evealed the area near the public nt lobby continued to be a high sidents going to the front lobby		689	1. On January 10, 2019 the door clocked Restroom #1 was repaired to preven door from slamming shut. The locks restrooms were changed to require a from the receptionist in order to enterestroom.  This was effective 1/10/2019.  2. All residents who enter the lobby request a restroom could be affected.  3. The Maintenance Director will enthe doors to the restroom are in work condition. The receptionist will report concerns to the Maintenance Director.  4. The Maintenance Director will incomplete the door operations as part of his preventantenance program. The Administ shall monitor for compliance and report of three months.	t the to both a key r the area and d. sure king, safe rt any or. clude trator	

Event ID; V3CM11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,		E CONSTRUCTION	COMPLETED			
		035099	B. WING			01/10/2019		
•	PROVIDER OR SUPPLIER	SING AND REHAB, LLC		29	TREET ADDRESS, CITY, STATE, ZIP CODE 900 EAST MILBER STREET UCSON, AZ 85714			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 695 SS=D	Continued From p partner of the facil 2019 at 12:35 p.m facility will be repardoes not slam shur Review of the facil Supervision of Restrives to make the accident hazards included resident assistance to previorities. Respiratory/Trach CFR(s): 483.25(i) § 483.25(i) Respiratory care and tracheal care, consistent with practice, the composer plan, the resident 483.65 of this This REQUIREMED by: Based on clinical and policy and prepare one reside	age 46 ity (staff #220) on January 10, . Staff #220 stated that the iring the door today so that it it. ity's policy Safety and sidents revealed "Our facility e environment as free from as possible". The policy safety and supervision and rent accidents are facility-wide eostomy Care and Suctioning eatory care, including e and tracheal suctioning. ensure that a resident who care, including tracheostomy suctioning, is provided such rith professional standards of orehensive person-centered idents' goals and preferences,	F	689	DEFICIENCY)	n to d be e en en	3/3/19	
	order. Findings include:				months.			
	October 26, 2018	readmitted to the facility on , with diagnoses that included failure with hypoxia, adult failure plegia.						

		AND HUN. SERVICES  & MEDICAID SERVICES				FORM.	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE	SURVEY PLETED .
		035099	B. WING	i ,		01/	10/2019
	PROVIDER OR SUPPLIER	SING AND REHAB, LLC	I	29	TREET ADDRESS, CITY, STATE, ZIP CODE 900 EAST MILBER STREET UCSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 695	Continued From pa	age 47	F	695			
	orders revealed an at 2 liters per minu October 26, 2018 a	ent summary of physician's order for oxygen continuously te via nasal cannula dated and an order to change the ry Wednesday on the night shift 2019.					
!	assessment dated Brief Interview for I 15, which indicated	terly MDS (Minimum Data Set) October 31, 2018 revealed a Mental Status (BIMS) score of I the resident was cognitively ment also included the resident yen therapy.	1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -				
	altered respiratory failure with hypoxia administering med monitoring for effe	lan revealed the resident had status related to respiratory a. The interventions included ication/puffers as ordered and ctiveness and side effects and enting/reporting abnormal to the physician.					
	on January 7, 2019 concentrator was of however, the resid cannula, as it was	v conducted with the resident 9 at 3:23 p.m., the oxygen observed to be set at 2.5 liters, ent did not have on the nasal lying on the resident's tray. Itubing revealed no date when on changed.					
	was observed sleed oxygen tubing on a 2.5 liters. The tubing	9 at 12:28 p.m., the resident eping in his wheelchair with the and the concentrator was set at ng was not observed to have a set the tubing had been last					

An interview was conducted with a certified

changed.

PRINTED: 02/20/2019

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLÍA IDENTIFICATION NUMBER:		l''		LE CONSTRUCTION	COMPLETED			
		035099	B. WINC	)		01/10/2019		
	PROVIDER OR SUPPLIE	R RSING AND REHAB, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2900 EAST MILBER STREET TUCSON, AZ 85714					
(X4) ID PREFIX TAG	(FACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	DBE	(X5) COMPLETION DATE	
F 695	nursing assistant 2019 at 9:14 a.m. the overnight shift oxygen concentrated at e on the tubing changed. She stated the tubing or if the overdue, she changed in the oxygen mach level of oxygen was at 9:22 a.m. with (LPN/staff #159), the night shift changed in the oxygen at 2 liters amount of oxygen at 2 liters. Review of the reincluding in the transport of the transport of the reincluding in the transport of the reincluding	(CNA/staff #58) on January 10, who stated that the CNA's on it change the tubing on the ators every Sunday, and tape the g to show when the tubing was ated that if there is no date on e date indicates that it is anges the tubing. After observing g, she confirmed that there was sident's tubing or anywhere on tine. She also confirmed that the was set at 2.5 liters per minute.  conducted on January 10, 2019 a licensed practical nurse, who stated that the CNA's on ange and date the oxygen tubing d document the tubing was computer in the task section. She did not see a date on the tubing, the the tubing. She also stated that esponsibility to monitor the in received per a minute. After ders, she stated the order is for 3.  sident's electronic record ask section, revealed there was on that the tubing was changed in December 2018.  ew conducted with the Director of taff #125) on January 10, 2019 at stated the expectation is that the to be changed by the CNA's on		695				

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		035099	B, WING_			01/1	0/2019
	ROVIDER OR SUPPLIER	SING AND REHAB, LLC		29	REET ADDRESS, CITY, STATE, ZIP CODE 00 EAST MILBER STREET ICSON, AZ 85714		
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F 695		nge 49 s procedure is to provide oxygen administration.	F6	95		300	and the state of t
3	-Verify that there is procedure.	a physician's order for this ian's order or facility protocol					
F 698 SS=E	monitoring when or changed. Dialysis	address a process for xygen equipment is to be	F6	98	1. Obveision order for dialygic was o	htained	
	require dialysis red with professional s comprehensive pe the residents' goals This REQUIREME by: Based on clinical and policy review,	record review, staff interviews, the facility failed to ensure			<ol> <li>Physician order for dialysis was on 1/10/19.</li> <li>All residents who receive dialysis be affected by this alleged deficiency. An audit was conducted on 2/27/19 fresidents receiving dialysis to ensure are in place.100% audited had the coorders.</li> <li>The admission audit process will residents needing dialysis to ensure are current physician orders.</li> <li>The DON/Designee will monitor for appliance and report to the OAA Commission and report to the OAA Commis</li></ol>	could  or all orders orrect dentify there	3/3/19
	November 16, 201	s admitted to the facility on 8 with diagnoses that included			compliance and report to the QAA Confor three months.	ommittee	
	An admission Mini assessment dated the resident had sl memory problems	sease, sepsis, and bacteremia.  mum Data Set (MDS)  November 23, 2018 included  nort-term and long-term  and had severe impairment  making. The MDS assessment		Lindows I and the second I among			

STATEMENT	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		035099	B. WING	i		01/1	0/2019	
•••	PROVIDER OR SUPPLIER	SING AND REHAB, LLC		2	STREET ADDRESS, CITY, STATE, ZIP CODE 1900 EAST MILBER STREET FUCSON, AZ 85714			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE.	(X5) COMPLETION DATE	
F 698	also included the real A nursing note date revealed the reside catheter.  Review of the clinic went out to dialysis occasions in Novel January 2019.  A care plan dated I the resident needs renal disease. Inte and changing the cand document.  However, review of evidence that there dialysis treatments to check and chand daily.  In an interview with (LPN/staff #165) of a.m., he stated that dialysis, there should treatment to include order to monitor the resident has a monitored every direviewed resident was unable to local dialysis treatment.  During an interview #153) caring for the resident for the resident was unable to local dialysis treatment.	esident was receiving dialysis.  ed November 23, 2018 ent had a right sided vascular  cal record revealed the resident appointments on several mber and December 2018 and  December 21, 2018 included dialysis related to end stage rventions included checking dressing daily at access site  If the clinical record revealed no e was a physician's order for is, to monitor the dialysis site, or ge the access site dressing  In a licensed practical nurse in January 10, 2019 at 10:31 at for a resident receiving and be an order for the dialysis le the days for dialysis and an ite dialysis site. He stated that if port site then it should be any for bleeding. The nurse #151's electronic record and ate an order for the resident's  w conducted with the LPN (staff its resident on January 10, 2019		698				
	at 10:38 a.m., she currently at the dia	stated the resident was llysis center. She stated she						

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			COMPLETED	
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,	PROVIDER OR SUPPLIER	SING AND REHAB, LLC		STREET ADDRESS, CITY, STATI 2900 EAST MILBER STREET TUCSON, AZ 85714			
(X4) ID PREFIX TAG	FACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
F 698	knows when the rebased on an appoevery day and her dialysis days and when the resident assessment is do site. She stated the documented every an order to monite.  In an interview wit (DON/staff #125) a.m., she stated the order in place for includes the locatistated there shou resident's dialysis port.	esident is scheduled for dialysis intment log that is reviewed report sheet that has the time. The LPN also stated that returns from dialysis an ne which includes checking the le site should be assessed and y shift, and that there should be or the site.  In the Director of Nursing on January 10, 2019 at 10:43 nere should be a physician's dialysis treatments which ion, day and time. She also id be an order to monitor the site, whether it is a fistula or a	[-				
F 725 SS=E	Access Care" did regarding a reside Per the DON, the to dialysis.  Sufficient Nursing CFR(s): 483.35(a)  §483.35(a) Suffic The facility must be the appropriate of provide nursing a resident safety ar practicable physic well-being of each resident assessment considering the safety of the safety ar practicable physic well-being of each resident assessment considering the safety are sa	)(1)(2)	, compared to the second secon	725			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				X3) DATE SURVEY COMPLETED	
		035099	B. WING			01/ <sup>,</sup>	10/2019
	PROVIDER OR SUPPLIER	SING AND REHAB, LLC		29	TREET ADDRESS, CITY, STATE, ZIP CODE 900 EAST MILBER STREET UCSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 725	at §483.70(e).  §483.35(a)(1) The by sufficient number types of personnel nursing care to all resident care plans (i) Except when was this section, licensed (ii) Other nursing plimited to nurse aid §483.35(a)(2) Exceparagraph (e) of the designate a license nurse on each tour This REQUIREME by:  Based on resident documentation and facility failed to have provide nursing an resident safety and practicable physical well-being of each.  Findings include:  Multiple resident in January 7, 2018 retrandom residents enough staff and the for staff assistance answered.  An interview was conursing assistant), unit for high acuity	facility must provide services ers of each of the following on a 24-hour basis to provide residents in accordance with state and ersonnel, including but not les.  The section, the facility must end nurse to serve as a charge of duty.  Note in the facility must end nurse to serve as a charge of duty.  The section is not met as evidenced at and staff interviews, facility it policies and procedures, the resufficient nursing staff to delated services to assure at attain or maintain the highest al, mental and psychosocial	F	725	1. The facility updated the call-in policy reflect a more structured procedure for who call in resulting in staff shortages policy was presented to staff on 2/22/ There has been an increase in the hir C.N.A.'s and nurses to fill open position. This will reduce the number of outside agency usage resulting in better and consistent patient care. The staffing patterns were reviewed to reflect a mincreased staffing on the Behavioral 2. All residents could be affected by the alleged deficiency.  3. The Resident Council Minutes are reviewed by the Administrator and monitored to ensure a response and a plan will be addressed for all concern An additional Guest Services Coordin has been hired as of 3/1/19 to also ac resident concerns and assist with any grievances.  4. The Administrator will monitor for compliance and report to the QAA Committee for three months.	eed for Unit. chis	3/3/19

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER;			CONSTRUCTION		SURVEY PLETED
		035099	B. WING			01/	10/2019
	ROVIDER OR SUPPLIER	SING AND REHAB, LLC		29	REET ADDRESS, CITY, STATE, ZIP CODE 00 EAST MILBER STREET JCSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 725	supposed to be in to to prevent resident that does not alway. An interview was converted that sor be monitoring the hoses not always hat The CNA stated we there is a call in the hallway and the residents when the An interview was converted that it is residents when the residents when there is further explained that can done when there is further explained that should and show. An interview was convented that the adequately, but so who stated that the this hallway and no stated that it was he because most of the require two staff to	A stated that one CNA is the hall at all times to monitor to resident altercations, but is happen because of call ins.  Onducted with another CNA, meone is always supposed to hallway on the A-1 unit, but that appen and it's kind of irritating. It do the best we can, but if ere is no one to monitor the sidents get in to altercations.  Onducted with another CNA is challenging to care for the are call ins.  Onducted with a fourth CNA, metimes it is hard to care for a there are call ins.  Onducted with another CNA, re and showers do not get in the care gets done but not like ers get missed.  Onducted with another CNA, or facility attempts to staff in the days they are short.  Onducted with a seventh CNA, or facility attempts to staff in the days they are short.  Onducted with a seventh CNA, or facility attempts to staff in the days they are short.  Onducted with a seventh CNA, or facility attempts to staff in the days they are short.  Onducted with a seventh CNA, are days they have three. The CNA ard to monitor the hallway, he residents on this hallway provide care.		725			
	An interview was c	onducted with another CNA,		Ì			1

OFILE	TO LOIT MEDICATOR	WINEDION OF OFFICE					
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		SURVEY PLETED
		035099	B. WING			01/1	0/2019
	PROVIDER OR SUPPLIER	SING AND REHAB, LLC		2	TREET ADDRESS, CITY, STATE, ZIP CODE 900 EAST MILBER STREET UCSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 725	could use more sta The CNA stated tha monitor, but do not  An interview was o stated that sometir on 2nd shift for this most of the resider staff to provide car facility is trying to s are now using age.  An interview was o practical nurse). Ti more staff. The LP short, I do not focu paperwork and hel  An interview was o who stated that the but when the new over they cut staff. best we can. The I are more CNAs so surveyors are here Review of the Res February 2018 thro the following concerFebruary 26: "Not -May 8: "The resid staff and residents answered promptiJuly 9: "Many say (pending concern -August 30: "Resid	e thought the afternoon shift aff especially on the weekends. at they used to have a hall anymore.  onducted with a CNA, who mes they only have two CNA's hallway and it's hard because into on this hallway require two e. The CNA stated that the staff adequately because they incy staff.  onducted with a LPN (licensed the LPN stated they could use in the CNAs.  onducted with another LPN, are used to have enough staff, management company took. The LPN stated we do the LPN further stated that there is the duled today, because the error the annual survey.  ident Council Minutes from ough December 2018 revealed the error from residents:  the enough staff all shifts."  the enough staff all shifts."		725			
	not being answere	ed promptly, Concerns with 7:00					

CENTE	10 LOU MEDIOVIVE	C MEDIO/ ND OFFICIOR					
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		035099	B. WING			01/1	0/2019
	PROVIDER OR SUPPLIER RE OF TUCSON NUR	BING AND REHAB, LLC		29	TREET ADDRESS, CITY, STATE, ZIP CODE 900 EAST MILBER STREET UCSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 725	a.m 3:00 p.m. B2 -September 13: "R staff." -October 12: "Call and residents and 15 minutes on B2.' -November 8: "Ove stated by one resid very good job but r -December 6: "B2 been 2 CNA's to 30 being met. Resident	! (long term care unit)." esidents feel like they lack lights are not answered quick family are waiting more than	F	725			
	documentation, a read to 2019 at 2:10 p.m., documentation, for that there was not to wait extended prassistance.	esident council meeting meeting was held on January 9, with six residents. Per the ur of the six residents stated enough staff and that they had eriods of time for staff	Market and Aller				
	for the above mon	f the Resident Council Minutes ths was a section titled, e implemented" however, each was blank.					
	director (staff #2) of Staff #2 stated that director since April minutes for the restated that she gar nursing and they a residents' concern resident council kr	conducted with the activity on January 9, 2019 at 2:45 p.m. t she has been the activity 2018, and that she took the sident council meeting. Staff #2 we the staffing concerns to are supposed to respond to the s so that we could let the now. Staff #2 stated that she esponses from nursing yet					

PRINTED: 02/20/2019 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COMP	LETED
		035099	B. WING			01/1	0/2019
	PROVIDER OR SUPPLIER	SING AND REHAB, LLC		2	TREET ADDRESS, CITY, STATE, ZIP CODE 900 EAST MILBER STREET 'UCSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE.	(X5) COMPLETION DATE
F 725	9:25 a.m. Staff #20 monitor in the halfy Staff #20 stated the residents concerns  An interview was concerns at 10:40 a.m. units have different stated the facility heresident altercation injury, because of ratio wise, there was concern could be to Staff #220 stated the stated the stated the staff #220 staff		F	725		Control and the control and th	
F 758 SS=D	revealed, "Our fac of staff with the sk to provide care an accordance with re facility assessmen to our facility's staf Administrator or hi Free from Unnec I CFR(s): 483.45(c) §483.45(e) Psycho §483.45(c)(3) A ps affects brain activi processes and be	Psychotropic Meds/PRN Use (3)(e)(1)-(5)		758			

PRINTED: 02/20/2019 FORM APPROVED OMB NO. 0938-0391

<u> </u>	10 1 OIL MEDIOLITA						A 1 4 1 1
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	PLETED
		035099	B. WING			01/1	0/2019
	PROVIDER OR SUPPLIER	SING AND REHAB, LLC		29	REET ADDRESS, CITY, STATE, ZIP CODE 100 EAST MILBER STREET UCSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 758	(i) Anti-psychotic; (ii) Anti-depressant (iii) Anti-anxiety; an (iv) Hypnotic  Based on a compreresident, the facility §483.45(e)(1) Resipsychotropic drugs unless the medicat specific condition a in the clinical recor §483.45(e)(2) Residugs receive grad behavioral interver contraindicated, in drugs; §483.45(e)(3) Resignation of the clinical recores shat medicated in the clinical recores shat medicated to 14 days, in the clinical recores shat medicated to 14 days, in rationale in the resindicate the duratic shat shat medicated the duratic shat shat shat shat shat shat shat shat	chensive assessment of a must ensure that dents who have not used are not given these drugs ion is necessary to treat a sidagnosed and documented d; dents who use psychotropic ual dose reductions, and ations, unless clinically an effort to discontinue these idents do not receive a pursuant to a PRN order ation is necessary to treat a condition that is documented	F	758	The following actions have been taken those residents noted to be affected be alleged deficient practice.  1. Resident #135 was discharged on 12/26/18.  2. All residents could be affected by the alleged deficiency. The Behavioral Health nurse manager conducted an audit be 1/28/19-2/11/19 to determine correct diagnosis for use of psychotropic drug.  3. The Behavioral Health nurse manager conduct ongoing random audits on on psychotropic medications for the correct diagnosis. For all new admiss the orders will be reviewed by nurse managers to check for appropriate diagnosis at daily clinical meeting.  4. The DON/Designee will monitor for compliance and report any issues to Committee for three months.	his lealth letween ligs. lager will lorders for ssions lagnosis. s will be	3/3/19

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: LTC0053

### PRINTED: 02/20/2019 DEPARTMENT OF HEALTH AND HUM. SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A, BUILDING \_\_\_ B. WING 035099 01/10/2019 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2900 EAST MILBER STREET SAPPHIRE OF TUCSON NURSING AND REHAB, LLC **TUCSON, AZ 85714** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 758 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

psychosis.

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

Review of the closed clinical record revealed a

### PRINTED: 02/20/2019 DEPARTMENT OF HEALTH AND HUM. SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING \_\_\_ B, WING 01/10/2019 035099 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2900 EAST MILBER STREET SAPPHIRE OF TUCSON NURSING AND REHAB, LLC **TUCSON, AZ 85714** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 758 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

		1			- a a u a mali a mait	(X3) DATE	QUDVEV
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		PLETED
		035099	B. WING			01/1	0/2019
	ROVIDER OR SUPPLIER E OF TUCSON NUR	SING AND REHAB, LLC		29	REET ADDRESS, CITY, STATE, ZIP CODE 1000 EAST MILBER STREET UCSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPERTION OF COMMERCE APPROPERTI	)BE	(X5) COMPLETION DATE
F 842	further stated that the drug for resident # with the physician.  During an interview 2019 at 9:35 a.m. Nurse/staff #165), diagnosis is inappropositional interview 2019 at 9:35 a.m. Nurse/staff #165), diagnosis is inappropositional interview attention.  The facility's policy Antipsychotic Medistatement that anticonsidered for residenter medical, physician psychiat causes of behavior identified and addresidents will only medications when conditions for whice effective.  Resident Records CFR(s): 483.20(f)(5) Resident-identifiable (ii) The facility may resident-identifiable accordance with a agrees not to use	he use of the antipsychotic and should have been clarified or conducted on January 10, with a RN (Registered the nurse stated that if a copriate for an ordered resewould bring it to the control of the included a policy psychotic medications may be dents with dementia but only sical, functional, psychological, and environmental real symptoms have been ressed. The policy included receive antipsychotic necessary to treat specific the they are indicated and - Identifiable Information 5), 483.70(i)(1)-(5)  dent-identifiable information that is e to the public. In release information that is e to an agent only in contract under which the agent or disclose the information that the facility itself is permitted	· F	758			
	[						

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		035099	B. WING	}		01/1	0/2019
	ROVIDER OR SUPPLIER	SING AND REHAB, LLC		29	TREET ADDRESS, CITY, STATE, ZIP CODE 900 EAST MILBER STREET UCSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 842	professional standamust maintain medithat are- (i) Complete; (ii) Accurately docu (iii) Readily access (iv) Systematically (iv) For the individual representative whe (ii) Required by Lav (iii) For treatment, poperations, as perrowith 45 CFR 164.5 (iv) For public health neglect, or domest activities, judicial a law enforcement proposes, research medical examiners a serious threat to by and in complian §483.70(i)(3) The frecord information unauthorized use. §483.70(i)(4) Medicior- (i) The period of tin (ii) Five years from there is no requirer	cordance with accepted ards and practices, the facility ical records on each resident mented; ible; and organized acility must keep confidential ained in the resident's records, orm or storage method of the en release is, or their resident re permitted by applicable law; v; bayment, or health care nitted by and in compliance	F	842	The facility does have a policy that access to all electronic medical rec. The current owners of this facility to August 2018. During the certification conducted 1/7-1/10 the facility made multiple attempts to obtain the elect medical records for Resident #225 f previous owners. The previous own (Avalon) would not send electronical PCC (Point Click Care) but did sent through email therefore allowing Sapphire of Tucson to print the medical record for the survey team.  2. The residents who are affected be alleged deficiency would be dischar residents that were under the control previous owners.  3. If there are future request for me records under the control of the previous owners, this facility will make every to obtain the records for all entities agencies that request them.  4. The Administrator will monitor are the point person for this issue	ords. ok over n survey ronic from the ners ally to d dical y this ged ol of the dical vious r effort	3/3/19

#### PRINTED: 02/20/2019 DEPARTMENT OF HEALTH AND HUN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING B. WING 01/10/2019 035099 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2900 EAST MILBER STREET SAPPHIRE OF TUCSON NURSING AND REHAB, LLC **TUCSON, AZ 85714** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 842 Continued From page 62 F 842 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

Findings include:

the State Survey Team.

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.

(iv) The results of any preadmission screening

(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced

Based on record review, staff interviews and policies and procedures, the facility falled to ensure that electronic and paper health records for one resident (#225) were readily accessible to

and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed

professional's progress notes; and

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

	MENT OF HEALTH				·		APPROVED 0938-0391
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	Γ			T	E SURVEY
STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		PLE CONSTRUCTION  3	COM	PLETED
		035099	B. WING			01/	10/2019
NAME OF F	PROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE		
SAPPHIR	RE OF TUCSON NUR	SING AND REHAB, LLC			2900 EAST MILBER STREET TUCSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ΙX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	.D BE	(X5) COMPLETION DATE
F 842	facility did not have for resident #225, a records had been rof the facility when the current owner i Administrator state previous owner than needed, and that they were suppose electronic health remarks and interview was a member (staff #220 starequirement that are to be maintained for stated that staff we previous owners of the health records  An interview was a requirement that are to be maintained for stated that staff we previous owners of the health records  An interview was a stated that staff #184 stated the electronic health records at 8:30 a.m. with most accessible, become accessible, become of the process of uple the process of uple the process of uple the process of the proces	ministrator stated that the access to electronic records and that access to those removed by the previous owner the facility was purchased by n August 2018. The ad that he would notify the at access to the records was ne facility staff were aware that ad to have access to all ecords for resident #225.  Conducted with a corporate staff (0) on January 7, 2019 at 1:45 ated that he was aware of the access to medical records was for 7 years. Staff #220 also for in communication with the fine facility to obtain access to for resident #225.  Conducted on January 8, 2019 the facility to obtain access to for resident #225.  Conducted on January 8, 2019 the facility to owner was the paper records and been evious owner of the facility; that the previous owner was to the facility. She stated that coading the documents would	ekomula ediği ere çekişilirinin karalı	842	2		
	take hours and the printed after the up	oading the documents would be blood. Staff #184 stated that					

resident #225 were being pre-screened by the previous owner prior to being uploaded.

administrator on January 8, 2019 at 9:24 a.m., the administrator stated that they were unable to

During an interview conducted with the

PRINTED: 02/20/2019

CENTER	O I ON MEDIOWA	WINEDIO/ND OF WIND	·····			WAL DATE	OT IDVICA
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	LETED
		035099	B. WING			01/1	0/2019
	PROVIDER OR SUPPLIER	SING AND REHAB, LLC	<u> </u>	29	REET ADDRESS, CITY, STATE, ZIP CODE 00 EAST MILBER STREET JCSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 842	obtain access to e the previous owner the previous owner on January 8, 201 provided a stack or resident #225 and access to electron #225.  Review of the faci Electronic Medica that authorized Fe as outlined in curraccess to electron QAPI/QAA Improv CFR(s): 483.75(g) §483.75(g) Quality §483.75(g) Quality §483.75(g)(2) The assurance commi (ii) Develop and in action to correct in this REQUIREMI by:  Based on concernstaff interview and assessment and failed to identify appropriate plans deficiencies.  Findings include:	lectronic health records from or of the facility.  Inview with staff #184 conducted 9 at 2:08 p.m., the staff #184 of printed paper records for stated that there would be not ic health records for resident.  Ity's policy and procedure titled I Records included a statement or and State survey agents the regulations may be granted nic medical records.  Ity medical records.	The American State of	842	<ol> <li>A new administrator was hired et 1/1/19.</li> <li>All residents could be affected be alleged deficiency.</li> <li>The QAA Committee will ensure concerns are identified and implent appropriate plans of actions to correct the quality deficiencies. An was conducted on 2/27/19 with the Committee reviewing the requirement systems to address care and manapractices.</li> <li>The Administrator will monitor to quality concerns are being address that the monthly QAA meetings are scheduled. This will be an ongoing</li> </ol>	quality nent inservice QAA ents for agement o ensure sed and e held as	3/3/19

### FORM APPROVED DEPARTMENT OF HEALTH AND HUN SERVICES OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING \_ B. WING 01/10/2019 035099 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2900 EAST MILBER STREET SAPPHIRE OF TUCSON NURSING AND REHAB, LLC TUCSON, AZ 85714 PROVIDER'S PLAN OF CORRECTION (X6) COMPLETION DATE ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 867 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 919

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

Resident Call System

CFR(s): 483.90(g)(2)

§483.90(g) Resident Call System

F 919

SS≍D

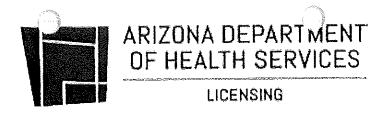
PRINTED: 02/20/2019

### PRINTED: 02/20/2019 FORM APPROVED DEPARTMENT OF HEALTH AND HUN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING \_ B. WING 01/10/2019 035099 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2900 EAST MILBER STREET SAPPHIRE OF TUCSON NURSING AND REHAB, LLC **TUCSON, AZ 85714** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 919 F 919 Continued From page 66 work area. §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced 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.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION		SURVEY PLETED
		035099	B. WING			01/	10/2019
	PROVIDER OR SUPPLIER	SING AND REHAB, LLC		2	TREET ADDRESS, CITY, STATE, ZIP CODE 900 EAST MILBER STREET 'UCSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 919	2019 revealed the a and front lobby con with residents going the facility.  An interview was conceptionist (staff # 11:00 a.m. Staff #1 were asked to not up #194 stated that the doors of the public residents could go in would not know that there is no call light doors used to be looked. An interview was conceptioned at 12:35 p.m. unlocked bathroom #220 stated that where thought it was a restroom and have when you were in the felt installing the ocon the door would residents.	ucted on January 8, 9, and 10, area near the public restrooms tinued to be a high traffic area of to the front lobby or out of anducted with another 194) on January 10, 2019 at 94 stated that the residents are the public restrooms. Staff a facility put the signs on the restrooms due to the fact that in there and fall and they they were in there because. Staff #194 further stated the cked.  Inducted with the managing of (staff #220) on January 10, Staff #220 stated that the doors were his fault. Staff then he first came to the facility dignity issue to be in the people knocking on the door here. Staff #220 stated that he cupied/unoccupied deadbolts esolve the dignity issue.	FS	919	The following action have been taken those residents noted to be affected alleged deficient practice.  1. The locks to both public restrooms changed to require a key from the receptionist in order to enter the restroom. The residents will not be to use the public restroom as there is call system in place. This was effective 1/10/19.  2. All residents who enter the lobby a and request a restroom could be affer this alleged deficiency.  3. The manging partner for the facility confirmed that the restrooms will remule locked with accessibility only through controlled method of obtaining a key from the receptionist.  4. The Administrator will monitor for compliance and report any issues to QAA Committee for 3 months.	by this were e allowed not a re crea cred by y has ain the	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

significant corrections are required (I).

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

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

constitute actual harm that is not immediate jeopardy, as evidenced by the attached form 2567 whereby

Sapphire Of Tucson Nursing And Rehab, Llc February 20, 2019 Page Two

### 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

Sapphire Of Tucson Nursing And Rehab, Llc February 20, 2019 Page Three

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

scane Edler

DE\sf

Attachments

PRINTED: 01/16/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG 01 - MAIN BUILDING 01		SURVEY PLETED
		035099	B. WING _		01/1	15/2019
	ROVIDER OR SUPPLIER	SING AND REHAB, LLC		STREET ADDRESS, CITY, STATE, ZIP CO 2900 EAST MILBER STREET TUCSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
K 000	42 CFR 483.41(a) The facility must m	Nursing Home neet the applicable provisions of the Life Safety Code of the	K 0	Preparation and/or execution of Correction does not constitute agreement by the Provider of facts alleged of the convictions in the statement of deficiencie provisions of the Federal and	admission of the truth of the s set forth s required by	
	under LSC 2012, 0 Skilled Nursing Fa	ation survey for Medicare Chapter 19, Existing. The entire cility, was surveyed. the standards, based on an of correction.	and the state of t	The trash containers were cl     The area by the Fire Department     Connection was cleaned of any	nt	3/3/19
	advised that the particular facility during the significant Director of Maintenager being dispositional flower pots or in the with trash. It was for the significant facility of the significant facil	and during the exit survey was atient smoking areas for the urvey. The surveyor and the nance observed cigarette butts ed of in the trash containers, he self closing metal containers rurther observed cigarette butts ed of on the ground by the Fire ection.		cigarette butts on 1/15/19 2. All residents could be affecte alleged deficiency. 3. Staff were in serviced on the smoking disposal of cigarettes by 2/2/22/19. 4. The Maintenance Director we compliance.	proper outts on	
K 291 SS=E	site and a patient supervision of the while on site at the Emergency Lightin CFR(s): NFPA 10  Emergency Lightin Emergency lightin is provided autom 18.2.9.1. 19.2.9.1	1	K	DEGEIV MAR 5 - 201 By	9	^

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.

Facility ID: LTC0053

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE COMF	PLETED
		035099	B. WING	ـــــ		01/1	5/2019
•		RSING AND REHAB, LLC		2	TREET ADDRESS, CITY, STATE, ZIP CODE 900 EAST MILBER STREET UCSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 291	lighting document Director of Mainte two battery back to located in the in the documented for the March 2018, June light one and Mark NFPA 101, Life Sa Section 19.2.9.1 "provided in accord 7.9.3 "Periodic To Equipment" "Section 19.2.9.1 "provided in accord 7.9.3 "Periodic To Equipment" "Section 19.2.9.1 "provided in accord 7.9.3 "Periodic To Equipment" "Section 19.2.9.1 "provided in accord 5.9.3 "Periodic To Equipment" "Section 19.2.9.1 "provided in accord 5.9.3 "Periodic To Leguipment" "Section 19.2.9.1 "provided in accord 5.9.3 "Periodic To Leguipment" "Section 19.2.9.1 "provided in accord 5.9.3 "Periodic To Leguipment" "Section 19.2.9.1 "provided in accord 5.9.3 "Periodic To Leguipment" "Section 19.2.9.1 "provided in accord 5.9.3 "Periodic To Leguipment" "Section 19.2.9.1 "provided in accord 5.9.3 "Periodic To Leguipment" "Section 19.2.9.1 "provided in accord 5.9.3 "Periodic To Leguipment" "Section 19.2.9.1 "provided in accord 5.9.3 "Periodic To Leguipment" "Section 19.2.9.1 "provided in accord 5.9.3 "Periodic To Leguipment" "Section 19.2.9.1 "provided in accord 5.9.3 "Periodic To Leguipment" "Section 19.2.9.1 "provided in accord 7.9.3 "Periodic To Leguipment" "Section 19.2.9.1 "provided in accord 5.9.3 "Periodic To Leguipment" "Section 19.2.9.1 "provided in accord 7.9.3 "Periodic To Leguipment" "Section 19.2.9.1 "provided in accord 7.9.3 "Periodic To Leguipment" "Section 19.2.9.1 "provided in accord 7.9.3 "Periodic To Leguipment" "Section 19.2.9.1 "provided in accord 7.9.3 "Periodic To Leguipment" "Section 19.2.9.1 "provided in accord 7.9.3 "Periodic To Leguipment" "Section 19.2.9.1 "provided in accord 7.9.3 "Periodic To Leguipment" "Section 19.2.9.1 "provided in accord 7.9.3 "Periodic To Leguipment" "Section 19.2.9.1 "provided in accord 7.9.3 "Periodic To Leguipment" "Section 19.2.9.1 "provided in accord 7.9.3 "Periodic To Leguipment" "Section 19.2.9 "provided in accord 7.9.3 "p	review of the battery backup ation and interview with the nance it was determined two of up emergency lighting units ne main kitchen were not ne monthly 30 second tests for through December of 2018 for ch 2018 for light 2.  afety Code, 2012, Chapter 19, Emergency lighting shall be dance with Section 7.9". Section esting of Emergency Lighting tion 7.9.3.1 Testing of required as follows: (1) Functional Testing of monthly with a minimum of 3 timum of 5 weeks between as than 30 seconds except as ed by 7.9.3.1.1.(2) The Test permitted to be extended beyond approval of authority having nctional testing shall be ally for a minimum of 1/1/2 hours lighting system is battery emergency lighting equipment rational for the duration of the 7.9.3.1.1 (1) and (3). (5) Written inspections and tests shall be refor inspection by the authority not the surveyor accompanied Maintenance reviewed the	K	291	<ol> <li>The facility has hired a new Maint Director as of 2/7/19. The new Dire a developed a Preventive Maintenan Testing system to monitor and sched testing of required emergency lightin equipment.</li> <li>All residents could be affected by alleged deficiency.</li> <li>The Maintenance Director will enrequired testing and inspections are a timely basis through his Preventive Maintenance system.</li> <li>The Administrator will monitor for compliance and report to the QA Committee for 3 months and will revall documentation related to required inspections.</li> </ol>	ctor has ice fulle all ing this sure all done on e	3/3/19
		mergency lighting Two of two battery back up					

PRINTED: 01/16/2019 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			DATE SURVEY COMPLETED	
		035099	B. WING			01/15/2019	
NAME OF PROVIDER OR SUPPLIER SAPPHIRE OF TUCSON NURSING AND REHAB, LLC				STREET ADDRESS, CITY, STATE, Z 2900 EAST MILBER STREET TUCSON, AZ 85714	IP CODE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO I	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
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		K 2	K 291			
K 325 SS=E	1		K C	325			

## DEPARTMENT OF HEALTH AND HU. SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/16/2019 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	F CORRECTION	IDENTIFICATION NUMBER:	1 ' '		21 - MAIN BUILDING 01	COMP	PLETED
		035099	B. WING		4	01/1	15/2019
	PROVIDER OR SUPPLIER RE OF TUCSON NUR	SING AND REHAB, LLC		29	FREET ADDRESS, CITY, STATE, ZIP CODE 200 EAST MILBER STREET UCSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 325	Section 18.3.2.6(11* ABHR is protecte 18.3.2.6, 19.3.2.6, 482, 483, and 485 This REQUIREME by: Based on record r determined the face Dispensers were not the manufactures of time a refill is instated in the manufactures of time a refill is instated in the manufactures of time a refill is instated in the manufactures of Level 1.  * Corridor is at lease * Maximum individing gallons (0.53 gallonounces of Level 1.  * Dispensers shall horizontal spacing * Not more than ar fluid or 135 ounces smoke compartment excluding one indited in the section 18.3 contains the protection of the Section 18.3.2.6(1.)  * ABHR lis protected in the section 18.3.2.6(1.)	d against inappropriate access 42 CFR Parts 403, 418, 460, NT is not met as evidenced eview and observation it was ilties Alcohol Based Hand Rub ot tested in accordance with care and use instructions each lled.  ety Code, 2012, Chapter 19, BHRs are protected in 7.3.1, unless all conditions are at 6 feet wide ual dispenser capacity is 0.32 ns in suites) of fluid and 18 aerosols have a minimum of 4-foot aggregate of 10 gallons of a serosol are used in a single ent outside a storage cabinet, vidual dispenser per room le smoke compartment greater plies with NFPA 30 not installed within 1 inch of an carpeted floors are in compartments exceed 95 percent alcohol dispenser shall comply with 1) or 19.3.2.6(11) ed against inappropriate access 42 CFR Parts 403, 418, 460,		325			

## DEPARTMENT OF HEALTH AND HUL A SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, .		CONSTRUCTION 11 - MAIN BUILDING 01	(X3) DATE COMF	SURVEY
		035099	B. WING	i	and the state of t	01/1	5/2019
***	PROVIDER OR SUPPLIER	SING AND REHAB, LLC		29	REET ADDRESS, CITY, STATE, ZIP CODE 00 EAST MILBER STREET JCSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 325	Operation of the di the following criterion. (F) The dispenser with the manufacture each time a refill is Findings include: On January 15, 20 by the Director of the facility did not that the facilities A Dispensers were that the facilities are time a refill is instantion of the facility of the facilities of the fa	spenser(s) shall comply with ia: shall be tested in accordance ures care and use instructions	K	325	<ol> <li>The facility has developed a syste the dispensers to ensure they are in compliance.</li> <li>All residents could be affected by alleged deficiency.</li> <li>The Housekeeping Supervisor wi in- service the staff on the proper teand procedures for changing the alc based dispensers on 3/3/19.</li> <li>The Maintenance Director will me the dispensers are being tested and</li> </ol>	this III chniques ohol onitor that	1
K 353 SS=E	During the exit conthe above findings the Administrator of the Administrator of the Manufactures time a refill is instanct to operate in a Sprinkler System CFR(s): NFPA 1000 Sprinkler System Automatic sprinkler inspected, tested, with NFPA 25, Standard in the Manufacture of the	reference on Janaury 15, 2019 were again acknowledged by and Director of Maintenance.  not tested in accordance with care and use instructions each alled could cause the dispenser in effective manner if needed.  Maintenance and Testing and standpipe systems are and maintained in accordance and maintained in accordance andard for the Inspection, taining of Water-based Fire	K	353			

## DEPARTMENT OF HEALTH AND HUN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE COMF	SURVEY PLETED
		035099	B. WING			01/1	5/2019
	PROVIDER OR SUPPLIE	R RSING AND REHAB, LLC		2	TREET ADDRESS, CITY, STATE, ZIP CODE 900 EAST MILBER STREET UCSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 353	maintenance, ins maintained in a savailable.  a) Date sprinkle  b) Who provided  c) Water system  Provide in REMA any non-required system.  9.7.5, 9.7.7, 9.7.8  This REQUIREM by: Based on obsentacility failed to multiple areas in  NFPA 101 Life Schapter 19, Section taining nursing throughout by an sprinkler system Chapter 9, Section sprinkler system this Code shall be following." NFP Installation of Sp Section 26.1 "Ge installed in accorproperly inspected property owner contaction in accordance with 5.2.1 "Sprinklers"	ns. Records of system design, pection and testing are ecure location and readily r system last checked d system test supply source  RKS information on coverage for or partial automatic sprinkler s, and NFPA 25 ENT is not met as evidenced vation it was determined that the naintain the sprinkler heads in	Transfer of the state of the st	3353			
		n materials, paint and physical	***************************************				

### DEPARTMENT OF HEALTH AND HUNN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/16/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		CONSTRUCTION 1 - MAIN BUILDING 01	(X3) DATE COMP	SURVEY PLETED
		035099	B. WING			01/1	5/2019
	PROVIDER OR SUPPLIER	SING AND REHAB, LLC		29	REET ADDRESS, CITY, STATE, ZIP CODE 00 EAST MILBER STREET JCSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 353	Findings Include:  On January 15, 20 by the Director of I heads with dust/lingrease on the sprilocations:  1. Room 220 spril 2. Shower room 23. Shower room 33. Shower room 34. Soiled Utility C-5. Bathroom in roroom 124 corrode 6. Main Kitchen two grease.  These were one to location noted about the Administrator of the above findings the Administrator of the sprinkler heads about	19 the surveyor accompanied Maintenance observed sprinkler t, paint, corrosion or lint and nkler heads in the following halfer head with dust/lint. 3-1 and B-2 sprinklers dust/lint. 3-1 and B-2 sprinklers dust/lint. 3-1 sprinkler paint, stucco and drusted 1-1 paint on sprinkler. 3-1 om 126 painted sprinkler and d/rusted sprinkler head. 3-2 sprinklers with lint and 3-3 three sprinklers in each ove:  Inference on January 15, 2019, and Director of Maintenance. 3-4 sprinkler heads could cause and staff by allowing a fire to temperature is reached to set and.  The view and interview with the nance it was determined the e visual monthly sprinkler ude gauges and control valves by a sprinkler company or by the nance for seven of twelve	K 3	53	1. Sprinkle heads in room 220 were with the removal of dust/lint. Sprinklin B-1 and B-2 shower rooms were this was done 1/18/19. The sprinkler heads with paint and corrosion will be scheduled to be reby contractor no later than 3/8/19. A perform the work was obtained on 3 2. All resident have the potential to affected by this alleged deficiency.  3. The Maintenance Director will so visual inspections by zones and not visual inspections which will be performed throughout the month.  4. The Maintenance Director and Administrator will monitor for compliment to the QAA Committee for the months.	er heads cleaned. pr placed quote to 3/1/19. be chedule e the formed	

Facility ID: LTC0053

### DEPARTMENT OF HEALTH AND HUE N SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/ŞUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE COMP	SURVEY PLETED
		035099	B. WING			01/1	5/2019
	ROVIDER OR SUPPLIER	SING AND REHAB, LLC		29	REET ADDRESS, CITY, STATE, ZIP CODE 2000 EAST MILBER STREET UCSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE.	(X5) COMPLETION DATE
K 353	Section 19.3.5.1, "E care facilities shall approved, supervis in accordance with automatic sprinkler required by this Co and maintained in a 2011 Edition, "Stan Testing, and Maint Protection Systems "Water Based Extirmonthly, quarterly a sprinkler systems.  Findings include:  On January 15, 20	ety Code, 2012, Chapter 19, Buildings containing health be protected throughout by an ed automatic sprinkler system Section 9.7." Section 9.7.5 "All and standpipe systems de shall be inspected, tested, accordance with NFPA 25, dard for the Inspection, tenance of Water-Based Fire s." NFPA 25, 2011 Edition, aguishment Systems," requires and annual testing of automatic	K	853			
	written visual sprin past visual sprinkle system or control vexcept for the quarcompleted by the smonths since the labove findings the Administrator a Failure to conduct unidentified sprinkle potential for fire sprinkle for injury due to exprinkle to conduct unidentified sprinkle potential for fire sprinkle placing all residential for sprinkle placing all placin	ference on January 15, 2019 were again acknowledged by and Director of Maintenance.  inspections may result in ler system problems with rinkler failure in the event of a dents, staff, and visitors at risk posure to fire.	Three designations of the second seco				
K 511 SS=D	!		K	511			

## DEPARTMENT OF HEALTH AND HUI SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION 1 - MAIN BUILDING 01	(X3) DATE COMP	SURVEY PLETED
		035099	B. WING			01/1	5/2019
	RE OF TUCSON NUR	SING AND REHAB, LLC		290	REET ADDRESS, CITY, STATE, ZIP CODE 00 EAST MILBER STREET JCSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	1	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
K 511	Utilities - Gas and Equipment using g complies with NFF electrical wiring an NFPA 70, National	Electric  pas or related gas piping  A 54, National Fuel Gas Code, ad equipment complies with Electric Code. Existing  continue in service provided no	K	511			
	by: Based on observation facility did not allow equipment room emaintenance shows the section 19.5.1.1 Uprovisions of Section 19.5.1 Uprovisions o	ention it was determined the waccess to the main electrical electrical panels adjacent to the constitution of the state of the constitution of the electrical panels adjacent to the constitution of the considered of the con		e de la companya de l			

## DEPARTMENT OF HEALTH AND HUN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/16/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES IF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE COMF	SURVEY PLETED
		035099	B. WING			01/1	5/2019
	SUMMARY ST (EACH DEFICIENC	SING AND REHAB, LLC  ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	29 T X	FREET ADDRESS, CITY, STATE, ZIP CODE  900 EAST MILBER STREET  UCSON, AZ 85714  PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 761 SS=F	Findings include:  On January 15, 20 by the Director of generator/ compres of the main electric During the exit conthe above findings the Administrator and the Administrator an	of the surveyor accompanied Maintenance observed two essors stored within three feet cal room electrical panel.  Inference on January 15, 2019 is were again acknowledged by and Director of Maintenance.  In the store of the facility of the	K	761	1. The generator/compressor units we removed from within the main electric.  2. All residents could be affected by alleged deficiency.  3. The Maintenance Director will enselectrical panels are not blocked and clean. The Maintenance Director will the maintenance staff regarding keep electrical panels clear from being blow. The Maintenance Director will mocompliance and report to QAA Compliance and report to QAA Compliance months.	cal panel this ure all areas in-service bing cked. nitor for	3/3/19

Facility ID: LTC0053

## DEPARTMENT OF HEALTH AND HU SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/16/2019 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	8 MEDICAID SERVICES			V	IAID LAC'	<u> 1 800-006</u>
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE COMP	SURVEY PLETED
		035099	B. WING			01/1	5/2019
	PROVIDER OR SUPPLIER	SING AND REHAB, LLC		29	REET ADDRESS, CITY, STATE, ZIP CODE 2000 EAST MILBER STREET UCSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	)BE	(X5) COMPLETION DATE
K 761	Based on interview Maintenance it was have written docur Inspection and Test accordance with N "Standard for Fire Protective's "  NFPA 101 2012 Lither Fire door and Winder Green and Winder Green assembles and the hardware, including anchorage and sill requirements of N Doors and Other Cotherwise specific NFPA 80 Section Fire door assemble tested not less that record of the inspect of the AHJ. Section 5.2.3.1 Further window assemble individuals with kind the operating combeing subject to test NFPA 80 Section 5.2.5 Horizontal strolling Doors. Section 5.2.14.3 A rolling Doors.	w with the Director of sedetermined the facility did not mentation of the Annual sting of Door openings in FPA 80, 2010 Edition, doors and Other Opening fees Safety Code Section 8.3.3. Dopenings fire protection rating by Table otected by approved, listed assemblies and fire window eir accompanying gall frames, closing devices, in accordance with the FPA 80, Standard for Fire Opening protective, except as din this code.  5.2* Inspections Section 5.2.1* ies shall be inspected and annually, and a written ection shall be signed and kept on 5.2.3 Functional Testing. Inctional testing of fire door and as shall be performed by lowledge and understanding of aponents of the type of door esting.  13.4 Automatic closing Section liding, Vertically Sliding, and will horizontal or vertical sliding or hall be inspected and tested for proper operation at frequent		761	The Annual Door Inspection was schon 2/28/19. This inspection will be performed on 3/11/19 by contractors 2. All residents have the potential to affected by this alleged deficiency. 3. The Maintenance Director has estal a monitoring system to track all require. Safety Inspections.  4. All required Life Safety inspection be reported to the QAA Committee for months and as needed. The Administration will monitor for compliance.	Cintas. be ablished ired as will or three	3/3/19

Facility ID: LTC0053

## DEPARTMENT OF HEALTH AND HUN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	' '	IPLE CONSTRUCTION IG 01 - MAIN BUILDING 01	(X3) DATE	SURVEY PLETED ·
		035099	B. WING _	· · · · · · · · · · · · · · · · · · ·	01/1	15/2019
	ROVIDER OR SUPPLIER	SING AND REHAB, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2900 EAST MILBER STREET TUCSON, AZ 85714		Addition of the state of the st
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETION DATE
K 761	by the Director of Nathe facility did not in Annual Inspection of in accordance with Doors and Other Oardoor door did not smoke tight when to 1. Smoke barrier doors and Smoke barrier doors in 1. Smoke barrier doors in 1. Smoke doors in 1. Shower room 1.	18 the surveyor accompanied Maintenance it was determined have written records of the and Testing of Door Openings NFPA 80 Standard for Fire upening Protective's flowing smoke barrier doors or obt close and latch or were not ested three of three times.  Doors adjacent to patient room oors in A-2 hallway.  C-1 hallway adjacent to patient patient for its control of the patient opening of the patient opening of the patient opening of the surveyor in A-2 hallway.	K 76	51		
K 914 SS=F	the above findings the Administrator a Failing to inspect a assemblies in according could cause harm Electrical Systems CFR(s): NFPA 101 Electrical Systems Hospital-grade recolocations and when an esthesia is administallation, replace testing is performed.	ference on January 15, 2019 were again acknowledged by and Director of Maintenance.  Inditest fire rated door ordance with NFPA 80 annually to the patients.  - Maintenance and Testing	К9	14		

### DEPARTMENT OF HEALTH AND HU N SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - <b>MAIN BUILDING 01</b>		SURVEY PLETED
		035099	B. WING	i		01/	15/2019
	PROVIDER OR SUPPLIE RE OF TUCSON NUI	RSING AND REHAB, LLC		29	REET ADORESS, CITY, STATE, ZIP CODE 2000 EAST MILBER STREET UCSON, AZ 85714	·	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 914	tested at intervals isolation monitors intervals of less the actuating the LIM which activates be LIM circuits with a manual test is periodic equal to 12 month 6.3.3.3.2 after an electric distribution maintained of repairs or modificarea tested, and 6.3.4 (NFPA 99). This REQUIREM by:  Based on interview Maintenance it will failed to conduct, electrical receptar	grade at these locations are not exceeding 12 months. Line (LIM), if Installed, are tested at nan or equal to 1 month by test switch per 6.3.2.6.3.6, oth visual and audible alarm. For automated self-testing, this formed at intervals less than or ns. LIM circuits are tested per y repair or renovation to the n system. Records are juired tests and associated ations, containing date, room or		914			
	Section 4.6.12.4 condition, arrang fire-resistive cons requiring periodic to ensure its main inspected or ope the Code or as dijurisdiction. NFP/Code, 2012, Characeptacles not patient bed locatisedation or gene	afety Code, 2012, Chapter 4, Any device, equipment, system, ement, level of protection, struction, or any other feature testing, inspection, or operation ntenance shall be tested, rated as specified elsewhere in irected by the authority having A 99, Health Care Facilities pter 6, Section 6.3.4.1.3 listed as hospital-grade, at ons and in locations where deep ral anesthesia is administered, intervals not exceeding 12	Anna Carlos Carl		· ·		

## DEPARTMENT OF HEALTH AND HUN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	ECONSTRUCTION 11 - MAIN BUILDING 01	(X3) DATE COMP	SURVEY
		035099	B, WING		01/1	5/2019
	ROVIDER OR SUPPLIER	SING AND REHAB, LLC	29	REET ADDRESS, CITY, STATE, ZIP CODE 000 EAST MILBER STREET UCSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
K 914	by the Director of N surveyor he could on the receptacle t were tested in all of	age 13  19 the surveyor, accompanied Maintenance advised the not provide any documentation esting for patient care areas f 2017 since the last survey tion was provided to review for	K 914	The new Maintenance Director be receptacle testing in February and vecontinue as required.     All residents have the potential traffected by this alleged deficiency.     The Maintenance Director will expending the implementation of Preventive Maintenance Testing Preventive	vill o be nsure of the ogram. r	3/3/19
K 918 SS=E	was no documental receptacle testing.  During the exit conthe above finding to Administrator and Failing to test the receptacles could patient care area of the patients.  Electrical Systems CFR(s): NFPA 10° Electrical Systems Maintenance and The generator or and associated easervice within 10°s criterion is not me process shall be papability for the limit Maintenance and transfer switches with NFPA 110.	- Essential Electric System	K 918	1. The facility has hired a new Ma Director as of 2/7/19. The new Dideveloped a Preventive Maintena system to monitor and schedule a testing of the emergency generate 2. All resident could be affected alleged deficiency.  3. The Maintenance Director will required weekly testing of the ger occurs as required by the NFPA Safety Code. This will be accomputilizing the tracking system deve Preventive Maintenance systems 4. The Administrator will monitor	rector has nce Testing ill weekly or, oy this ensure all nerator 101 Life lished by loped for all	3/3/1

## DEPARTMENT OF HEALTH AND HUNN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION  1 - MAIN BUILDING 01		E SURVEY PLETED
		035099	B. WING	·		01/1	15/2019
	PROVIDER OR SUPPLIER	SING AND REHAB, LLC		29	REET ADDRESS, CITY, STATE, ZIP CODE 00 EAST MILBER STREET JCSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 918	under load conditions simulated cold state transfer of all EES competent person stored energy power accordance with Noticuit breakers are program for periodic components is est manufacturer requirement and readily available. Experience is a design installations. 6.4.4, 6.5.4, 6.6.4 111, 700.10 (NFP/This REQUIREMENT) Based on record Director of Mainter facility failed to do the emergency get Testing of the diese NFPA 101 Life Sasection 19.7.6 "Mainter authority havir "HEALTH CARE Section 3-5.4.1.1" Generator sets sets of the section sets is set of the section sets in the section sets is set of the section sets in the section sets is set of the section sets in the section sets is set of the section sets in the section sets is set of the section sets in the section sets is set of the section sets in the section set of the section sets in the section set of the section set	nuous hours. Scheduled test ons include a complete of and automatic or manual loads, and are conducted by nel. Maintenance and testing of the resources (Type 3 EES) are in IFPA 111. Main and feeder in the inspected annually, and a dically exercising the reablished according to differents. Written records of testing are maintained and the inspected panels and the readily identifiable, and mal power circuits. Minimizing amage of the emergency power consideration for new (NFPA 99), NFPA 110, NFPA		918			

## DEPARTMENT OF HEALTH AND HU. N SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

K 918 Continued From page 15 equipment systems shall be in accordance with NFPA 110, Chapter 6, Section 8.4.1 "Level 1 and continued from page 15. Section 8.4.1 "Level 1 and continued from page 15. Section 8.4.1 "Level 1 and continued from page 15. Section 8.4.1 "Level 1 and continued from page 15. Section 8.4.1 "Level 1 and continued from page 15. Section 8.4.1 "Level 1 and continued from page 15. Section 8.4.1 "Level 1 and continued from page 15. Section 8.4.1 "Level 1 and continued from page 15. Section 8.4.1 "Level 1 and continued from page 15. Section 8.4.1 "Level 1 and continued from page 15. Section 8.4.1 "Level 1 and continued from page 15. Section 8.4.1 "Level 1 and continued from page 15. Section 8.4.1 "Level 1 and continued from page 15. Section 8.4.1 "Level 1 and continued from page 15. Section 8.4.1 "Level 1 and continued from page 15. Section 8.4.1 "Level 1 and continued from page 15. Section 8.4.1 "Level 1 and continued from page 15. Section 8.4.1 "Level 1 and continued from page 15. Section 8.4.1 "Level 1 and continued from page 15. Section 8.4.1 "Level 1 and continued from page 15. Section 8.4.1 "Level 1 and continued from page 15. Section 8.4.1 "Level 1 and continued from page 15. Section 8.4.1 "Level 1 and continued from page 15. Section 8.4.1 "Level 1 and continued from page 15. Section 8.4.1 "Level 1 and continued from page 15. Section 8.4.1 "Level 1 and continued from page 15. Section 8.4.1 "Level 1 and continued from page 15. Section 8.4.1 "Level 1 and continued from page 15. Section 8.4.1 "Level 1 and continued from page 15. Section 8.4.1 "Level 1 and continued from page 15. Section 8.4.1 "Level 1 and continued from page 15. Section 8.4.1 "Level 1 and continued from page 15. Section 8.4.1 "Level 1 and continued from page 15. Section 8.4.1 "Level 1 and continued from page 15. Section 8.4.1 "Level 1 and continued from page 15. Section 8.4.1 "Level 1 and continued from page 15. Section 8.4.1 "Level 1 and continued from page 15. Section 8.4.1 "Level 1 and continued from page 15. Section 8.4.		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED		
SAPPHIRE OF TUCSON NURSING AND REHAB, LLC  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  K 918 Continued From page 15 equipment systems shall be in accordance with NFPA 110, Chapter 6, Section 8.4.1 "Level 1 and"			035099	B. WING			01/1	15/2019
K 918 Continued From page 15 equipment systems shall be in accordance with NFPA 110, Chapter 6, Section 8.4.1 "Level 1 and continued from page 15. Section 8.4.1 "Level 1 and continued from page 15. Section 8.4.1 "Level 1 and continued from page 15. Section 8.4.1 "Level 1 and continued from page 15. Section 8.4.1 "Level 1 and continued from page 15. Section 8.4.1 "Level 1 and continued from page 15. Section 8.4.1 "Level 1 and continued from page 15. Section 8.4.1 "Level 1 and continued from page 15. Section 8.4.1 "Level 1 and continued from page 15. Section 8.4.1 "Level 1 and continued from page 15. Section 8.4.1 "Level 1 and continued from page 15. Section 8.4.1 "Level 1 and continued from page 15. Section 8.4.1 "Level 1 and continued from page 15. Section 8.4.1 "Level 1 and continued from page 15. Section 8.4.1 "Level 1 and continued from page 15. Section 8.4.1 "Level 1 and continued from page 15. Section 8.4.1 "Level 1 and continued from page 15. Section 8.4.1 "Level 1 and continued from page 15. Section 8.4.1 "Level 1 and continued from page 15. Section 8.4.1 "Level 1 and continued from page 15. Section 8.4.1 "Level 1 and continued from page 15. Section 8.4.1 "Level 1 and continued from page 15. Section 8.4.1 "Level 1 and continued from page 15. Section 8.4.1 "Level 1 and continued from page 15. Section 8.4.1 "Level 1 and continued from page 15. Section 8.4.1 "Level 1 and continued from page 15. Section 8.4.1 "Level 1 and continued from page 15. Section 8.4.1 "Level 1 and continued from page 15. Section 8.4.1 "Level 1 and continued from page 15. Section 8.4.1 "Level 1 and continued from page 15. Section 8.4.1 "Level 1 and continued from page 15. Section 8.4.1 "Level 1 and continued from page 15. Section 8.4.1 "Level 1 and continued from page 15. Section 8.4.1 "Level 1 and continued from page 15. Section 8.4.1 "Level 1 and continued from page 15. Section 8.4.1 "Level 1 and continued from page 15. Section 8.4.1 "Level 1 and continued from page 15. Section 8.4.1 "Level 1 and continued from page 15. Section 8.4.			SING AND REHAB, LLC	:	29	000 EAST MILBER STREET		
equipment systems shall be in accordance with NFPA 110, Chapter 6, Section 8.4.1 "Level 1 and	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	(X5) COMPLETION DATE
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 920  Electrical Equipment - Power Cords and Extens		equipment systems NFPA 110, Chapter Level 2 EPSSs, incomponents shall be exercised under 110, Chapter 8, Se Level 1 and Level 2 least once monthly minutes  Findings Include:  On January 15, 20 by the Director of Magenerator test record documentation of and transfer times documented for for 1. Last week of Fe generator checks of 2. March 2018 the inspections to include for 30 minutes and 2. April 2018 the first yisual generator checks of the properties of March 2018 the first yisual generator of March 2018 the first yisual generator of March 2018 the first yisual generator of March 2018 the generator of March 2018 the first yisual generator of March 2018 the gener	s shall be in accordance with 6. Section 8.4.1 "Level 1 and cluding all appurtenant be inspected weekly and shall r load at least monthly. NFPA ction 8.4.2 "Generator sets in 2 service shall be exercised at 6, for a minimum of 30 and tests within 10 seconds were llowing periods.  bruary 2018 no weekly visual documented. entire month no weekly ude a monthly load bank test at transfer time not documented. rest three weeks, no weekly necks documented.  Inference the above findings wiedged by the Administrator aintenance.  and test and document the ator under load monthly and sual inspections and document power to emergency power m to patients during emergency m to patients during emergency					

## DEPARTMENT OF HEALTH AND HU N SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/16/2019 FORM APPROVED OMB NO. 0938-0391

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		035099	B. WING			01/	15/2019
	PROVIDER OR SUPPLIER	SING AND REHAB, LLC		29	REET ADDRESS, CITY, STATE, ZIP CODE 000 EAST MILBER STREET UCSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 920 SS=D	Electrical Equipment Extension Cords Power strips in a pused for compone patient-care-relate (PCREE) assembly qualified person 10,2,3,6. Power smay not be used felectronics), exceprooms that do not PCREE meet UL strips for non-PCF (outside of vicinity care rooms, powe standards. All powers and powers and powers and ards. All powers and powers and powers and powers in the substitute for fixed extension cords upon which it was instal 10,2,4. 10,2,3,6 (NFPA 98 (NFPA 70), 590,3 (This REQUIREMENT). Based on observational for a Christin NFPA 101, Life Sasetion 2,1 The foundation of the requirement of	ent - Power Cords and patient care vicinity are only	K	920	<ol> <li>The extension cord was taken or room 152.</li> <li>All residents could be affected be alleged deficiency.</li> <li>Staff in serviced on 2/22/19 regardered extension cords usage.</li> <li>The Maintenance Director will make for compliance.</li> </ol>	y this arding	3/3/19

Event ID: V3CM21

## DEPARTMENT OF HEALTH AND HU N SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES OF CORRECTION			(X2) MULTIPLE CONSTRUCTION  A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		035099	B. WING			01/	15/2019	
	PROVIDER OR SUPPLIER RE OF TUCSON NURS	SING AND REHAB, LLC		2	TREET ADDRESS, CITY, STATE, ZIP CODE 900 EAST MILBER STREET UCSON, AZ 85714			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE	
K 920	Chapter 6, Section Areas," Sections 6. 6.3.2.2.6.2 (E) Rec Number of Recepta receptacles shall be use of the patient of sufficient receptach need for extension adapters.  Findings include:  On January 15, 20 by the Director of Nof an extension contree in room 152. The plugged directly into the room.  During the exit conthe above findings the Administrator and Maintenance.  The use of multiple an overload of the	6.3.2,2.6.2, "All Patient Care 3.2,26.2 (A) through eptacles (2)" Minimum acles." "The number of e determined by the intended are area. There shall be es located so as to avoid the cords or multiple outlet  19 the surveyor, accompanied Maintenance observed the userd to be used for a Christmas he Christmas tree was not o the wall outlet receptacle in inference on January 15, 2019, were again acknowledged by and Director of the	K	920				

n-service Title:	<i>W////</i> ·	
Copics Discussed (May Attach C		^
Imployee Hand	Book / Attendance &	olica
Musias/Alm	ruch Duller	Site Safed Coles
nstructor's Name & Title:	MIGGINS, Administrate + Staff Geon Isely-DON	Customer Service
equired Departments: 4//	SHAFF Glow Psely-DON	answern; Cell &
Pate: 2/8/19 _		Odors, Cace Kour
Name – Please Print	Title	Hours Earned
Tagried Pervaiz	LPN	
jillia La Crojo	Operations	
Amber Stogner	CNA	
March Waldenado	UPN	
Heidi Snith	you.	
IKINB VAKAYE	pn	
Gnet Unchimbo	LPN	
LONNA BROOM	SLP	
FRENE ARRIERO	CNA	
MARY ELLEN WOZDIAN	mos rn	
ana Greenlee	Cota/L	
ENDER DOZINE	PZ LA14	
CHINA RUGOS	1 La rely reserving	
	HOUSEKEERY	I
Angela Edivards	HOUSEREPING	
1000 CA MARCH	Laurela 2	
Charles Will's	LPN	
MA COLLA	CWA	
ions in Ukriante	cha	
I da Tries.	119	
TA 1-AD (95-91	CNA	
licheola Cales	CNA	
A Jey Max	2 0 0 X C 10	A r



In-service Title:	All Stath	•
Topics Discussed (May Attach O	utline):	
nstructor's Name & Title:		
Required Departments:		
Name - Please Print	Title	Hours Earned
Manuela Brano	Mhuion	
Corinne Pineda	LPN	
Cornil morris	ALPH	
Jaimes icochea	floorteen	•
hungterpusan	LPN .	
JEFF ARMS TRang	Dret Aid	
amantha mallin	UPIV CM	
Child Brillian	Hr.	
Citally Cotienes	100	
DETIMULATION OF	PN Unit Manage	P
Lead dellar	RD 0	
me Hadley	Q ( ) A	
	CNA	
ta h. Ronero	CWA	t .
-Avocture Winn	Cor	
abon Untinez	CNA Diettech	
The state of the s	FIEL TECH	



The state of the s

In-service Title:	1 Stell	
Topics Discussed (May Attach Ou	utline):	
Instructor's Name & Title:		
Required Departments:		
Date: 28/19		
Name – Please Print	Title	Hours Earned
Verlone Antone	How Kening	
Desirae whitehead	Housekeeping	
Lilla Downs	nuersena	
Kyva Wigguns	GK-	
Tryp / (was		
Ana Kosas	ACT	
Tema Beck	med Kec	
Makylon Aguirre	HIM	
Mariah Arenivas	CNA	
Ernansy Homings	CNH	
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•		
·		1
		,
		:

# Inservice & Training Sign-In Sheet

PASRR & Procedure

Amelia Gabusi MSW

2/28/19

Name	Department/Title
Jean Cseley	RN DON
IRMA TINCE	RN MDS Dinecron
Marylou T. Aguirre	HIM
Patricia Soto	BH Director
Larina Copez	55
Abriana, Silva Samantha Malun	50
Carden Glover	CUPIN Upot Manager
Manualer Whe	Cho beh an
Christing Espinoza	Christing Esperara
Brittany Waldbillia	AN Jalana
J	

and on the same of the same of	19 100 100
to Coding of M	DS records
.11	
RMA TINUCCE, PA	/ MDS DIRECTOR
Coordinator	
Title	Hours Earned
MDS COOPDINATOR	/ Hour
<u> </u>	
	,
	,
	to Coding of M  utline):  and accuracy i  atur  Charlington  Title

In-service Title:	Plan Intervention	s Updati
Topics Discussed (May Attach (	Outline):	
all new orders wi	Il be reviewed by	The IDT team e
morning a clinica	rl. Care plans & is	nthurntime update
Instructor's Name & Title:		
Required Departments: The	apa MOS nus	ing, social services
Date: 2/25/19	0930 d	ing, social services ietary, activities
Name – Please Print	Title	Hours Earned
Deidre Pender	DOR Min	
IRMA TINVCCI	MDS OMERTON ).	
Amelia Gabrest	Social Servalino	
tatricia soto	BH Mag Director Se	
Gila Deloya	RN unit manager	
Joby Martinez	Dist tech	
Kanna liper	55	
Ana tosas	ACT	
Dean Cselly	DON SM Sel	KN.
11 MICHALINE	40/pm	J
.7.		
	-	
		,
3		

In-service Title: DAA Co	ommittee	,
Topics Discussed (May Attach O	utline):	
Plan of Cornect	tion for annual 3	Survey
Regrusements For	Systems to addre	es cale and Monajemone 15thata Practices
Instructor's Name & Title:	Rila NIGGIAS, ARMUNI	istrata fractices
Required Departments:	All Defartment	Managers
Date: 2/27/19		
Name - Please Print	Title	
1 Kirical GNUPER	Den Nus Dyn (	
LIMOTHY COBERTS	amothy Kober	<b>₹</b> , ∨
Jean Cselly	RN DON	AMERICA RV
Samantha Mallin	LPN CM	Slaven
Eitan Morse	JP5 .	Ent
C'Bochme.	HA	CBrehme
IRMATINUCCI	MD Jinecron	
Marylou T. Agairre	HIM	Mat
ratricu soto	Behavioral Leady ling Diver	
KUVIU LOPEZ	CS.	Kimm
Woly Martiner	Bet 7ech	2 ch
Ana Rosas	ACT	J.F.
Apriana Silva	SS	Apriano ilva
Deidre Pender	POR	Mindle
Dovid Beloya	HSk. Director	David
Gila Deloya	RN unit manager	Golye
Fyra Niggins	LAP	<i>X</i> 0
PRISTURESPINOR	Homesins	
Ben Larson	Cantral Supply	376-0
Juny Nunch	11 STASTING	Gaffa
Carolyn Glaver	LAN unit manager	
,	U	



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 Prepardness 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,

Sapphire of Tucson Nursing and Rehab, L.L.C. February 20, 2019
Page Two

- 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

iane, Edles

DE\sf

Attachments

## DEPARTMENT OF HEALTH AND HUNN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

(X2) MULTIPLE CONSTRUCTION

PRINTED: 01/16/2019 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

AND PLAN O	ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED	
		035099	B. WING			01/1	15/2019
NAME OF F	PROVIDER OR SUPPLIER			0.00	TREET ADDRESS, CITY, STATE, ZIP CODE		
SAPPHIR	RE OF TUCSON NURS	SING AND REHAB, LLC			900 EAST MILBER STREET UCSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
E 000	Initial Comments		ΕŒ	000	Correction does not constitute admi-	ssion or	
	42 CFR 483.73 Lo	ong Term Care Facilities.			agreement by the Provider of the tru facts alleged of the convictions set f	orth in he	)
	State and local emo requirements as ou Medicaid Programs Requirements of M	eet all applicable Federal, ergency preparedness itlined in the Medicare and s: Emergency Preparedness edicare and Medicaid lers and Suppliers Final Rule tember 16, 2016.			statement of deficiencies required b provisions of the Federal and State		
E 009 SS=C	acceptance of a pla Local, State, Tribal	Collaboration Process	Ε(	009		*	
	and maintain an en that must be review	n. The [facility] must develop nergency preparedness plan ved, and updated at least must do the following:]					
	collaboration with le Federal emergency to maintain an integ disaster or emerge documentation of the such officials and, participation in collaboration with left collaboratio	ocal, tribal, regional, State, and			DECEIVED MAR 5 - 2019		
ABORATOR	to maintain an integ disaster or emerge documentation of t	y preparedness officials' efforts grated response during a ncy situation, including he dialysis facility's efforts to	NATURE		10 TITLE		(X6) DATE
	Malle Mi	MM		1	Hammistreth 3	12/19	7

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.

Event ID: V3CM21

Facility ID: LTC0053

#### DEPARTMENT OF HEALTH AND HU N SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/16/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		035099	B. WING		1.000	01/1	5/2019
	PROVIDER OR SUPPLIER	SING AND REHAB, LLC		29	REET ADDRESS, CITY, STATE, ZIP CODE 100 EAST MILBER STREET JCSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
E 009	participation in colliplanning efforts. The local emergency least annually to confide the dialysis facilities are gency. This REQUIREME by:  Based on record right was determined the process for cooper local, tribal, regions emergency preparticity. The surveyor, alon Director of Mainter reviewed the facilities are gency Plan diagonal documentation, and collaboration with Federal emergency. The Administer and confirmed during the 15, 2019 that the findicate a process collaboration with the findicate and the surveyor and the surveyor alon Director of Mainter reviewed the facilities and the surveyor alon Director of Mainter reviewed the facilities and the surveyor and the surveyor along the surveyor and the surveyo	als and, when applicable, of its aborative and cooperative he dialysis facility must contact by preparedness agency at onfirm that the agency is aware try's needs in the event of an NT is not met as evidenced eview and staff interview, it e facility failed to include a ration and collaboration with al, State, and Federal edness officials.  In with the Administrator and nance on January 15, 2019 y's Emergency Plan. The id not indicate, with supportive process for cooperation and ocal, tribal, regional, State, and y preparedness officials.  In Director of Maintenance their exit conference on January acility emergency plan did not for cooperation and local, tribal, regional, State, and	E	009	1. The Administrator signed a Memor of Understanding (MOU) on 1/21/19 v Southern Arizona Health Care Coalitic 2. All residents have the potential to affected by this alleged deficiency.  3. The Administrator and Maintenand Director will be a part of all coalition a and training.  4. The Administrator will be responsite maintain active participation and membership in this coalition.	vith the on. be	3/3/19
E 015 SS=C	Failure to include a collaboration could and staff. Subsistence Need	y preparedness officials.  a process for cooperation and idead to harm to both patients is for Staff and Patients  (1)	E	015			

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: LTC0053

DEPARTMENT OF HEALTH AND HUNN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING \_\_ B. WING 035099 01/15/2019 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2900 EAST MILBER STREET SAPPHIRE OF TUCSON NURSING AND REHAB, LLC **TUCSON, AZ 85714** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION ID: (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) E 015 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

limited to the following:

following:

supplies.

(iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not

(A) Food, water, medical, and pharmaceutical

PRINTED: 01/16/2019

## DEPARTMENT OF HEALTH AND HU N SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	•	035099	B. WING			01/	15/2019
NAME OF PROVIDER OR SUPPLIER SAPPHIRE OF TUCSON NURSING AND REHAB, LLC				290	REET ADDRESS, CITY, STATE, ZIP CODE 00 EAST MILBER STREET ICSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
E 015	(B) Alternate sout following:	urces of energy to maintain the tres to protect patient health the safe and sanitary storage y lighting.		015			

## DEPARTMENT OF HEALTH AND HUNN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
			035099	B. WING			01/1	5/2019
NAME OF PROVIDER OR SUPPLIER SAPPHIRE OF TUCSON NURSING AND REHAB, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2900 EAST MILBER STREET TUCSON, AZ 85714					
	(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE,	(X5) COMPLETION DATE
	E 015	safety and for the sprovisions.  (B) Emergency I (C) Fire detection systems. (D) Sewage and Findings include:  On January 15, 20 Administrator and Ireviewed the facility did not include polition sewage and was During the exit continuity the above finding value Administrator and Failure to include presewage and waste could adversely implement to the sewage and waste could adversely implement of the sewage and proceed and proceed in the section. The previewed and update the section. The previewed and update the section in the section. The previewed and update the section in the section in the section. The previewed and update in the section in the section in the section in the section. The previewed and update in the section in the section in the section in the section in the section. The previewed and update in the section in the secti	ighting.  n, extinguishing, and alarm  waste disposal.  19 the surveyor, along with the Director of Maintenance, y's Emergency Plan. The plan cies and procedures to provide aste disposal.  Iference on January 15, 2019 was again acknowledged by the Director of Maintenance.  Colicies and procedures for disposal in an emergency pact resident care during an es for Medical Documentation (5)  rocedures. The [facilities] must ment emergency preparedness dures, based on the emergency tragraph (a) (1) of this section, risk ragraph (a)(1) of this section, eation plan at paragraph (c) of olicies and procedures must be ated at least annually. At a cies and procedures must		023	1. The facility developed a policy and procedure that addressed sewage and disposal during a disaster.  2. All residents have the potential to affected by this alleged deficiency.  3. The policy and procedure will be implemented in the facility EPP.  4. The Administrator will monitor for a updates and report to the QAA Committee months.	d waste be	3/3/19
ı								1

## DEPARTMENT OF HEALTH AND HUN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED			
		035099	B. WING			01/1	5/2019
	PROVIDER OR SUPPLIES	RSING AND REHAB, LLC		29	TREET ADDRESS, CITY, STATE, ZIP CODE 900 EAST MILBER STREET UCSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 023	preserves patient confidentiality of pand maintains ava (3),(4),(6)] A syste that preserves pare confidentiality of pand maintains ava *[For RNHCIs at procedures. (5) A that does the folio (i) Preserves patie (ii) Protects confid (iii) Secures and records.  *[For OPOs at §4 procedures. (2) A documentation the donor information potential and actus secures and main This REQUIREM by:  Based on review and staff interview failed to develop procedures that a documentation the protects confident secures and main Findings include:  The Administrator reviewed the faci surveyor on January and staff include:	redical documentation that information, protects patient information, and secures callability of records. [(5) or em of medical documentation tient information, protects patient information, and secures callability of records.  §403.748(b):] Policies and a system of care documentation owing:  ent information.  dentiality of patient information.  maintains the availability of estate preserves potential and actual and preserves potential and actual and protects confidentiality of unid donor information, and intains the availability of records.  ENT is not met as evidenced of the facility Emergency Plan, w, it was determined the facility and implement policy and address a system of medical callability of patient information, and intains availability of records.		023	<ol> <li>A policy and procedure was develonable.</li> <li>2/28/19 that addresses Protection of Information during a disaster and or emergency.</li> <li>All residents have the potential to affected by this alleged deficiency.</li> <li>The policy will be included the facter.</li> <li>The Administrator shall monitor for compliance and ensure any changes additions are included in the policy up. The Administrator shall report to QAA months.</li> </ol>	Patient be ility EPP. r or odates.	3/3/19

## DEPARTMENT OF HEALTH AND HU SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		035099	B. WING		And the state of t	01/1	5/2019
	PROVIDER OR SUPPLIER	SING AND REHAB, LLC		29	REET ADDRESS, CITY, STATE, ZIP CODE 00 EAST MILBER STREET JCSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	SE ATE	(X5) COMPLETION DATE
E 024 \$S=C	patient information patient information availability of recording the Administrator confirmed on Janu Emergency Plan disprocedures to addidocumentation, and Failure to include paddress a system preserved patient is confidentiality of pand maintained avergency could address and emergency could addring an emergency could address forth in passessment at parand the communic this section. The previewed and updiminimum, the policies the follow (6) (or (4), (5), or (volunteers in an estaffing strategies for integration of Strateg	documentation that preserved protected confidentiality of and secured and maintained ds.  and Director of Maintenance ary 15, 2019 the facility id not include policies and ress a system of medical d was updated annually.  colicies and procedures to of medical documentation that information, protected attent information, and secured allability of records in an adversely impact resident care necy.  concedures. The [facilities] must be ment emergency preparedness dures, based on the emergency aragraph (a) of this section, risk regraph (a) (1) of this section, cation plan at paragraph (c) of colicies and procedures must be ated at least annually. At a cies and procedures must be ated at least annually. At a cies and procedures must be ated at least annually. At a cies and procedures must be ated at least annually. At a cies and procedures must be ated at least annually at a cies and procedures must be ated at least annually. At a cies and procedures must be ated at least annually at a cies and procedures must be ated at least annually at a cies and procedures must be ated at least annually at a cies and procedures must be ated at least annually at a cies and procedures must be ated at least annually at a cies and procedures must be ated at least annually at a cies and procedures must be ated at least annually at a cies and procedures must be ated at least annually at a cies and procedures must be ated at least annually at a cies and procedures must be ated at least annually at a cies and procedures must be ated at least annually at a cies and procedures must be ated at least annually at a cies and procedures must be ated at least annually at a cies and procedures must be ated at least annually at a cies and procedures must be ated at least annually at a cies and procedures must be ated at least annually at a cies and procedures must be ated at least annually at a cies and procedures must be ated at least annually at a cies and procedures must be ated at least annually at a cies and procedures must be ated at least	11	023	The facility developed a policy and proto address the use of volunteers in an emergency or other emergency staffin strategies. 2/27/19  2. All residents have the potential to be affected by this alleged deficiency.  3. The Administrator will ensure the possimplemented in the Emergency Preparedness Plan.  4. The Administrator will report to QA Committee on this policy and procedure.	ng be policy	3/3/19

#### PRINTED: 01/16/2019 DEPARTMENT OF HEALTH AND HU N SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING 035099 B. WING ... 01/15/2019 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2900 EAST MILBER STREET SAPPHIRE OF TUCSON NURSING AND REHAB, LLC **TUCSON, AZ 85714** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) E 024 Continued From page 7 E 024 \*IFor 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 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,

address the following:

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

(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.

### DEPARTMENT OF HEALTH AND HU N SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/16/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED		
		035099	B. WING			01/1	5/2019
NAME OF PROVIDER OR SUPPLIER SAPPHIRE OF TUCSON NURSING AND REHAB, LLC				29	REET ADDRESS, CITY, STATE, ZIP CODE 000 EAST MILBER STREET UCSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 024	Continued From pa	ge 8	ΕC	)24			i.
E 025 \$S=C	Administrator and reviewed the facility did not include poli address the use of other staffing strate State and Federally professional during.  During the exit conthe above findings the Administrator at Failure to address emergency could aduring an emerger Arrangement with CFR(s): 483.73(b)  [(b) Policies and proceplan set forth in parassessment at parand the communication this section. The previewed and updaminimum, the policies at follow.  *[For Hospices at	ference on January 15, 2019 were again acknowledged by and Director of Maintenance the use of volunteers in an adversely impact resident care ncy. Other Facilities (7)  rocedures. The [facilities] must ment emergency preparedness dures, based on the emergency aragraph (a) of this section, risk ragraph (a)(1) of this section, cation plan at paragraph (c) of colicies and procedures must be atted at least annually. At a cies and procedures must ing:]  §418.113(b), PRFTs at		025			
	§441.184 (b) Hosp Facilities at §483. (7) [or (5)] The de	pitals at §482.15(b), and LTC 73(b):] Policies and procedures. velopment of arrangements with ad] other providers to receive	1				

Event ID: V3CM21

## DEPARTMENT OF HEALTH AND HUNN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

035099 B. WING		04/45/0040
		01/15/2019
CARREIDE OF THESON NURSING AND REHAR LLC	ET ADDRESS, CITY, STATE, ZIP CODE EAST MILBER STREET SON, AZ 85714	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION E DATE
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):] Policles 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.	The facility Administrator on 1/11/19 did locate the transfer agreements established with the following facilities: //illa Compana, Sabino Canyon Rehab, Devon Gables Rehab Center. All agreements are current and meet the equired standards.  All residents have the potential to be affected by this alleged deficiency.  The Administrator will maintain all agreements in the facility Emergency Preparedness binder and update as need. The Administrator will monitor for compliance and report to the QAA Common three months and as needed.	

### DEPARTMENT OF HEALTH AND HUNN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/16/2019 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING	(X3) DATE SURVEY COMPLETED	
035099 B. WING	/15/2019	
NAME OF PROVIDER OR SUPPLIER  SAPPHIRE OF TUCSON NURSING AND REHAB, LLC  SAPPHIRE OF TUCSON, AZ 85714  STREET ADDRESS, CITY, STATE, ZIP CODE 2900 EAST MILBER STREET TUCSON, AZ 85714		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
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 026 SS=C Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8)  [(b) Policies and procedures, The [facilitles] must develop and Implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) 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 RNHCls at §403,748(b):] Policies and procedures, (8) The role of the RNHCl 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	3/3/19 pe	

Event ID: V3CM21

### DEPARTMENT OF HEALTH AND HU N SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` ′	ING		COMPLETED	
		035099	B. WING		0,	1/15/2019
NAME OF PROVIDER OR SUPPLIER SAPPHIRE OF TUCSON NURSING AND REHAB, LLC			STREET ADDRESS, CITY, STATE, ZIP 2900 EAST MILBER STREET TUCSON, AZ 85714		į	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
E 026	by: Based on observative record review the implement emerge procedures to destat alternate care s Findings include:	ation, interview and facility facility failed to develop and ency preparedness policies and cribe its role in providing care ites during an emergency.	EO	026		
	Administrator and reviewed the facilidid not include pol describing the facilitreatment at altern waiver.  During the exit conthe above finding	on the surveyor, along with the Director of Maintenance ty's Emergency Plan. The plan licies and procedures illty's role in providing care and late care sites under an 1135 inference on January 15, 2019, was again acknowledge by the Director of Maintenance.	- Contractive via			
E 036 SS=F	procedures at alte harm to the reside EP Training and TCFR(s): 483.73(d) (d) Training and ted develop and main preparedness train based on the eme paragraph (a) of the paragraph (a)(1) of procedures at part the communication section. The train		E	036		

### DEPARTMENT OF HEALTH AND HU N SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/16/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>	TIPLE CONSTRUCTION ING		TE SURVEY MPLETED
		035099	B. WING		01	/15/2019
	PROVIDER OR SUPPLIER	SING AND REHAB, LLC		STREET ADDRESS, CITY, STATE, ZIP CO 2900 EAST MILBER STREET TUCSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
E 036	*[For ICF/IIDs at §4 testing. The ICF/IID an emergency prepared that is based forth in paragraph (assessment at parapolicies and proceduces and proceduces and proceduces and proceduces annually. The requirements for ex §483.470(h).  *[For ESRD Facilitit testing, and orientates develop and maintapreparedness train orientation program emergency plan sesection, risk assess this section, policie (b) of this section, policie (b) of this section, paragraph (c) of this and orientation proupdated at least an This REQUIREMED by:  Based on observative record review the frimplement emerge procedures for Emtesting program for Based on observative firesting Requirement emergence interview, it was desired.	B83.475(d):] Training and must develop and maintain paredness training and testing sed on the emergency plan set a) of this section, risk agraph (a)(1) of this section, dures at paragraph (b) of this mmunication plan at a section. The training and ust be reviewed and updated at ICF/IID must meet the vacuation drills and training at es at §494.62(d):] Training, thion. The dialysis facility must ain an emergency ing, testing and patient in that is based on the at forth in paragraph (a) of this sement at paragraph (a) of this sement at paragraph (a)(1) of and procedures at paragraph and the communication plan at its section. The training, testing gram must be reviewed and	E	036		

### DEPARTMENT OF HEALTH AND HU N SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/16/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TIPLE	(X3) DATE COMP	SURVEY LETED	
		035099	B. WING		A delignment of the second of	01/1	5/2019
	PROVIDER OR SUPPLIER	SING AND REHAB, LLC		29	REET ADDRESS, CITY, STATE, ZIP CODE 000 EAST MILBER STREET UCSON, AZ 85714		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X5) COMPLETION DATE
E 036	least annually.  Finding include:  On January 15, 20 Administrator and reviewed the facili did not include poid describing the devor a training and to based on the Emergency Prep  (d)(1) Training Promust do all of the  (i) Initial training in policies and procestaff, individuals parrangement, and their expected role (ii) Provide emergency Procedures.  On January 15, 2 Administrator and reviewed the facil Testing Requirem Preparedness Tedocumented the facil treatment of the faci	O19 the surveyor, along with the Director of Maintenance ty's Emergency Plan. The plan licies and procedures velopment and implementation esting program for the facility ergency Plan, facility risk the communications plan as  Training Program  Ogram. The Long Term Care following:  In emergency preparedness edures to all new and existing providing onsite services under a volunteers, consistent with the estimates. The training energy preparedness at least energy preparedness at least energy preparedness at least energy preparedness at least energy preparedness that is the Emergency Preparedness that is full-scale exercise that is		036	1. The new administrator (hired 1/11 the new Maintenance Director (hired will ensure the facility trains and tests plan for new and existing staff. This include: participation in a full-scale exthat is community based, facility base exercise, and a table-top exercise.  2. All residents have the potential to affected by this alleged deficiency.  3. The Administrator will ensure the reviewed annually and that drills are conducted according to state and fed regulations.  4. The Administrator will report to the Committee on when the drills and traoccurs. The Administrator will review QAA this requirement for three montas needed.	2/7/19) the EPP will tercise ed be EPP is leral e QAA ining w with the	3/3/19

### DEPARTMENT OF HEALTH AND HUTTON SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/16/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CON ING	(X3) DATE SURVEY COMPLETED			
		035099	B. WING		· · · · · · · · · · · · · · · · · · ·	01/	15/2019	
	PROVIDER OR SUPPLIER RE OF TUCSON NUF	RSING AND REHAB, LLC		STREET 2900 EA TUCSO				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
E 036	include, but is not (A) A second individual, facility- (B) A tabletop discussion led by clinically- relevant of problem statem prepared question emergency plan.  During the exit co the above findings the Administrator  Failure to provide training and testin untrained staff in may result in harmemergency. Failure	ditional exercise that may limited to the following: full-scale exercise that is based.  exercise that includes a group a facilitator, using a narrated, emergency scenario, and a set tents, directed messages, or as designed to challenge an inference on January 15, 2019 is were again acknowledge by and Director of Maintenance.  policy and procedures for the ag program may lead to an emergency situation and in to the residents during an are to conduct drills/exercises to by plan could lead to harm to	E	036				

### LONG-TERM CARE FACILITY APPLICATION FOR MEDICARE AND MEDICAID **Extended Survey:** Standard Survey: To: F4 (mmlddlyyyy) From: F1 (mmlddlyyyy) To: F2 (mmldd/yyyy) From: F3 (mm/dd/yyyy) Fiscal Year Ending: F5 (mm/dd/yyyy) Provider Number Name of Facility Sapphire of Tucson Nursing FRehab Street Address 035099 2900 .E. Milber St. Zip Code County 85714 Rima Incson State/Region Code: F8 Telephone Number: F6 State/County Code: F7 520-294-0005 Is this facility hospital based? F10 ...... Yes • No 01 Skilled Nursing Facility (SNF) - Medicare Participation If yes, indicate Hospital Provider Number: F11 02 Nursing Facility (NF) - Medicaid Participation 03 SNF/NF - Medicare/Medicaid Ownership: F12 For-Profit Non-Profit Government 07 State 10 City/County 04 Church Related 01 Individual 11 Hospital District 08 County 02 Partnership 05 Nonprofit Corporation 06 Other Nonprofit 09 City 12 Federal 03 Corporation 13 Limited Liability Corporation Name of Multi-Facility Organization: F14 Dedicated Special Care Units: (show number of beds for all that apply) F16 Alzheimer's Disease F17 Dialysis F15 AIDS F20 Hospice F19 Head Trauma F18 Disabled Children/Young Adults F23 Other Specialized Rehabilitation F22 Ventilator/Respiratory Care F21 Huntington's Disease Does the facility currently have an organized residents' group? F24...... Does the facility currently have an organized group of family members of residents?......O Yes 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 walved for each type of waiver granted. If the facility does not have a waiver, write NA in the blanks. Waiver of 24 hr licensed nursing requirement: Waiver of seven day RN requirement: Hours waived per week: F31 Date: F30 (mm/dd/yyyy) Hours waived per week: F29 Date: F28 (mmlddlyyyy) Name of Person Completing Form moureux Signature

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

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

		RESIL	DENT CENSUS AND	CONDITIO	ONS OF	RESI	DENT	S				
Provider No	).	Medicare F75 19	Medicaid F 129	76			Total	Residents F78 <i>178</i>				
ADL		Independent	Assis	t of One	or Tw	o Staf	f	Dependent				
Bathing	F79	9 /	F80	101				F81 76				
Dressing	F82	2 21	F83	138		F84 19						
Transferring	y F88		F86	111	***			F87	34	1.000		
Toilet Use	F88		F89	125				F90	30			
Eating	F91			27				F93 ·	14			
A. Bowel/B	ladder	· Status		B. Mot	oility							
F94	<u>26</u>	With indwelling or externa	l catheter	F100		<u>15</u>	Bedf	ast all or m	ost of time			
		total number of residents		F101		<u>121</u>	in a c	chair all or	most of tim	ne		
	•	were present on admission		F102		<u>21</u>	Indep	pendently a	ambulatory			
F96		Occasionally or frequently bladder		F103		<u>50</u>	Ambi devic		assistanc	e or assistive		
F97		Occasionally or frequently bowel	incontinent of	F104		<u>0</u>	Phys	ically restra	ained			
F98	<u>122</u>	On urinary toileting progra	m		F105					with restraints,		
F99 .	86	On bowel toileting program	n					were admit estraints <u>0</u>		lmitted with		
				F106		<u>38</u>	With	contracture	es			
					F107	contr				with ontracture(s) or		
C. Mental S	Intuc			D. Skin	ı İntea	ritv						
		ate the number of resider	nts with:		•	-	the n	umber of	residents	with:		
F108	<u>5</u>	Intellectual and/or develo		F115		<u>21</u>	Pres	ssure ulcer	s (exclude	Stage 1)		
F109	<u>75</u>	Documented signs and s depression			F116	uicers	s exclu		1, how m	with pressure any residents n 7?		
F110	<u>88</u>	Documented psychlatric dementias and depression		F117		<u>153</u>		eiving prev				
F111	<u>67</u>		ody, vascular or totemporal such as entia related to	F118		<u>0</u>	Ras	hes				
F112	<u>94</u>	Behavioral healthcare ne	eeds									
F113	hea	the total number of resider althcare needs, how many ividualized care plan to suj	have an									
F114	<u>0</u>	Receiving health rehabili Mt and/or ID/DD	itative services for									
				1								

Form CMS-672 (05/12)

Page: 1 of 2

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

					FIOOT All
E. Spec	cial (	Care			
F119-1	132 -	indicate the number of residents receiving:	F127	<u>0</u>	Suctioning
F119	<u>Z</u>	Hospice care	F128	<u>34</u>	Injections (exclude vitamin B12 injections)
F120	<u>0</u>	Radiation therapy	F129	<u>4</u>	Tube feedings
F121	<u>0</u>	Chemotherapy	F130	44	
F122	Z	Dialysis			chopped food (not only meat)
F123	Z	Intravenous therapy, IV nutrition, and/or blood transfusion	F131	<u>32</u>	Rehabilitative services (Physical therapy, speech- language therapy, occupational therapy, etc.) Exclude health rehabilitation for MI and/or ID/DD
F124	<u>8</u>	Respiratory treatment	F132	4	Assistive devices while eating
F125	1	Tracheostomy care			
F126	<u>10</u>	Ostomy care			
F. Medic	catlo	ns	G. Othe	er	
F133-1	39 -	indicate the number of residents receiving:	F140	<u>11</u>	With unplanned significant weight loss/gain
F133	<u>109</u>	Any psychoactive medication	F141	Z	Who do not communicate in the dominant
!	F134	49 Antipsychotic medications			language of the facility (include those who use American sign language)
ı	F135		F142	<u>0</u>	Who use non-oral communication devices
I	F136	8 88 Antidepressant medications	F143	<u>91</u>	With advance directives
,	F137		F144	<u>86</u>	Received influenza immunization
F138	<u>30</u>	Antibiotics	F145	<u>62</u>	Received pneumococcal vaccine
F139	<u>84</u>	On pain management program			
<del> </del>					

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

Signature of Person Completing the Form	Title	Date
Alrado	DON	1/8/19

### TO BE COMPLETED BY SURVEY TEAM

F146	Was ombudsman notified prior to survey?  Ves _ No		1
F147	Was ombudsman present during any portion of the survey?	Yes	<u>√</u> No
F148	Medication error rate 20 %		

1/8/19 March, Don



Last Update: 01/03/2019 Run Date: 01/04/2019 Job # 76551425

Page 1 of 5

Arizona

Phone Number: (520)294-0005 Participation Date: 02/05/1985 SAPPHIRE OF TUCSON NURSING AND REHAB, LLC CCN: 035099 2900 EAST MILBER STREET TUCSON, AZ 85714

Compliance Status: Provider meets requirements based on an acceptable plan of correction

State's Region Code: TUC

Provider Category: SNF/NF (DUAL) Provider Beds Total: 240

Type Action: RECERTIFICATION Type Ownership: FOR PROFIT - CORPORATION Certified: 240

## Program Requirements

1/06/2017
7.
Dates .
evisit
rvey/R
Su
Current

	30.00																1000	Wagner of the last										
		Requirement	F0154-INFORMED OF HEALTH STATUS, CARE, & TREATMENTS	F0156-NOTICE OF RIGHTS, RULES, SERVICES, CHARGES	F0157-NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)	F0159-FACILITY MANAGEMENT OF PERSONAL FUNDS	F0164-PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS	F0166-RIGHT TO PROMPT EFFORTS TO RESOLVE	F0167-RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE	F0174-RIGHT TO TELEPHONE ACCESS WITH PRIVACY	F0204-PREPARATION FOR SAFE/ORDERLY	F0221-RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS	F0223-FREE FROM ABUSE/INVOLUNTARY SECLUSION	F0225-INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS	F0226-DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES	F0241-DIGNITY AND RESPECT OF INDIVIDUALITY	F0242-SELF-DETERMINATION - RIGHT TO MAKE CHOICES	F0246-REASONABLE ACCOMMODATION OF	F0247-RIGHT TO NOTICE BEFORE ROOM/ROOMMATE	F0250-PROVISION OF MEDICALLY RELATED SOCIAL SERVICE	F0253-HOUSEKEEPING & MAINTENANCE SERVICES	F0258-MAINTENANCE OF COMFORTABLE SOUND LEVELS	F0272-COMPREHENSIVE ASSESSMENTS	F0278-ASSESSMENT ACCURACY/COORDINATION/CERTIFIED	F0279-DEVELOP COMPREHENSIVE CARE PLANS	F0280-RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F0281-SERVICES PROVIDED MEET PROFESSIONAL	F0309-PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING
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### CASPER Report 0003D Provider History Profile

Run Date: 01/04/2019 Job # 76551425 Last Update: 01/03/2019 Page 2 of 5

SAPPHIRE OF TUCSON NURSING AND REHAB, LLC CCN: 035099

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Requirement	F0312-ADL CARE PROVIDED FOR DEPENDENT RESIDENTS	F0313-TREATMENT/DEVICES TO MAINTAIN HEARING/VISION	F0314-TREATMENT/SVCS TO PREVENT/HEAL PRESSURE	F0315-NO CATHETER, PREVENT UTI, RESTORE BLADDER	F0318-INCREASE/PREVENT DECREASE IN RANGE OF MOTIC	F0323-FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F0328-TREATMENT/CARE FOR SPECIAL NEEDS	F0329-DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F0332-FREE OF MEDICATION ERROR RATES OF 5% OR MORE	F0333-RESIDENTS FREE OF SIGNIFICANT MED ERRORS	F0356-POSTED NURSE STAFFING INFORMATION	F0364-NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP	F0371-FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F0425-PHARMACEUTICAL SVC - ACCURATE PROCEDURES,	F0431-DRUG RECORDS, LABEL/STORE DRUGS &	F0441-INFECTION CONTROL, PREVENT SPREAD, LINENS	F0463-RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH	F0490-EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING	F0508-PROVIDE/OBTAIN RADIOLOGY/DIAGNOSTIC SVCS	F0513-X-RAY/DIAGNOSTIC REPORT IN RECORD-SIGN/DATED	F0514-RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE	F0520-QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLAN	
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Last Update: 01/03/2019 Run Date: 01/04/2019 Job # 76551425

Page 3 of 5

CCN: 035099 SAPPHIRE OF TUCSON NURSING AND REHAB, LLC

Edition of LSC Applied

LSC Deficiencies - Bldg # 01	K0281-Illumination of Means of Egress	K0321-Hazardous Areas - Enclosure	K0324-Cooking Facilities	K0331-Interior Wall and Ceiling Finish	K0353-Sprinkler System - Maintenance and Testing	K0363-Corridor - Doors	K0372-Subdivision of Building Spaces - Smoke Barrie	K0374-Subdivision of Building Spaces - Smoke Barrie	K0379-Smoke Barrier Door Glazing	K0511-Utilities - Gas and Electric	K0712-Fire Drills	K0741-Smoking Regulations	K0753-Combustible Decorations	K0781-Portable Space Heaters	K0914-Electrical Systems - Maintenance and Testing	K0923-Gas Equipment - Cylinder and Container Storag
	STD	STD	STD	STD	STD	STD	STD	STD	STD	STD	STD	STD	STD	STD	STD	STD
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Run Date: 01/04/2019 Job # 76551425

Last Update: 01/03/2019

Page 4 of 5

CCN: 035099 SAPPHIRE OF TUCSON NURSING AND REHAB, LLC

## **Deficiency Summary**

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

# Complaint Survey Information

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



Run Date: 01/04/2019

Last Update: 01/03/2019 Job # 76551425

Page 5 of 5

CCN: 035099 SAPPHIRE OF TUCSON NURSING AND REHAB, LLC

## LTC Resident Census

Resident Census on 10/05/2017

Fotal: 152

Medicare: 7

Medicaid: 120 Other: 25

ICF/IID 0 Total Certified Beds: 240 Ľ o SNF/NF 240 SNF

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

3/25/2019

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

rizona Department of Healt Division of Public Health

I tennetue Comitence

MAR 26 2019

150 N. 18th Ave #400 Phoenix. AZ 85007

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

MAR 2 6 2019

By



3/2/19

Diane Eckles, Bureau Chief AZDHS 150 North 18<sup>th</sup> 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

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MAR 5 - 2019

By