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

# MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL
## PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: YZPM11
Facility ID: LTC0053

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **035099**

2. STATE VENDOR OR MEDICAID NO. (L2) **835118**

3. NAME AND ADDRESS OF FACILITY
(L3) **AVALON SOUTHWEST HEALTH & REHABILITATION**
(L4) **2900 EAST MILBER STREET**
(L5) **TUCSON, AZ** (L6) **85714**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY (L34)

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital, 05 HHA, 09 ESRD, 13 PTIP, 22 CLIA, 02 SNF/NF/Dual, 06 PRTF, 10 NF, 14 CORF, 03 SNF/NF/Distinct, 07 X-Ray, 11 ICF/IID, 15 ASC, 04 SNF, 08 OPT/SP, 12 RHC, 16 HOSPICE

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

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

10. THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
X 1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A1*** (L12)

12. Total Facility Beds **240** (L18)

13. Total Certified Beds **240** (L17)

14. LTC CERTIFIED BED BREAKDOWN

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

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
Avalon Southwest is back in compliance with federal regulations based on acceptable plan of correction 04/21/2016 (S/S None) recertification is recommended effective 06/27/2016 .

17. SURVEYOR SIGNATURE Date: Joel Bunes / Dede Adams Team Lead Sv 06/27/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date: [signature] 06/27/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **02/05/1985** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **01101** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

**Public Health Licensing Services**
*Bureau of Long Term Care Licensing*
150 North 18th Avenue, Suite 440
Phoenix, Arizona 85007-3242
(602) 364-2690 Office
(602) 324-0993 Fax

DOUGLAS A. DUCEY, GOVERNOR
CARA M. CHRIST, MD, DIRECTOR

April 14, 2016

Mr. Brian Balliet, Administrator, Administrator
Avalon Southwest Health & Rehabilitation
2900 East Milber Street
Tucson, AZ 85714

Dear Mr. Balliet:

Enclosed please find the Statement of Deficiencies and Plan of Correction for the Complaint Investigation # YZPM11 conducted on February 26, 2016 which was submitted to the Bureau of Long Term Care on April 13, 2016.

The Plan of Correction is unacceptable for the following reasons:

Per your disclaimer, "the submission of this plan is not an admission that a deficiency exists" and that "the facility is filing this plan of correction solely because it is required by federal and state law."

Based on these statements it appears the plan of correction is being filed only because it has to be filed according to law. This is not a credible allegation of compliance as there is no indication you intend to make any of the corrections or changes stated on the plan of correction.

Please either change the disclaimer or add a sentence stating you intend to make the changes outlined.

The revised Plan of Correction must be returned to this office no later than **April 22, 2016,** retaining a copy for your files. If the Plan of Correction is not received by this office on or before this date, 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.

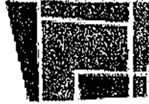
Sincerely,

Joel Bunis

Joel Bunis, MBA
Bureau Chief

bh

Enclosure



ARIZONA DEPARTMENT OF HEALTH SERVICES
LICENSING

**Public Health Licensing Services**
*Bureau of Long Term Care Licensing*
150 North 18th Avenue, Suite 440
Phoenix, Arizona 85007-3242
(602) 364-2690 Office
(602) 324-0993 Fax

DOUGLAS A. DUCEY, GOVERNOR
CARA M. CHRIST, MD, DIRECTOR

June 28, 2016

Brian Balliet, Administrator
Avalon Southwest Health & Rehab
2900 East Milber Street
Tucson, AZ 85714

Dear Mr. Balliet:

Enclosed is the **Post-certification Revisit Report** forms which indicate that the following deficiencies were found to be corrected on 06/27/2016 at the time of the follow-up investigation to Complaint #YZPM12. A copy will be filed in your public file.

Thank you for the time extended to us during the recent inspection of your facility. Please contact the Bureau of Long Term Care at (602) 364-2690 if we may be of assistance.

Sincerely,

Belinda Hernandez
Examine Technician II

\ib

Enclosures

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

# POST-CERTIFICATION REVISIT REPORT

| PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER | MULTIPLE CONSTRUCTION | DATE OF REVISIT |
|---|---|---|
| 035099 Y1 | A. Building<br>B. Wing Y2 | 6/27/2016 Y3 |

| NAME OF FACILITY | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| AVALON SOUTHWEST HEALTH & REHABILITATION | 2900 EAST MILBER STREET<br>TUCSON, AZ 85714 |

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

| ITEM Y4 | DATE Y5 | ITEM Y4 | DATE Y5 | ITEM Y4 | DATE Y5 |
|---|---|---|---|---|---|
| ID Prefix F0428<br>Reg. # 483.60(c)<br>LSC | Correction Completed 04/01/2016 | ID Prefix F0431<br>Reg. # 483.60(b), (d), (e)<br>LSC | Correction Completed 04/01/2016 | ID Prefix<br>Reg. #<br>LSC | Correction Completed |
| ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |
| ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |
| ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |
| ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |

| REVIEWED BY STATE AGENCY ☒ | REVIEWED BY (INITIALS) AA | DATE 6/27/16 | SIGNATURE OF SURVEYOR [signature] | DATE 6/27/16 |
|---|---|---|---|---|
| REVIEWED BY CMS RO ☐ | REVIEWED BY (INITIALS) | DATE | TITLE | DATE |

| FOLLOWUP TO SURVEY COMPLETED ON 2/26/2016 | ☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO |
|---|---|

**Public Health Licensing Services**
*Bureau of Long Term Care Licensing*
150 North 18th Avenue, Suite 440
Phoenix, Arizona 85007-3242
(602) 364-2690 Office
(602) 324-0993 Fax

DOUGLAS A. DUCEY, GOVERNOR
CARA M. CHRIST, MD, DIRECTOR

June 27, 2016

Brian Balliet, Administrator
Avalon Southwest Health & Rehab
2900 East Milber Street
Tucson, AZ 85714

Dear Mr. Balliet:

On February 26, 2016, complaint survey YZPM11 was conducted at your facility. You have alleged that the deficiencies cited on that survey have been corrected. We are accepting your allegation of compliance and presume that you have achieved substantial compliance. Based on this presumed compliance, we are not forwarding to the Centers for Medicare/Medicaid Services (CMS) Regional Office and/or the State Medicaid Agency our recommendation that the remedies we indicated in our letter to you of 04/01/2016 be imposed at this time.

We may be conducting a revisit of your facility to verify that substantial compliance has been achieved and maintained. We will certify your facility in compliance if we find that your facility is in substantial compliance at the time of the revisit. If we find that your facility has failed to achieve or maintain substantial compliance, the following remedies (or revised, if appropriate) will be imposed:

Civil money penalty of $200.00, effective February 26, 2016

A civil money penalty, if imposed, will continue until you have achieved substantial compliance or your provider agreement is terminated

If you have any questions concerning the instructions contained in this letter, please call the Bureau of Long Term Care at (602) 364-2690.

Sincerely,

Belinda Hernandez
Examine Technician II

JB/bh

cc: State Ombudsman (with POC)

**Public Health Licensing Services**
*Bureau of Long Term Care Licensing*
150 North 18th Avenue, Suite 440
Phoenix, Arizona 85007-3242
(602) 364-2690 Office
(602) 324-0993 Fax

DOUGLAS A. DUCEY, GOVERNOR
CARA M. CHRIST, MD, DIRECTOR

April 01, 2016

Mr. Brian Balliet, Administrator
Avalon Southwest Health & Rehabilitation
2900 East Milber Street
Tucson, AZ 85714

Dear Mr. Balliet:

The purpose of this letter is to inform you that the Department of Health Services, Bureau of Long Term Care has investigated complaint #YZPM11 on February 26, 2016. During this investigation, some deficiency(ies) were found. A statement of Medicare deficiencies is attached to this letter.

**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).**

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 **April 16, 2016**. You must include all pages of the Statement of Deficiencies when submitting your PoC. Avalon Southwest Health & Rehabilitation failure to submit an acceptable PoC by **04/16/2016** 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.

Mandatory Remedies

**Your current period of noncompliance began on February 26, 2016. 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 08/24/2016.**

Recommended Remedies

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

Civil money penalty of $200.00 per day, effective February 26, 2016

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 **05/24/2016.** 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.

Appeal Rights

If you disagree with the determination of noncompliance (and/or substandard quality of care, if applicable), you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board. Procedures governing this process are set out in 42 CFR §498.40, et. seq. You may appeal the finding of noncompliance that led to an enforcement action, but not the enforcement action or remedy itself.

A written request for hearing must be filed no later than (60 days from the date of receipt of this letter). Such written request should be made directly to:

**Attention: Ms. Karen Robinson**
**Departmental Appeals Board**
**Civil Remedies Division**
**Cohen Building, Room G-644**
**330 Independence Avenue S.W.**
**Washington, D.C. 20201**

A request for 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 be represented at a hearing by counsel at your own expense.
Be sure to include a copy of this letter with your request to the Departmental Appeals Board. In addition, please forward a copy of your request to:

**Attention: Paula Perse, Manager**
**Long Term Care Branch**
**Division of Survey and Certification**
**Centers for Medicare & Medicaid Services**
**90 1h Street, Suite 5-300 (5W)**
**San Francisco, CA 94103-6707**

**Alternatively, you can file your appeal electronically** at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at https://dab.efile.hhs.gov. To file a new appeal using DAB E-File, you first need to register a new account by: (1) clicking Register on the DAB E-File home page; (2) entering the information requested on the "Register New Account" form; and (3) clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.

The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user's access to DAB E-File is restricted to the appeals for which he or she is a party or authorized representative. Once registered, you may file your appeal by:

-Clicking the File New Appeal link on the Manage Existing Appeals screen, then clicking Civil Remedies Division on the File New Appeal screen.
And,
-Entering and uploading the requested information and documents on the "File New Appeal-Civil Remedies Division" form.

At minimum, the Civil Remedies Division (CRD) requires a party to file a signed request for hearing and the underlying notice letter from CMS that sets forth the action taken and the party's appeal rights. All documents must be submitted in Portable Document Format ("PDF"). Any document, including a request for hearing, will be deemed to have been filed on a given day, if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day. A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the Administrative Law Judge, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service. More detailed instructions on DAB E-File for CRD cases can be found by clicking the CRD E-File Procedures link on the File New Appeal Screen for CRD appeals.

**If you choose to file your appeal electronically, please also send a copy of the hearing request to:**

**Attention: Paula Perse, Manager**
**Long Term Care Branch**
**Division of Survey and Certification**
**Centers for Medicare & Medicaid Services**
**90 7th Street, Suite 5-300 (5W)**
**San Francisco, CA 94103-6707**

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 **04/10/2016.**

**If, upon a subsequent revisit, your facility has not achieved substantial compliance, the Office 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.**

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 Joel Bunis, 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 **April 16, 2016,** 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,

Joel Bunis, MBA
Bureau Chief

JB:bh

Attachments

AOC 4.1.16
APOC 4.21.16

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

PRINTED: 04/01/2016
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 035099 | A. BUILDING ______<br>B. WING ______ | C<br>02/26/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| AVALON SOUTHWEST HEALTH & REHABILITATION | 2900 EAST MILBER STREET<br>TUCSON, AZ 85714 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 000 | INITIAL COMMENTS<br><br>A complaint (AZ00133448, AZ00130654, AZ00131417, AZ00132297, AZ00131802, AZ00132636, AZ00132712, AZ00132820, AZ00132901, AZ00130584, and AZ00132735) investigation survey was conducted on February 22 through February 24, 2016. The following deficiencies were cited. | F 000 | "This plan of correction constitutes the facility's allegation of compliance for the deficiencies cited in the CMS 2567. However, the submission of this plan is not an admission that a deficiency exists. The Plan of Correction is prepared solely because it is required by federal and state law. This response and Plan of Correction does not constitute an admission or agreement by the provider of the facts alleged or the conclusions set forth in the Statement of Deficiencies. We have implemented the Plan of Correction as stated below to correct the deficiencies cited." | |
| F 428<br>SS=E | 483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON<br><br>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.<br><br>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on clinical record review, facility documentation, and staff interview, the facility failed to act on a pharmacist recommendation to discontinue a resident #1 medication even after the physician saw the review and agreed with the pharmacist.<br><br>Findings include:<br><br>Resident #1 was admitted to the facility on November 22, 2013, with diagnoses that include bipolar disorder, major depressive disorder, intermittent explosive disorder, and hemiplegia. | F 428 | **F428**<br><br>The requirement is not met as evidenced by: Based on clinical record review, facility documentation, and staff interview, the facility failed to act on a pharmacist recommendation to discontinue a resident #1 medication even after the physician saw the review and agreed with the pharmacist.<br><br>**Continue on next page...** | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Brian D. Balbut
TITLE: NURSING HOME ADMINISTRATOR
(X6) DATE: 4/21/16

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 035099 | A. BUILDING ______ B. WING ______ | C 02/26/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| AVALON SOUTHWEST HEALTH & REHABILITATION | 2900 EAST MILBER STREET TUCSON, AZ 85714 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 428 | Continued From page 1<br><br>Review of the resident's physician's order revealed two anti-psychotic medications ordered.<br>-Geodon capsule 160 milligrams (mg) given by mouth at dinner ordered October 3, 2015.<br>-Haldol 3 mg by mouth two times a day ordered September 24, 2015.<br><br>Review of the clinical record revealed a pharmacy monthly consultation dated October 24, 2015, that asked if the Haldol could be discontinued and the Geodon capsule could be increased in strength as the Haldol had much worse side effects then the Geodon capsule. It went on to say that the benefits from both medications were pretty much equal. The physician reviewed the recommendation and agreed to the recommendation on November 9, 2015.<br><br>Review of the Medication Administration Record (MAR) dated February 2016, documents that both medications are being administered to the resident at this time and that no changes were ever made to either medication.<br><br>An interview was conducted with the Director of Nurses at 9:45 a.m. on February 24, 2016, where she related how the pharmacy recommendations are handled. She said the forms first come to her and she distributes them to the physicians to review and sign. They are then sent to medical records for auditing if their was any changes in orders and then entered into the electronic chart. She said somehow this was missed. | F 428 | **How corrective action will be accomplished for those residents found to have been affected by deficient practice.**<br><br>Residents #1 Haldol was discontinued.<br><br>**How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br><br>All residents could potentially be affected.<br><br>The DON/designee shall review all pharmacy recommendations after the MD/NP has signed off to ensure they are noted and appropriate action has been taken.<br><br>**What measures will be put into place or what systemic changes the facility will make to ensure the deficient practice does not reoccur.**<br><br>DON/designee will note all pharmacy recommendation after the MD/NP has reviewed and signed.<br><br>Medical Records staff have been educated on 2/19/2016 not to scan in any recommendation until the DON/designee has noted the order.<br><br>**Continue on next page...** | |
| F 431 SS=D | 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS<br><br>The facility must employ or obtain the services of | F 431 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 035099 | A. BUILDING ______ B. WING ______ | C 02/26/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| AVALON SOUTHWEST HEALTH & REHABILITATION | 2900 EAST MILBER STREET TUCSON, AZ 85714 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 431 | Continued From page 2<br>a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br><br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on clinical record review, facility documentation, and staff interview, the facility failed to ensure for one resident (#2) that the reconciliation of the resident's Oxycodone was | F 431 | **How facility plans to monitor its performance to make sure solutions are sustained.**<br><br>The DON or designee will monitor all pharmacy recommendations monthly.<br><br>Responsible Individual: DON<br><br>Date of Compliance: 4/01/2016<br><br>**F431**<br><br>This requirement is not met as evidenced by: Based on clinical record review, facility documentation, and staff,interview, the facility failed to ensure for one resident (#2) that the reconciliation of the resident's Oxycodone was complete and accurate when comparing the Medication Administration Record and the Controlled Drug Record.<br><br>**Continue on next page...** | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 035099 | A. BUILDING ______ B. WING ______ | C 02/26/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| AVALON SOUTHWEST HEALTH & REHABILITATION | 2900 EAST MILBER STREET TUCSON, AZ 85714 |

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|---|---|---|---|---|
| F 431 | Continued From page 3 complete and accurate when comparing the Medication Administration Record and the Controlled Drug Record.<br><br>Findings include:<br><br>Resident #2 was admitted to the facility March 13, 2015, with diagnoses that include schizophrenia, dementia, bipolar disorder, and chronic pain.<br><br>Review of the physicians orders for the resident an order for Oxycodone HCL 5 milligrams (mg) a narcotic pain reliever, to be given every 4 hours as needed for pain level of 5 thru 10 on the 10 point pain scale.<br><br>Review of the Medication Administration Record (MAR) for the resident revealed that on September 18, 2015, 1 dose of Oxycodone was given at 4:42 a.m..<br><br>Review of the Controlled Drug Record for the resident's Oxycodone revealed that four doses were signed out on the 18th of September 2015. They were at 4:41 a.m., 11:45 a.m., 4:05 p.m., and 8:10 p.m.. The last three dose times do not appear on the resident's MAR. A quick review four doses were signed out for September 7, 2015, and no Oxycodone was signed out on the MAR. It appears that the reconciliation between the two sign out forms are not complete and accurate.<br><br>An interview was conducted with the Director of Nurses at 9:50 a.m. on February 24, 2015, and she could not explain why the Oxycodone was signed off on the Controlled Record but not the MAR. | F 431 | **How corrective action will be accomplished for those residents found to have been affected by deficient practice.**<br><br>Residents #2s orders have been reviewed and staff have been educated on 2/19/2016 to follow the orders.<br><br>**How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br><br>All residents could potentially be affected.<br><br>Completed 4/01/2016.<br><br>**What measures will be put into place or what systemic changes the facility will make to ensure the deficient practice does not reoccur.**<br><br>All staff received education on 2/19/2016 regarding following orders as written. Audits will be conducted weekly for three months by DON/Designee to ensure orders are being followed as written.<br><br>**Continue on next page ...** | |

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| --- | --- | --- | --- | --- |
| | | | **How facility plans to monitor its performance to make sure solutions are sustained.**<br><br>The DON or designee will identify trends from weekly audits and report to the Quality Assurance Committee for a minimum of three months or until our QAPI team deems a lesser frequency is appropriate.<br><br>Responsible Individual: DON<br><br>Date of Compliance: 04/01 | |

April 21, 2016

Mr. Joel Bunis, MBA
Bureau Chief
Bureau of Long Term Care Licensing
150 North 18th Avenue, Suite 440
Phoenix, AZ 85007-3242

Dear Mr. Bunis:
Enclosed please find the Statement of Deficiencies with the corresponding Plans of Correction for each of the citations received from the investigation of complaint #YZPM11, February 26, 2016. Included are the F-Tags and the Y-Tags.

This corrected Plan of Correction is in response to the Unacceptable Plan of Correction letter dated April 14, 2016.

Please accept this Plan of Corrections as the credible allegation of substantial compliance.

Please contact me with any questions.

Sincerely,

Brian D. Balliet
Administrator